POLICIES AND PROCEDURES
for
Community Behavioral Health Rehabilitation Services



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

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Policy Revision Record
from 2024 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
01/01/2025	Appendix C	Modified Procedure and Rate Table (New Rates)	M	
01/01/2025	Appendix D and H	Modified Georgia Families, Georgia Families 360 and Non-Emergency Medical Transportation (NEMT) Appendices.	M	
01/01/2025	Appendix J	Remove Appendix J (Blank Page)	D	

[1] The revisions outlined in this Table are from 2024 to current. For revisions prior to 2024, please see prior versions of the policy.

Community Behavioral Health Rehabilitation Services
Chapter 600: Special Conditions of Participation

601. Definition of Services

Community Behavioral Health Rehabilitation Services (CBHRS) are those services provided by outpatient mental health centers to persons of age 4 and above who are emotionally or mentally disturbed, drug or alcohol abusers.

602. Enrollment

602.1. Enrollment is open to all providers who meet the conditions of participation in Part I Policies and Procedures for Medicaid/Peachcare for Kids (Part I) and meet the special conditions listed in Part II Policies and Procedures, Section 603.

602.2. To enroll, the applicant must complete the DBHDD Application and the Medicaid Provider Enrollment packet.

602.3. The applicant must FIRST follow and complete the DBHDD established procedures for becoming a Provider of Behavioral Health Services. The procedure is found at the following website: www.dbhdd.georgia.gov

602.4. Upon completion of the DBHDD established procedures for becoming a Provider of Behavioral Health services, DBHDD will notify applicants that have met the requirements and that they have been recommended to DCH for enrollment as a Medicaid Provider. That notification will also include a specific directive to complete the online Facility Application or Additional Location Application for Medicaid Provider Enrollment. (10/2014)

602.5. ONLY applicants that have received this notification should go online and complete the facility or additional location application for Medicaid Provider Enrollment. Any online applications for the CBHR Program submitted by applicants who have not completed the DBHDD established procedures and have not been specifically directed to submit will not be processed.

602.5.1. Instructions on how to complete the online application can be accessed as follows:

602.5.2. Go to www.mmis.ga.gov

602.5.3. Click ‘Provider Information’

602.5.4. Click ‘Web Portal Training’

602.5.5. Scroll down to find the ‘Online Enrollment form Behavioral Health COS 440 Providers – Step by Step’

602.5.6. Applicants may also call (800) 766-4456 for assistance with completing the online application.

602.6. DBHDD recommends providers for approval or denial of enrollment to DCH. DCH requires a recommendation for approval from DBHDD for DCH approval of any Medicaid provider application. If the application is denied, DBHDD and DCH will notify the applicant of the reason for the denial. Applicants have the right to appeal an enrollment denial as indicated in Part I, Policies and Procedures for Medicaid/Peachcare for Kids Manual.

NOTE: Applicants may not re-apply as a CMH provider for one (1) year after date of denial.

602.7. Gainwell Technologies reviews and sends an approval letter with a provider number and corresponding approved service name(s) to the provider.

602.8. Once approved by Gainwell Technologies, a Letter of Agreement or Provider Agreement from DBHDD is required for participation in this program.

602.9. Providers are responsible for notifying the DBHDD that they are approved to conduct business. The DBHDD grants approval to operate and has the provider sign a Letter of Agreement or Provider Agreement.

602.10. Loss of or failure to maintain a Letter of Agreement or Provider Agreement with DBHDD will result in termination of the provider's Medicaid enrollment.

603. Special Conditions of Participation

CBHRS agencies must:

603.1. Be determined eligible by the Department of Behavioral Health and Developmental Disabilities (DBHDD)

604. For Providers approved prior to June 30, 2010:

604.1. Be fully and appropriately nationally accredited, as defined by the DBHDD policy, or

604.2. Have applied to one of the national accrediting bodies identified in Section 604 below and be within the eighteen (18) month allowed time between the date of the DBHDD approval and the achievement of national accreditation.

605. For Providers approved after July 1, 2010:

605.1. Be fully and appropriately nationally accredited, as defined by the DBHDD policy, and

605.2. Meet the conditions established by DBHDD as contained in the DBHDD Provider Manual for the Department of Behavioral Health & Developmental Disabilities and the DBHDD contract specific to the provision of these services.

605.3. Maintain such records as are necessary to fully disclose the extent of services provided and to furnish DBHDD with information upon demand

605.4. Provide accurate documentation of costs and agree to participate in cost studies as requested to determine reimbursement rates for services

605.5. Develop a billing system to report to DCH to appropriately identify and bill all liable third parties (Part I Policy and Procedures, Section 106).

606. Provider Certification

Each provider of CBHRS must be accredited and then approved as a provider by DBHDD in accordance with the procedures in this manual and as articulated in the **DBHDD** Provider Manual for the Department of Behavioral Health & Developmental Disabilities. The electronic version of this manual is located at http://dbhdd.georgia.gov/portal/site/DBHDD. The DBHDD's provider enrollment process requires that these organizations fully and appropriately comply with requirements and standards of one of the following national accreditation entities: The Joint Commission on Accreditation for Healthcare Organizations (TJC), Commission on Accreditation for Rehabilitation Facilities (CARF), Council on Accreditation of Services for Children and Families, Inc. (COA), and/or the Council on Quality Leadership (CQL).

All applications for Provider Enrollment must be sent directly to the DBHDD.

607. Categories of Applicants

Providers will find that they will fall into categories for application to this CBHRS

Provider Category	Guidance
New Provider	Please see www.dbhdd.georgia.gov, "Provider Enrollment" for specific instructions in completing application.
Current Provider requesting New Services at a currently established site	Please see www.dbhdd.georgia.gov, "Provider Enrollment" for specific instructions in completing application
Current Provider requesting New Services at a new site	Please see www.dbhdd.georgia.gov, "Provider Enrollment" for specific instructions in completing application
Current Provider requesting address change	Memo to the Department of Community Health, Provider Enrollment, cc: to Maya Carter (Division of Medicaid) and Camille Richins (Department of DBHDD), which articulates the site from which the agency is moving services and the site to which the agency is moving services. This memo must include an effective date.

Chapter 700: Special Eligibility Conditions

701. Special Eligibility Conditions

In addition to the special conditions listed in Part I, the following requirements also must be met.

701.1. Services must be provided to Medicaid eligible members who are emotionally disturbed, mentally ill, or addicted to substances or are users of substances.

701.2. Members as a general practice may not receive services while a resident or an inmate of an institution (state hospital) or, jail.

701.3. An outpatient is a person who is receiving services/supports in accordance with behavioral health criteria as outlined in the State of Georgia DBHDD Provider Manual and is an identified Medicaid member.

NOTE: For specific instructions related to serving Nursing Home residents please refer to Appendix I for full description of PASRR.

Chapter 800: Prior Approval

801. Prior Approval

Prior Authorization is required for services in the CBHRS program. DCH and DBHDD use an external review organization for issuing prior authorization. Service limitations are contained in the DBHDD Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases. For each consumer deemed medically necessary, an initial amount of service is authorized. The provider may obtain authorization for additional segments/types of service by contacting the external review organization.

The Division of Medicaid reimburses providers only for services that are medically necessary, provided by approved providers of that specific service, and are provided in compliance with applicable policies and procedures.

NOTE: The units indicated on a member's service plan should reflect an amount that is medically necessary *for that individual*. A member-specific number of units or a reasonable range of units must be determined for each member served. The number of units in a member's service plan should not automatically equal the maximum number of units available for the services/procedure codes in the prior authorization package unless absolutely and medically necessary.

Chapter 900: Scope of Services

901. Definition of Community Behavioral Health Services (CBHRS)

CBHRS are those services/supports provided by outpatient behavioral health agencies offering a comprehensive range of mental health services or specialty services that meet conditions of the Medicaid Program (Care Management Organizations who utilize this program may have varied specifications to this rule which will be specified in CMO-Provider Agreements and to which providers shall adhere).

902. Covered Services

902.1. Specific services or procedures covered by the Division are listed below. The service definitions recognized by the Division are contained in the DBHDD Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases All procedure codes billed to the Division must match the service definition and be titled and described in the progress notes of the client's record.

902.2. To be reimbursed for services, providers must be approved by the DBHDD and enrolled by the Division of Medicaid for each applicable procedure.

Providers who want to enroll for new procedures should contact the: Department of DBHDD
200 Piedmont Avenue, S.E. West Tower, 14th Floor
Atlanta, GA 30334
(404) 232-1622

902.3. Services may be provided outside the clinic if the following conditions are met:

902.3.1. Services are not provided in public institutions or, free- standing psychiatric hospitals.

902.3.2. The out-of-center service is clinically or programmatically necessary or will lead to member enhancement

903. Non-Covered Services

903.1. Services provided to patients in intermediate care facilities, public institutions, or in free-standing psychiatric facilities (except services provided on the date of admission or date of discharge to PRTF) are non-covered services, except as described above for Health Check (EPSDT) eligible children, and adults excepting transition planning for those moving from institutions in accordance with service guidelines

903.2. Services which are not provided in compliance with the services and limitations described in this manual or the DBHDD Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases are not eligible for reimbursement.

904. Related Services

Other direct, indirect services, administrative or support services (other than those defined herein) to members, charting or internal (within an agency) coordination, are included in rates developed for services listed in Sub-Section 902 above as prescribed in the Manual of Accounting and Reporting Specifications for CBHRS.

905. Mental Health Center Pharmacy Reimbursement

Pharmacies operating within CBHRS are exempt from the Division's policy regarding the reimbursement limitation of six (6) new prescriptions or refills per member per calendar month. All other policies and procedures which apply to all enrolled pharmacy providers also apply to those enrolled pharmacies operating within CBHRS.

Chapter 1000: Basis For Reimbursement

1001. Rate Methodology

Rates per procedure code are determined based on a cost accounting reporting methodology and information from time studies. Following review of cost reports by the Division of Medicaid and the Department of Behavioral Health & Developmental Disabilities, rates for existing procedures will be calculated from the median base year cost and the rates for new procedures will be based on estimated cost and utilization data. A single statewide reimbursement rate will be established for each procedure code. * Rate adjustments are made as deemed necessary by the Division. Re imbursement rates are based on the lower of actual reasonable costs or the limitations as set forth in federal regulations

* The rates for each procedure code are listed in Appendix C.

1002. General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the **claim cannot be paid**.

Effective 4/1/2014, DCH will edit claims for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

1002.1. For claims entered via the web:

1002.1.1. Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

1002.2. For claims transmitted via EDI:

1002.2.1. The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

1002.3. The following resources are available for more information:

1002.3.1. Access the department's DCH-i newsletter and FAQs at http://dch.georgia.gov/publications

1002.3.2. Search to see if a provider is enrolled at https://www.mmis.georgia.gov/portal/default.aspx

Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider's last name.

1002.3.3. Access a provider listing at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provid er%20Notices/tabId/53/Default.aspx

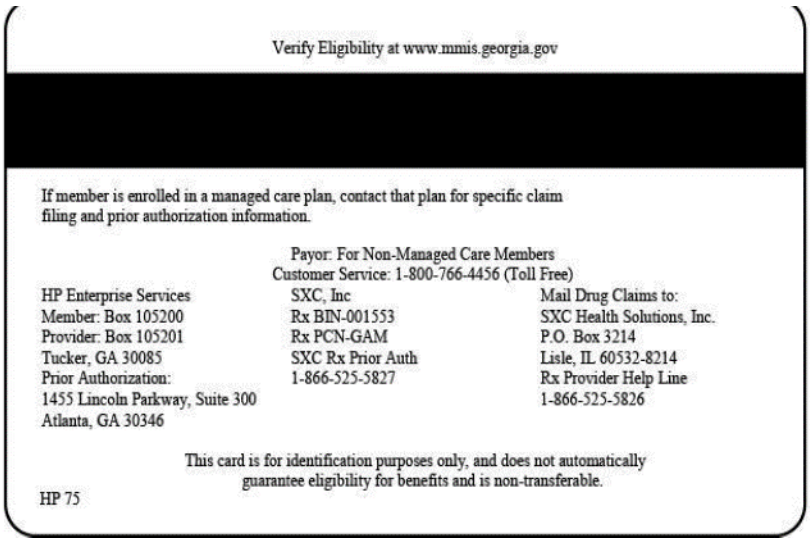
Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

Appendix A
Gainwell Technologies Contact Information

The most current and accurate contact information for Gainwell Technologies can be found at the following link: https://www.mmis.georgia.gov/portal/PubAccess.Contact%20Information/Links/tabId/45/Default.aspx

Appendix B
Medicaid Member Identification Card Sample





Appendix C
Procedure Code and Rate Table

For information on the Procedure Codes and Rate table, please access the overview document at the following link:

https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/NOTICES/cbhrs%20(cos%20440)%20july%201%202024%20code%20listing%20with%20increased%20rates%20202412030195905.pdf

Appendix D
Georgia Families, Georgia Families 360

For information on the Georgia Families or Georgia Families 360, please access the overview document at the following link:

i. Georgia Families Overview: https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

ii. Georga Families 360 Overview: https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

Appendix E
Audit Protocol

DCH Policy: Response to Audits Performed by DBHDD via the External Review Organization

The Department of Community Health (DCH) and its partner, the Department of Behavioral Health and Developmental Disabilities (DBHDD), are invested in compliance and adherence to standards for the Medicaid CBHRS. To this end, these Departments contract with an External Review Organization (ERO), a Utilization Review Accreditation Commission (URAC) accredited organization, to conduct compliance and quality audits of participating behavioral health providers.

A. Audit Procedures

Audits provide the Departments with detailed analysis regarding core components of compliance and quality of service delivery within the Medicaid Rehabilitation Option. Audit and scoring procedures are outlined in the ERO policy and supporting documents found at http://www.georgiacollaborative.com/providers/prv-quality.html

B. Notification of Audit Results

Results of provider audits are simultaneously distributed to DCH, DBHDD, and the audited provider by the ERO.

C. Adverse Actions

In addition to any action imposed by DBHDD, DCH and/or the DCH Program Integrity Unit (PIU) will make a determination regarding the necessity of any adverse action as defined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual, chapter 400 (hereinafter "Part I"). Any adverse action taken by DCH may be appealed in accordance with Part I.

i. Procedures

Procedures for critical issues found in audits

Audits that reveal the following critical issues will be immediately referred to the DCH PIU:

Suspicion of fraud

(i) Suspicion of Member endangerment

Audits that reveal the following issues may result in a recommendation for an adverse action as defined in Part I

(ii) Unlicensed staff providing services that require the skill of a licensed practitioner;

(iii) 30% or more of records reviewed having no diagnosis by a practitioner authorized by Georgia law to assign a diagnosis; Any single component of the audit remains below 70% for 3 consecutive audit cycles or total average score below 70% for 3 consecutive audit cycles.

ii. Procedures for findings of unjustified claims

All findings of unjustified claims found during the ERO audit are included in the audit findings and additional information is forwarded to DCH PIU upon request. The DCH PIU will make a determination regarding the necessity of any adverse action as defined in Part I.

iii. DBHDD Procedures in response to audit scores below 70%

One score above 50% and below 70%

(a) Within 10 business days of the audit summary being posted by the ERO, DBHDD will submit a "yellow flag" notice to DBHDD Regional Office, DCH Policy Section, and PIU via email notification.

Two consecutive scores above 50% and below 70%:

(b) Within 10 business days of the audit summary being posted by the ERO, DBHDD will submit a "red flag" notice to the DBHDD Regional Office, DCH Policy Section, and PIU via email notification; and

(c) DBHDD may recommend a course of action to DCH. Recommendations may include:

(i) Prepayment Review managed by DCH;

(ii) Suspension of new members being allowed to access services through the provider agency;

(iii) Suspension or Termination of the provider enrollment number for DHBDD services in accordance with Part I; and/or

(iv) Any other recommended course of action determined appropriate

Three consecutive scores above 50% and below 70%:

(d) Within 10 business days of the audit summary being posted by the ERO, DBHDD will submit an urgent notice to the DBHDD Regional Office, DCH Policy Section, and PIU via email notification; and

(e) DBHDD may recommend a course of action to DCH. Recommendations may include:

Recommendations may include:

(i) Prepayment Review managed by DCH;

(ii) Suspension of new members being allowed to access services through the provider agency;

(iii) Suspension or Termination of the provider enrollment number for DHBDD services in accordance with Part I; and/or

(iv) Any other recommended course of action determined appropriate.

Any audit score of 50% or below:

(f) Within 10 business days of the audit summary being posted by the ERO, DBHDD will submit an urgent notice to the DBHDD Regional Office, DCH Policy Section and PIU via email notification; and

(g) DBHDD may recommend a course of action to DCH. This recommendation may include:

(i) Prepayment Review managed by DCH;

(ii) Suspension of new members being allowed to access services through the provider agency;

(iii) Suspension or Termination of the provider enrollment number for DHBDD services in accordance with Part I; and/or

(iv) Any other recommended course of action determined appropriate

DCH Procedures in response to audit findings and/or program integrity concerns:

(h) The DCH will communicate as necessary with DBHDD via regular and/or ad hoc meetings or otherwise to review audit findings, consider the recommendations of DBHDD, and determine whether to take action. Such action may include:

(i) Prepayment Review managed by DCH;

(ii) Suspension of new members being allowed to access services through the provider agency;

(iii) Suspension or Termination of the provider enrollment number for DHBDD services in accordance with Part I; and/or

(iv) Any other recommended course of action determined appropriate.

The DCH reserves the right to pursue adverse action for cause, including termination, in accordance with the Part I and/or Part II Policy and Procedures Manual(s) independent of DBHDD recommendations or ERO audit findings.

Appendix F
Maintenance Of Records

Maintain such written records for Medicaid/PeachCare for Kids members as necessary to disclose fully the extent of services provided and the medical necessity for the provision of such services, for a minimum of five (5) years after the date of service.

Providers should ensure that member records are forwarded to a member's new provider during a change of ownership, voluntary or involuntary termination, transfer of a member to a new provider or any other action that requires the review of member records to determine course of treatment.

Member records must, at a minimum, reflect the date of service, member name and medical history, the service provided, the diagnosis and the prescribed drugs or treatment ordered, and the signature of the treating provider. The Department will accept secure electronic signatures as defined in the Definitions section of this Manual.

Appendix G
Pasrr Process and Specialized Services

All nursing facilities (NFs) must be in compliance with Federal Regulations 42CFR483.100-138, Subpart C the Preadmission Screening and Resident Review (PASRR) function. Applicants and residents with suspected serious mental illness (SMI) and intellectual disability/related condition (ID/RC) are required to be evaluated by Department of Behavioral Health and Developmental Disabilities (DBHDD) regardless of the pay source, prior to admission into the facility or due to a resident's change in condition. DBHDD will evaluate the applicant or resident to determine:

i. There is a diagnosis of SMI and/or ID/RC

ii. The individual requires the level of care appropriately provided by a nursing facility

iii. The individual requires specialized services for the determined diagnoses

Specialized Services (SS) are services provided by the NFs in combination with other service providers to implement an individualized plan of care (POC). The POC is developed to contribute to the prevention of regression or loss of current functional status through treatment to stabilize and/or restore the level of functioning that preceded any acute episode for the resident. The POC is also directed toward the acquisition of behaviors necessary for the resident to function with as much independence as possible.

Information regarding "Dual Eligible" (Medicaid and Medicare) member's access to Community Mental Health Services:

iv. Those residents with dual eligibility in the Medicare and Medicaid programs will receive mental health care reimbursed through the Medicare program, with Medicaid as the payor of last resort.

v. Though not available in all areas of the State, Medicare-funded mental health services are currently provided to nursing home residents via telemedicine, face-to-face visits by providers in the nursing home, and nursing home resident visits to psychiatric/mental health clinics/offices for those individuals able to travel outside the nursing facility

NOTE: Though 440 codes allow for Medicaid members to have a variety of mental health professionals serve members in nursing facilities, please note that Medicare has more stringent requirements regarding these professionals to serve the Medicare eligible members in nursing facilities. (Please review the approved practitioner levels listed later in this appendix.) When Nursing Facilities refer/coordinate Specialized Services for the PASRR approved resident, Nursing Facility staff should communicate to the Community Behavioral Health Service Provider (CBHSP), the DCH enrolled MH provider that the member is either dual eligible or Medicare only.

NOTE: The listing of Community Behavioral Health Service Providers are listed at the end of this appendix.

A. PREADMISSION SCREENING (PAS)

The PAS process begins with a Level I Assessment (DMA-613). The Division's Medical Management Contractor (MMC) evaluates the DMA-613 and Level I and refers applicants requiring a Level II assessment (i.e., those who are suspected of or diagnosed with SMI, ID/RC) to the DBHDD PASRR contractor. The Level II assessment is a comprehensive medical, psychosocial and functional assessment. There are two (2) Level II instruments used by DBHDD for both SMI and ID/RC for PASRR determinations: (a)

the record review for all assessments; and (b) the Face-to-Face assessment for applicants or residents when the record review is insufficient to make a conclusive determination. DBHDD may apply categorical determinations for the PAS based on certain diagnoses, levels of severity of illness, or need for a particular service that indicate that admission to a NF is warranted. DBHDD may also determine provisional admissions, with time limits, pending further assessment due to delirium, for emergency protective services placement not more than 7 days, or for respite. (Longer stays would require a Level II Resident Review).

A PAS is required prior to the initial entry into the nursing facility and for current residents who present a behavioral health change or status change as identified by the MDS 3.0 A1500. The PAS as identified by the MDS 3.0 status change is a Residential Review (RR). A PAS is also required for re-entry of a resident that has a "break in service" due to discharge of resident out of the system to home and then seeks to return to a nursing facility.

Individuals discharged from a hospital directly to a nursing facility for a stay of less than 30 days for treatment of a condition for which they were hospitalized, will not require a PAS, provided the attending physician certified before the admission that the admission is for an anticipated stay of not more than thirty (30) days and treatment continues for the same acute care diagnosis. No PAS will be required for readmission to a nursing facility within one (1) year of a previous Level II for an individual or for an individual transferred to an acute care hospital for treatment, with the exception of mental health stabilization. A PAS is required for re-admission of individuals who meet any one of the following criteria regardless of date for previous Level II:

i. Is diagnosed with a new SMI condition

ii. Is transferred to an acute care hospital for SMI treatment

iii. Any Hospitalization over one year in length

The PAS provides information that the nursing facility staff can use in performing the Resident Assessment and in patient care planning. A PAS may serve as a starting point for the initial mental health assessment and/or treatment plan for the resident after admission to a nursing facility.

B. PASRR ASSESSORS (Level II)

Level II screening is triggered by a diagnosis or suspicion of SMI/ID/RC on the Level I and is performed by the DBHDD contractor

i. Assessors complete Level II assessments on any individual referred with a confirmed or suspected SMI/ID/RC diagnosis for first time admissions or for residents (RR) with identified SMI or ID, who demonstrates a significant change in physical or psychological status (the Status Change Assessment as identified by the MDS 3.0).

ii. Assessors make initial contact with the hospital or nursing facility staff for the patient's record for clinical review (a record review).

iii. If a determination can be made from the clinical review that the patient does not have a serious MI or ID/DD, then NF approval may be given dependent on the record review.

iv. Categorical determinations permit the Assessors to omit the full Level II Evaluation in certain circumstances that are time-limited or where need is clear.

v. If the record review finds that the patients does have MI or ID/DD, then an on-site Face- to-Face evaluation must be made.

vi. Assessors contact the individual listed on the intake referral form (PAS assessments) or a nursing facility staff member to schedule a convenient time to conduct the Face-to-Face assessment.

vii. Assessments are completed during regular/customary working hours (excluding official State holidays and weekends). Assessments may be conducted outside normal business hours only for the convenience of the facility, applicant or resident, or the resident's family.

viii. The assessor arrives at the hospital or nursing facility with appropriate identification which includes a letter of introduction from DBHDD contractor identifying the assessor as an agent of DBHDD.

ix. Nursing facility or hospital staff will make available copies of the most recent physical examination performed or signed by a physician, the most recent care plan and any other pertinent information.

C. LEVEL II ASSESSMENT

i. In order to complete the Level II assessment, the assessor will need access to the individual's medical record and will need copies of pertinent medical data. The assessor is responsible for conducting a face-to-face interview with the individual within five (5) days of Level II request. The assessor should meet with the facility staff who is knowledgeable of the individual, as well as available family members (if permission is obtained from the resident or legal guardian).

ii. Federal law requires each Level II assessment to include a physical examination signed by a physician. If a physician does not conduct the physical examination, a physician must review and concur with the findings presented in a previous examination's documentation. In order to fulfill this requirement, the assessor will need a copy of the resident's most recent physical examination performed and/or signed by a physician.

The Level II assessment will determine and report the following:

1.the individual's diagnoses

2.whether the individual meets criteria for a nursing facility level of care.

3. whether the individual requires specialized services

If the individual needs SMI or ID/RC services, treatment recommendations will be included. The Level 2 assessor will make every attempt to discuss the findings with the requesting entity, usually the hospital or nursing facility.

The DBHDD contractor will send a Summary of Findings, including the determinations made to the nursing facility and the member. A Prior-Authorization (PA)number is generated and issued out to the admitting nursing facility. The nursing facility must ensure that the PA number is documented in the appropriate section 9A or 9B on the DMA-6. The DMA-6 and the Summary of Findings should be placed in the front of the resident's file so that the PA number and medical data are available to review by surveyors from the Department's, Healthcare Facilities Regulation Division (HFR) (formerly known as the Office of Regulatory Service) and other professionals.

Additionally, all Level 2 findings are used in development of the resident's plan of care. The nursing facility must request a copy of an individual's Summary of Findings from DBHDD contractor once an individual has been admitted to the facility.

Contact information for the Level II assessment staff:
Phone: 1-855-606-2725
Website: www.GeorgiaCollaborative.com

The DBHDD contractor is required to notify applicants and residents both verbally and in writing, of the outcome of the assessment and interpret the assessment findings. Verbal notification is made by phone to applicants and residents or their legal representatives. A written notice is mailed to applicants and residents or their legal representatives, as well as to the individual's primary care physician and hospital (if applicable).

D. TRANSFERS

When a resident transfers from one nursing facility to another, there is specific information that must be communicated to the new facility by the current facility to ensure coordination and continuity of care for the resident receiving Specialized Services as approved through PASRR. In addition, documentation by the nursing facility staff is required for all referrals to community mental health service providers. Community Behavioral Health (CBH) Service Provider Agency name and date of referral including follow up on the status of the referral is required. The following documentation should follow the resident/member to the new facility:

i. DMA-613

ii. DMA-6 – with Prior-Authorization number as assigned by GMCF or Beacon Health Options for new facility to share with CBH provider to coordinate specialized services and Medicaid facility reimbursement

iii. Resident's Diagnosis

iv. Beacon Health Options' Evaluation/Summary of Findings

v. CBH notes and information regarding resident's SMI information (Acquired from copy in NH chart):

1.Symptom's behaviors or skill deficits

2.Treatment Plan and Objective

3. Interventions

4. On-going progress toward the objectives

5. Termination or discharge summary

E. OUT-OF-STATE APPLICANT/RESIDENT

PASRR assessors will coordinate all out-of-state assessments. For any individual residing in another state

who desires nursing facility placement in Georgia, the PASRR process remains the same. Level 2 assessors will arrange for the PASRR office in the applicant's state of residence to complete a PASRR screening. The Level II assessment will be forwarded to DBHDD for determination. The PA number will be issued using the same process as in state resident admissions and documented in the appropriate section 9A or 9B on the DMA-6.

F. DENIALS, ALTERNATIVE PLACEMENTS AND APPEALS

Applicants have the right to appeal PASRR Level II findings. A letter of denial will be issued by the Level 2 assessor to individuals who do not meet criteria for a nursing facility level of care. Residents will not be discharged based on a PASRR denial until a discharge notice is issued by the Division of Medical Assistance. Residents or their family members will be advised of their appeal rights in the denial letter. Alternative placements for residents requiring discharge will be coordinated with DBHDD in accordance with federal regulations.

i. Any applicant requesting an appeal must do so in writing within 10 working days following the receipt of the Medical History Assessment/Summary of Findings. The appeal must detail the rationale for the 'ineligible' decision. If additional documentation needs to be sent, the provider may fax or mail this information. The appeal should be addressed to:

PASRR Project Director
Beacon Health Options
Phone: 1-855-606-2725
Website: www.GeorgiaCollaborative.com

ii. The PASRR Project Director, Medical Director, or the designee will review the appeal, review the evaluator's Summary of Findings, and interview the appropriate Level II Healthcare Evaluator. A response will be sent to the applicant within 5 business days of receipt of the PASRR Level II appeal. The response will include:

A determination to uphold or overturn the decision

If overturned, what steps will be taken to correct the decision

If upheld, the rationale to maintain the decision

iii. The applicant may request an appeal through DBHDD. Upon receipt of the second written appeal notification, Beacon Health Options will contact DBHDD. The DBHDD designee may request additional information from either party if deemed necessary. The DBHDD designee has 5 business days to make a determination and respond in writing to the applicant and to Beacon Health Options.

G. NURSING FACILITY SPECIALIZED SERVICES

Effective July 1, 2009, the Department has approved Community Behavioral Health Service Providers (CBHS) to provide specialized services to residents in the PASRR SMI and dually diagnosed (SMI and ID/RC) population; services which are beyond those services typically provided in a nursing home. Nursing facilities are required to maintain the most recent copies of the Level II assessment and the Summary of Findings for all residents in the PASRR population residing in the facility.

Once resident is admitted to the nursing facility, nursing home staff will contact enrolled community

mental health service providers to arrange an assessment or treatment plan development and collaboratively determine the need for ongoing mental health services. The CBHS Providers will be responsible for providing specialized services to Medicaid recipients that are above and beyond those services typically provided in a nursing facility. The NF is responsible for scheduling appointments and ensuring member's presence at each appointment, as well as obtaining or providing services of a lesser intensity than specialized services to appropriate non-Medicaid and Medicaid residents. Refer to section on "dually" eligible recipients on page H-4 of this appendix.

The NF and CBHS providers will communicate to arrange for the provision of specialized services to residents either in the nursing facility, via telemedicine, or at the Community Behavioral Health location. The service location will be determined by the condition of the resident, ability to travel to the nearest clinic, and evaluation of both nursing facility and mental health staff regarding the most appropriate service delivery venue for the individual resident. If the nursing home resident can be assessed and treated in the outpatient clinic, NET transportation can be used to facilitate this visit. Those residents whose interest is best served by receiving mental health services in the nursing facility or in a nearby telemedicine site can receive services in either of those locations, with the practitioner using out-of-clinic or telemedicine procedure codes.

The CBHS provider documents the specific services provided to residents in the nursing facility chart to include the individual's treatment plan, progress, and goals. The CBHS provider consults with NF staff regarding the resident's behaviors, progress in the treatment plan, and outcomes to ensure continuity of care and to involve nursing facility staff in the behavioral intervention plan.

H. FOR RESIDENT'S REQUIRING ID/RC CARE:

Effective July 1, 2009, Medicaid Certified Nursing Facilities must contact the appropriate Region through DBHDD to communicate when a new resident with a diagnosis of ID/RC enters the nursing facility. With the consent of the member, the nursing facility contacts the appropriate Region Board and specifically the Intake and Evaluation (I & E) manager to notify of the member's presence (See end of this appendix after Community Behavioral Health listing for the Regional Board contact information). The I & E Manager will then communicate with the member and the nursing facility to schedule an assessment to determine eligibility for the appropriate waiver program and per the member's choice assist with the individual 's placement on the waiting list for services should the member choose community placement.

Effective July 1, 2009, when a nursing home resident covered under PASRR experiences a behavioral health crisis, the nursing facility team plays a critical role in contacting the Crisis and Access Line (G-CAL) at 1-800-715-4225 for crisis assistance which may include assessment and management of the situation to achieve stabilization of the resident. G-CAL is staffed and can be accessed 24 hours a day for urgent and immediate crisis intervention for PASRR identified residents. In the event that hospitalization is required, the G-CAL clinical team will evaluate and assist in the hospitalization process to ensure an effective flow of information to the receiving facility.

A behavioral health crisis is defined as an event, behavior, situation or vocalization by a covered resident that is primarily non-medical in nature, but that involves potential danger to the resident, peers or staff. The crisis can be reported by any staff of the nursing home. Examples of crisis where G-CAL should be contacted include, but are not limited to:

i. Suicidal statements and/or actions of a high risk in intent or lethality.

ii. Homicidal statements and/or actions of a high risk in intent or lethality.

iii. Acute psychosis rendering the resident unsafe to self or others.

iv. Disorganization from mental illness resulting in a resident unable to control their actions.

v. Acute and potentially life-threatening deterioration in the resident's medical condition as a result of mental illness (such as paranoia causing non-compliance with required medical interventions and medications, or refusal to eat causing medical decline from depression or psychosis).

vi. Potentially dangerous, threatening, violent, self-harming, destructive, or suicidal behavior which has been evaluated by a qualified NF staff who feels that emergent hospitalization is necessary for psychiatric reasons.

vii. Violence, either impulsive or premeditated.

viii. Strange, bizarre, or unusual behaviors and symptoms that have not been previously evaluated or treated.

Effective July 1, 2009, the following procedure is to be used when a resident does not want to be seen by a particular SMI or ID/RC professional:

ix. Upon written or verbal notification from a resident or the resident's responsible party that the resident does not want to be seen by a particular SMI or ID/RC professional, the nursing facility staff must document the request in the medical record at the nursing facility and assist the member with locating either a new provider or a new professional with the current provider.

x. The request as written by the resident or documented by nursing facility staff must be placed in the resident's medical record and be retained until the resident withdraws/rescinds the request.

xi. The nursing home must notify the CBHS provider by phone of the resident's request within 24 hours and then begin to work with the member to assist in locating a new professional.

xii. The CBHS provider must comply with all such requests from residents.

DOCUMENTATION:
Documenting for the PASRR qualified member receiving Specialized Services must include documentation located with the nursing facility provider as well as with the Community Mental Health provider.

Practitioner Type

Level 1:	Physician, Psychiatrist
Level 2:	Psychologist, Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist, Pharmacist
Level 3:	Registered Nurse, Licensed Dietician, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT)
Level 4:	Licensed Practical Nurse (LPN); Licensed Associate Professional Counselor (LAPC); Licensed Master's Social Worker (LMSW); Licensed Associate Marriage and Family Therapist (LAMFT); Certified/Registered Addictions Counselors (e.g. CAC-I/II, CADC, CCADC, GCADC, MAC), Certified Peer Specialists, Trained Paraprofessionals and Certified Psychosocial Rehabilitation Professionals (CPRP) with Bachelor's degrees or higher in the social

	sciences/helping professions
Level 5:	Trained Paraprofessionals, Certified/Registered Addiction Counselors (CAC-I, RADT), Certified Peer Specialists, Certified Psychosocial Rehabilitation Professionals, and Qualified Medication Aides with at least a high school diploma/equivalent

PROCEDURE CODES:
KEY: Code Modifiers Used:
GT = Via interactive audio and video telecommunication systems
U1 = Practitioner Level 1 (see below for description of all practitioner levels) U2 = Practitioner Level 2
U3 = Practitioner Level 3
U4 = Practitioner Level 4
U6 = In-Clinic
U7 = Out-of-Clinic

For all procedures noted on the next page, practitioners must hold the license appropriate to the activity.

To provide the most accurate and fair methodology for billing for services rendered. The state utilizes the following ***Rounding Rules*** as it relates to those services provided in 15-minute increments. Providers should review this table when determining how many units will be billed following rendering of services. Documentation with actual time spent rendering services will be reflected in the member's service notes.

Units Number of Minutes 15 Minute Units
1 unit: ≥ 8 minutes through 22 minutes
2 units: ≥ 23 minutes through 37 minutes
3 units: ≥ 38 minutes through 52 minutes
4 units: ≥ 53 minutes through 67 minutes
5 units: ≥ 68 minutes through 82 minutes
6 units: ≥ 83 minutes through 97 minutes
7 units: ≥ 98 minutes through 112 minutes
8 units: ≥ 113 minutes through 127 minutes

Units Number of Minutes (1) One Hour Units
1 unit ≥ 30 minutes through 60 minutes

The following procedure codes may be used for service delivery and claims billing for specialized behavioral health services provided to nursing home residents: (Daily/Annual Max units are effective 4/1/2013)

Description	Procedure Code	Modifier	Service Group	Max Daily Units	Max Month Units	Max Year Units
Psychiatric Diagnostic Assessment (session) Or Via Telemedicine *Report with 90785 for interactive complexity when appropriate*	90791, 90792 (Formerly 90801, 90802) 90791, 90792	U2 U6, U2 U7 U3U6, U3U7 (Encounter) GT U1, GT U2, GTU3	10103	1 *Encounter*	1	12

Mental Health Assessment (15 min unit)	H0031	U2 U6, U2 U7 U3 U6, U3 U7 U4 U6, U4 U7	10101	10	10	80
Mental Health Service Plan (15 min unit)	H0032		U2 U6, U2 U7 U3 U6, U3 U7 U4 U6, U4 U7		4	
Individual Outpatient Therapy (**30 min unit**) *Report with 90785 for interactive complexity when appropriate*	90832 (Formerly 90804)	U2 U6, U2 U7 U3 U6, U3 U7 U4 U6, U4 U7 U5 U6, U5 U7	10160	1	10	52
Family Outpatient Therapy (15 min unit)	90846, 90847	U2 U6, U2 U7 U3 U6, U3 U7 U4 U6, U4 U7	10180	8	10	192
Crisis Intervention ***(Encounter)***	H2011	U1 U6, U1 U7 U2 U6, U2 U7 U3 U6, U3 U7 U4 U6, U4 U7	10110	10	20	144
	90839	U1 U6, U1 U7 U2 U6, U2 U7 U3 U6, U3 U7		1	1	
	90840			8	8	

Description	Procedure Code	Modifier	Service Group	Max Daily Units	Max Month Units	Max Year Units
Psychiatric Treatment Therapy with Evaluation and Management (session)	Appropriate Evaluation and Management Code – See below (Formerly 90805)	U1 U6, U1 U7 U2 U6, U2 U7	10120	2	2	24
			see above	see above	see above	see above
Psychiatric Treatment/Pharmacologic al Management (session) Or Via Telemedicine Report with add-on code for psychotherapy time	Appropriate Evaluation and Management Code-see below (Formerly 90862)	U1 U6, U1 U7 U2 U6, U2 U7 GT U1, GT U2				
Evaluation and Management Codes						
E&M (New Pt - 10 min)	99201	U1 U6, U2 U6 U1 U7, U2 U7 GT U1, GT U2	10120	1	2	24
E&M (New Pt - 20 min)	99202					
E&M (New Pt - 30 min)	99203					
E&M (New Pt - 45 min)	99204					
E&M (New Pt - 60 min)	99205					
E&M (Estab Pt - 5 min)	99211					
E&M (Estab Pt - 10 min)	99212					

E&M (Estab Pt - 10 min)	99212					

Description	Procedure Code	Modifier	Service Group	Max Daily Units	Max Month Units	Max Year Units
E&M (Estab Pt - 15 min)	**99213**					
E&M (Estab Pt - 15 min)	**99213**					
E&M (Estab Pt - 25 min)	**99214**					
E&M (Estab Pt - 40 min)	**99215**					
E&M - 30-minute add-on code	**90833**	**U1 U6, U2 U6 U1 U7, U2 U7**		**1**		
Interactive Complexity Codes (billed at $0)						
Interactive Complexity	90785	With or without TG	10104	4	--	76
Interactive Complexity						

*Note: The maximum units noted here are claims limits on units. The units on the prior authorization may differ slightly due to information system limitations.

MI/ID/DD PASRR Level II Determination Codes

Code	OBRA Status	Explanation
1.0	**PAS Approval** SNF Approval, Serious Mental Illness, No Specialized Services	-Individual has a serious mental illness; -Is appropriate for SNF level of care; **-Does NOT need specialized services for SMI;** -SNF to provide routine MI services of lesser intensity. (i.e. Basic Mental Health Services).
1.1	**PAS Approval** SNF Approval, Serious Mental Illness, Specialized Services	-Individual has a serious mental illness -Is appropriate for SNF level of care; **-NEEDS specialized services for SMI;** (i.e. A continuous and aggressive individualized plan of care that is developed and supervised by an interdisciplinary team, prescribes specific therapies and activities by trained personnel to treat acute episodes of serious mental illness, and is directed towards outcomes that increase functional level and reduce the need for specialized services and institutionalization).

1.2	**PAS Approval** SNF Approval, No Serious Mental Illness	-Individual does not have a serious mental illness; -Is appropriate for SNF level of care.
2.0	**PAS Non-Approval** SNF Non-Approval, Serious Mental Illness, Community with Specialized Services	-Individual has a serious mental illness; -Is NOT appropriate for SNF level of care and should be considered for alternative community setting; -**NEEDS specialized services** for SMI in alternative community setting.
2.1	**PAS Non-Approval** SNF Non-Approval, Serious Mental Illness, Inpatient Psychiatric Hospital	-Individual has a serious mental illness; -Is NOT appropriate for SNF level of care and should be considered for psychiatric hospitalization since Applicant's needs are such that they may only be met in an inpatient setting.
2.2	**PAS Non-Approval** SNF Non-Approval, No Serious Mental Illness	-Individual does not have a serious mental illness; -Is NOT appropriate for SNF level of care.
3.0	**PAS Approval** SNF Approval, Developmental	-Individual is ID/DD;

Code	**OBRA Status**	**Explanation**
	Disability, No Specialized Services	-Is appropriate for SNF level of care; -**Does NOT need Specialized Services** for ID/DD; -SNF to provide routine ID/DD services for individuals who require services of a lesser intensity (Basic ID/DD Services).
3.1	**PAS Approval** SNF Approval, Developmental Disability, Specialized Services	-Individual is ID/DD; -Is appropriate for SNF level of care; -NEEDS Specialized Services for ID/DD (i.e. a demonstration of severe maladaptive behaviors that place the person or others in jeopardy to health and safety, the presence of other skill deficits or specialized training needs that necessitate the availability of trained ID personnel, 24 hours per day, to teach the person functional skills).
3.2	**PAS Approval** SNF Approved, No Developmental Disability	-Individual is not ID/DD; -Is appropriate for SNF level of care.
4.0	**PAS Non-Approval** SNF Non-Approval, Development Disability, Community with Specialized Services	-Individual is ID/DD; -Is NOT appropriate for SNF level of care and should be considered for alternative community setting; -**NEEDS specialized services** for ID/DD in alternative community setting.

4.1	**PAS Non-Approval** SNF Non-Approval, Developmental Disability, ICF/IID	-Individual is ID/DD; -Is NOT appropriate for SNF level of care and should be considered for ICF/IID since Applicant's needs are such that they can be met only in an ICF/IID. (Please see Intermediate Care Facility (ICF/IID) Level Of Care Criteria).
4.2	**PAS Non-Approval** SNF Non-approval, No Developmental Disability	-Individual is not ID/DD; -Is NOT appropriate for SNF level of care.

PASRR Specialized Services Provider Listing – Revised Oct 2015

Agency Name	**Address**	**Phone**	**Counties Served**	Region
Malinda Graham & Associates, Inc.	1518 Airport Road Hinesville, Ga. 31313	912-559-5536 Fax: 614-388-3712	Bryan, Bulloch Camden,, Chandler, Emanuel, Evans, Glynn, Laurens, Liberty, Long, McIntosh, Montgomery, Tattnall, Toombs, Montgomery, Wayne	**(South/SW)**
AKC Healthcare	1180 McKendree Church Road Suite 207 Lawrenceville Georgia 30043	770-676-6741 Cell: 770-337-2037	Statewide	**Multiple Regions**
CareNow Services, LLC	401 Bombay Lane, Roswell GA 30076	770-664-1920 Fax: 866-373-5426	Statewide	**Multiple Regions**
United Psychology Center DBA Unite Behavioral Health Solutions	2900 Chamblee Tucker Road, Suite 16, Atlanta Georgia 30341	770-939-1288 Fax: 866-545-8645		**Multiple Regions**
Psych On Site of Georgia	1765 Temple Avenue, Atlanta GA 30337-2736	713-528-2328 Fax: 713-533-1408	Statewide	**Multiple Regions**

NOTE: Providers of the PASRR Specialized Services program are required to submit accurate and current contact information to DCH. Any discrepancies or changes in contact information housed in GAMMISand/or this policy manual should be reported via change of information instructions at www.mmis.ga.gov

Appendix H
Non-Emergency Transportation

For information on Non-Emergency Medical Transportation program, please access the overview document at the following link: https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

Appendix I
PeachCare for Kids® Co-payments

For children ages 6 and over, the following co-payments apply for each CMO:

Category of Service	**Co-Payment**
Ambulatory Surgical Centers / Birthing	$3.00
Durable Medical Equipment	$2.00
Federally Qualified Health Centers	$2.00
Free Standing Rural Health Clinic	$2.00
Home Health Services	$3.00
Hospital-based Rural Health Center	$2.00
Inpatient Hospital Services	$12.50
Oral Maxillofacial Surgery	Cost-Based
Orthotics and Prosthetics	$3.00
Outpatient Hospital Services	$3.00
Pharmacy - Preferred Drugs	$0.50
Pharmacy - Non-Preferred Drugs	Cost-Based
Physician Assistant Services	Cost-Based
Physician Services	Cost-Based
Podiatry	Cost-Based
Vision Care	Cost-Based

Cost-Based Co-Payment Schedule	
Cost of Service	
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

*There are no co-payments for children below the age of 6 years old, for children in Foster Care, or for children who are American Indians or Alaska Natives.

Appendix J
CMS 1500 Claim Form

Effective May 1, 2015, the Department will only accept electronic claims. Any paper claims submitted to the fiscal agent for payment will be returned to the provider. Please refer to the Medicaid and Peachcare for Kids Part I Policies and Procedures manual, Section 112, for more information.

Appendix K
Crossover Claim Submission Process and Rates

The Georgia Department of Community Health (DCH) is providing guidance to providers of Community Behavioral Health Rehabilitation Services related to Medicare Crossover Claims. Per the DCH Medicaid Secondary Claims User Guide (Helpful Information, page 8), once a Medicare claim crosses over to Medicaid, it may not be modified or adjusted. Federal rules require that claims be billed for a dually eligible Medicare/Medicaid member in the same manner to Medicare as they are to Medicare. However, because Medicare does not recognize the modifiers used in the Community Behavioral Health Rehabilitation Services (CBHRS) program, the Georgia Medicaid Management Information System (GAMMIS) accommodates for CBHRS crossover claims as described below.

To ensure the standardized and consistent adjudication of CBHRS providers' (Category of Service 440) claims through the Medicare crossover process, the DCH incorporated specific pricing logic into GAMMIS that utilizes weighted practitioner-level blended rates. Because a claim to Medicare cannot use modifiers to establish the practitioner level and associated rate of reimbursement, the pricing is set at weighted average based on historic utilization.

A. Updated Instruction for Billing Crossover Claims:

Medicaid/COS 440 providers that are also enrolled Medicare providers will continue to submit crossover claims to Medicare ONLY for members covered by both Medicaid and Medicare with applicable procedure codes, but with:

i. ONLY the modifiers allowable by CMS for Medicare claims;

ii. or with no modifiers at all.

A table with applicable procedure codes and pricing follows below.

Those dual-member claims will crossover to Medicaid as they normally do but will pay at the assigned blended rate or less. The affected CPT codes and associated Medicare Crossover-specific rates are listed in the table below. This pricing logic will be applicable ONLY to COS 440 Crossover claims and (barring any Third Party Liability/other insurance payments) will be the only payment providers will receive.

Changes in GAMMIS were implemented on April 1, 2017. The changes will affect crossover claims with dates of service January 1, 2016 and after.

CBHRS providers are reminded of the policy outlined in the PART I Policies and Procedures for Medicaid/PeachCare for Kids Manual; Chapter 300; Section 302; Subsection 302 which states: "PLEASE NOTE: When billing either Medicare FFS or Medicare Advantage Plan, you must bill Medicaid in the same manner in which you submitted the bill to Medicare." Providers should not add COS 440 modifiers to adjudicated crossover claims and submit them directly to the GAMMIS.

Appendix L
2017 State Plan Amendment Codes

On April 21, 2017, a State Plan Amendment to the CBHRS program was approved by Centers for Medicare & Medicaid Services. The amendment adds to the scope of services to children, youth and families, modifies service modalities and revises reimbursement methodology for CBHRS. The procedure codes, modifiers, rates and units for the services included in the State Plan Amendment are listed in the table below and are effective 10/01/2017/

Appendix M
2019 CPT Code Crosswalk for Psychological Testing codes as utilized in COS 440

Effective January 1, 2019, the Department of Community Health (DCH) and Gainwell Technologies updated the Georgia Medicaid Management Information System (GAMMIS), with the 2019 Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) procedure codes as mandated by the Centers for Medicaid and Medicare Services (CMS). Two (2) old CPT procedure codes were updated by CMS and replaced in 2019 with six (6) new replacement codes in the Category of Service (COS) 440 CBHRS program. The two (2) old Psychological testing procedure codes being replaced for the COS 440 program are 96101 and 96102. The six (6) new replacement codes in 2019 are 96130, 96131, 96136, 96137, 96138, and 96139.

The table below provides a cross-walk of the current (old) Psychological testing codes to the six (6) new 2019 replacement procedures codes to be configured in GAMMIS. Please note that the historical location, practitioner specific modifiers, AND the previous rate methodology will all still apply for the new 2019 replacement procedure codes. Additionally, in accordance with CMS' recent mandate to State Medicaid Agencies, the six (6) new replacement Psychological testing procedure codes' unit of service may change as noted below.

Appendix N
CBHRS Telemedicine Guidance

This appendix will outline use of Telemedicine for Behavioral Health services within the Community Behavioral Health and Rehabilitation Services (CBHRS) program.

A. Telemedicine

Involves the use of two-way, real time interactive communication equipment to exchange medical/clinical information between a healthcare practitioner and the member from one site to another via a secure electronic communication system. This includes audio and video communications equipment designed to facilitate delivery of healthcare services in a face-to-face interactive, though distant, engagement.

Originating Site: For CBHRS, members may be located at home, schools, and other community-based settings or at more traditional sites named in the Department of Community Health (DCH) Telemedicine Guidance manual including:

i. Physician and Practitioner's Offices;

ii. Hospitals;

iii. Rural Health Clinics;

iv. Federally Qualified Health Centers;

v. Local Education Authorities and School Based Clinics;

vi. County Boards of Health;

vii. Emergency Medical Services Ambulances; and

viii. Pharmacies

B. Security and Confidentiality:

In compliance with all applicable Federal and State statutes and regulations, providers of the CBHRS program are permitted to incorporate usage of Telemedicine for certain services they provide. The goal for enabling telemedicine methods is to improve and increase access and efficiency of behavioral health service delivery to Georgia Medicaid members. Appropriate use of Telemedicine shall consider its safe and confidential use always. Special considerations in the use of electronic-facilitated treatment must include informed consent of the individual served, authorization through the process of Individualized Recovery Plans, educational components in assessment and service delivery which indicates ongoing agreement with the treatment method and under what circumstances electronic communications may and may not be used.

Telemedicine Services must be HIPAA compliant and in accordance with Safety and Privacy regulations. All transactions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmitted information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver. All interactive video telecommunications must comply with HIPAA patient privacy regulations at the site where the member is located, the site

where the consulting provider is located and in the transmission process. All communications must be on a secure network in compliance with HIPAA Encryption (Encryption is the conversion of plaintext into cipher text using a key to make the conversion) and Redundancy requirements.

C. Consent:

The Telemedicine Member Consent Form for each member is outlined in the Telemedicine Guidance Document and is to utilize. Complete and detailed Guidance on Telemedicine and Telehealth can be accessed by visiting https://www.mmis.georgia.gov/portal/; then clicking Provider Information, Provider manuals and Telemedicine Guidance.

D. Language Interpreters Scope of Use:

NOTE: Currently, the Department of Behavioral Health and Developmental Disabilities (DBHDD) has authorized Telemedicine to be used to provide some of the services in the CBHRS program. For other specifics on Telemedicine and its scope of use, see the DBHDD Provider Manual at: http://dbhdd.org/files/Provider-Manual-BH.pdf

Services that can be rendered via Telemedicine are identified in Appendix C, Appendix M, and Appendix G by procedure codes that include the 'GT' modifier. Please refer to these Appendices to determine which services can and cannot be provided via the telemedicine option. While some CBHRS services allow telephonic interactions, telephonic interventions do not qualify as telemedicine.

E. Billing:

Originating fees (as referenced in some of the other Georgia Medicaid programs) are not offered for telemedicine when utilized in the CBHRS category of service. Care Management Organizations may have specific billing requirements and practices which will be outlined in their unique agreements with providers

F. Other definitions:

Telehealth is a broad definition of remote healthcare that does not always involve clinical services. Telehealth can be used in telecommunications technologies for patient education, home health, professional health education and training, administrative and program planning, and other diverse aspects of a health care delivery system.

Tele-Mental Health is utilized for licensed practitioners under the guidance of the Georgia Secretary of State's office (Social Workers, Professional Counselors and Marriage & Family Therapists), there are specific practice guidelines and mandatory training pertaining to what is identified as Tele-Mental Health. Providers are encouraged to ensure these guidelines are followed for all members receiving services provided by licensed practitioners impacted by the Georgia Secretary of State's office.

Other references:

*Cite as Ga. Comp. R. & Regs. R. 135-11-.01
Authority: O.C.G.A. §§ 43-1-19, 43-1-24, 43-1-25, 43-10A-2, 43-10A-5, 43-10A-16, 43-10A-17.
History. Original Rule entitled "Telemental Health" adopted. F. Sep. 17, 2015; eff. Oct. 7, 2015.

*The US Department of Health and Human Services offers guidance on HIPAA compliance at https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/in

Appendix O
2020 CMS CPT Code Update

Effective January 1, 2020, two (2) procedure codes utilized for prior authorization and claims submission for the CBHRS program were replaced. Per the 2020 CMS CPT code update and the American Psychological Association Crosswalk for 2020 Health Behavior Assessment and Intervention CPT Codes, Procedure codes 96150 and 96151 were both replaced by ONE procedure code – 96156. The below crosswalk reflects details about the code conversion. The above rate tables also reflect the conversion as it relates to modifiers, rates and unit increments