Georgia Medicaid Autism Services Presentation

For access to this presentation, please visit: www.mmis.georgia.gov -> Provider Information -> Provider Notices –“Presentation – Autism Spectrum Disorder – February 2023”

Georgia Department of Community Health

gainwell

Agenda

- Scope of Services
- Common Denials
- Procedure Code and Modifier Combination
- Prior Authorization Request
- Contacting Gainwell Technologies
- Closing - Questions and Answers

Mission

The Georgia Department of Community Health

We will provide access to affordable, quality health care to Georgians through effective planning, purchasing and oversight.

We are dedicated to A Healthy Georgia.

Oversight Agencies

- Beginning in State Fiscal Year 2018, the legislature aligned funds for services and supports to individuals with ASD, ages 0 through 20.

- The three state agencies named below were charged with enhancing the state's capacity to support individuals with ASD and their families/caregivers through several initiatives.

Department of Public Health

Early Identification and Intervention Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Department of Community Health

Adaptive Behavior Assessment and Treatment

Department of Behavioral Health and Developmental Disabilities

ASD Crisis Support Services

Department of Community Health

- The Georgia Department of Community Health (DCH) is offering an outpatient treatment benefit specific to ASD for Medicaid recipients ages 0 through 20.
- Services are called Adaptive Behavior Services (ABS) and include adaptive behavior treatment including social skills groups.
- For more information, including the Provider Manual, visit https://medicaid.georgia.gov/autism-spectrum-_disorder

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Autism Spectrum Disorder (ASD)

Autism Spectrum Disorder (ASD)

- 1:64 children (ages 0 to 21) in Georgia have Autism Spectrum Disorder (ASD)
  - 1.1 million children in GA on Medicaid younger than 21 years of age
    - Estimated 17,000 children with Autism Spectrum Disorder enrolled in GA Medicaid
- Spring 2017: Governor's Budget Proposal/Legislative Approval
- Initiated Tri-department Planning Initiative
  - Department of Community Health
  - Department of Public Health
  - Department of Behavioral Health & Developmental Disabilities
  - Partner Informants include DHS and DOE

ASD Services

ASD Adaptive Behavior Services (ABS) Outpatient Benefit

- ABS and other ASD services do **not** require a NOW/COMP waiver.
- ABS are available through age 20.
- IDEA supports are for ages through 21.

ABS services are available to Medicaid recipients only

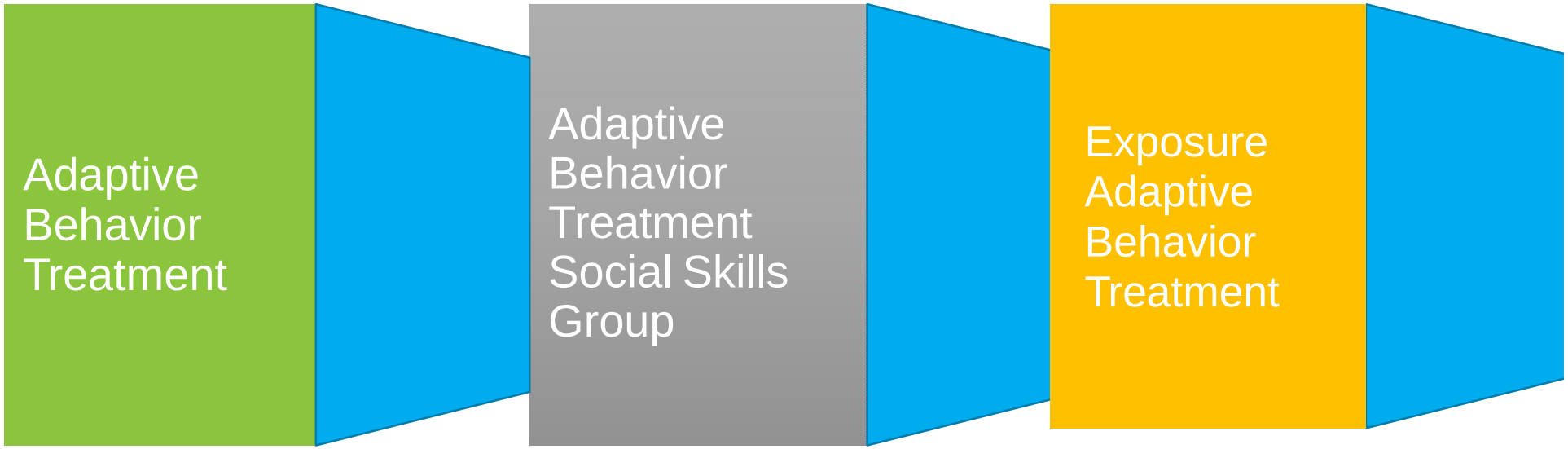
- ABD Medicaid
- CHIP/LIM Medicaid (Georgia Families and Georgia Families 360°)
- If an individual does not have Medicaid, a GAMMIS search for ABS providers is recommended to identify enrolled practitioners who may accept other forms of payment and insurance.

ASD ASSESSMENT

Services: Assessment

ASD Treatment

Services: Treatment



Autism Therapy Request Guidelines & Restrictions

- The Cover Page should be completed and signed by the BCBA.
- The prior authorization (PA) type for Autism Therapy services is AU.
- Providers must have COS code of 445 and a Specialty Code of 565 or 566.
- Only Applied Behavioral Analysis (ABA) procedure codes may be entered on the request.
- Providers should submit one PA for assessment codes and one PA for treatment codes.
- Behavioral Assessment must be performed within two months of the treatment PA request. Graphs/grids are required.
- Requests must have an effective/start date equal to or greater than the request date.
- All requests may be submitted with a procedure start date up to **60 days** in the future. Alliant Health has 30 days to review a PA request.
- If a member leaves an Autism provider's service, it is that provider's responsibility to ensure that they submit an end-date request for an existing PA. Alliant will **not** end-date the existing PA until an end-date is communicated to Alliant by the **current** provider. The request **must** be submitted in writing utilizing the "contact us" feature (please be sure to include the effective end date). This allows them the opportunity to bill for all dates of service rendered before the member transfers to a new provider.

Autism Therapy Request Guidelines & Restrictions

NOTE

- ALL PAs for ALL Medicaid Members MUST be requested prior to services being rendered. Any services not prior approved or provided prior to the PA Effective date will not be authorized or covered for reimbursement. Effective dates on existing PA's cannot be made retro or backdated under any circumstance or for any reason.

- Per the ASD DCH policy manual, retro authorizations are **not** allowed.

Procedure Codes

Procedure Codes	Max Daily Units as allowed by CMS
0362T	16
97151/97152 *Family of Codes	32/16
97153/97154/97155 *Family of Codes	32/18/24
97156	16
97157	16
97158	16
0373T	32

*Family of Codes: It is only necessary to enter one code from a bundle (family of codes) since the entire family is sent to the claim system. If more than one code from the same family is entered, only the actual code entered is sent to claims and not the complete family of codes.

Change Request for Approved Prior Authorization (PA)

Providers have the option to submit a “Change Request” requesting a modification to the approved PA. The following criteria must be met:

1. A significant change in treatment needs must be documented by submission of an updated and signed LMN/POC uploaded to the web portal. If additional units are requested, a treatment plan addendum that outlines the new goals with baseline data is required.
2. For a member whose name and Medicaid ID number has changed due to an adoption, the change request must also include the new Medicaid ID number. If there have been any paid claims against the PA, the GAMMIS will not accept changed made to the PA.
3. If a change in modality is requested, the units to be withdrawn (for substitution) must be specified.

Prior Authorization Reconsideration?

Reconsideration of the decision rendered on an Autism PA can be submitted on the Medical Review Portal.

Reconsiderations are allowed when the PA has one or more procedure lines that are:

1. Approved but not for all units requested - requests must be submitted within **30** calendar days of the decision.
2. Peer consultant denied - requests must be submitted within **30** calendar days of the decision. **Please Note: Only one (1) reconsideration request submission per PA request following a peer denial can be submitted.**
3. Tech Denied but **NOT** Final Tech Denied - requests must be submitted within **10** calendar days of the decision.

Prior Authorization Reconsideration?

(continued)

- Providers are required to attach additional documentation to support the reconsideration request. It is not necessary to re-submit all information sent with the original request but only the information to support the request for reconsideration.
- If a **technical denial** is received, the provider has 10 calendar days from the date of the technical denial to electronically attach the missing information. If the information is not received within the 10 calendar days, the provider will have to re-submit the entire PA request packet.
- If a request for **additional units** is denied, the provider has the right to submit a request for “A Reconsideration of the PA Request” within 30 calendar days of the peer denial. Only one reconsideration request submission per PA request following a peer denial can be submitted.

FFS Autism User Guide

- Select Provider Information
- Select Provider Education
- Select User Manuals
- Select Provider Workspace User Manual
- Select FFS Autism User Guide

Effective May 28, 2020, the provider match criteria for Prior Authorization (PA) Type 'AU' (Autism) was removed from the MMIS. This change was completed to allow both affiliated and unaffiliated ASD providers access to all existing ASD PA's for members. Additionally, ASD providers can now render services in accordance with the date range specified not to exceed the maximum approved units. Providers will no longer be required to submit a Change Request via the Medical Review Portal for the remaining services when a member changes providers.

Common Denials

Common Denials

There are several reasons why a claim may be denied after it is submitted even if prior authorization was obtained.

1. The member has become ineligible for services and is no longer covered by the health plan.
2. Services are not billed with the CPT/HCPCS code identified in the prior authorization.
3. Additional services, not included in the initial prior authorization that also require prior authorization are submitted on the claim.

The final determination of whether to pay for service is made by thoroughly reviewing the member's plan *and* the payer's medical coverage policy on the day of service.

Common Denials

(continued)

Edit 5265 – Autism Service Duplicate
This edit is triggered when the current COS 445 claim and a history COS 445 claim have same procedure, modifier, rendering provider ID, and same or overlapping dates of service.

Method of Correction – No correction is needed if claim is an exact duplicate of a claim in the history file. If claim billed has overlapping dates correct date span and resubmit claim. To locate the paid claim, search claim panel with member ID, DOS, and Claim Type to locate paid claim in history.

Edit 2504 - Member Covered by Private Insurance; no attachments
This edit is triggered if the member has private coverage that is not exhausted using the header FDOSTDOS Span. There is no claim attachment and the TPL amount on the claim is zero.

Method of Correction - Verify the COB information and bill the claim to the appropriate Insurance Carrier first or re-submit your claim with the Primary Carrier's EOB information or resubmit your claim with the DMA-410 COB notification form. Medicaid is always the payer of last resort.

Edit 4257 - Modifier Restriction For Proc Billing Rule
This edit is triggered when the claim modifier does not meet the procedure billing rule modifier configuration in GAMMIS.

Method of Correction – Review the Part 2 program specific manual to determine what codes are billable and also check the Procedure Search panel to determine the billing rules for the code. The procedure search results will show the applicable COSs, associated modifiers, claim types, age restrictions, and if a PA/Precert is required. Once reviewed, submit or resubmit the claim. In this example, the modifier(s) can be corrected on the GAMMIS Web Portal.

Common Denials

(continued)

Edit 3011 - DOS Not Within PA/Precert Effective Dates
This edit is triggered when the date on the claim is outside the approved dates on the PA/Precert.

Method of Correction - Providers may submit a Change Request Form to Alliant Health/GMCF through the Medical Review Portal within 30 days of the PA request date or within 30 days of the date of service.

Edit 3052 - PA Units/Amount Exhausted
This edit is triggered when the approved number of units have all been used.

Method of Correction - Check PA for accuracy. Provider may need to submit a request for a new authorization or a request for more units.

Edit 3050 - Procedure code on claim not on PA file
This edit is triggered when the procedure code on the claim does not match the Prior Authorization line-item procedure code.

Method of Correction - Check PA against the denied claim for accuracy. Make necessary corrections and resubmit claim.

Timely Filing

Common Timely Filing Denials

Edit: 512, 516, and 545 - Timely Filing

These edits are triggered when a claim is submitted outside of the six month or one year timeframe.

- Claim submission -Within six months of the DOS
- Claim adjustment -Within three months of the month of payment
- Claim resubmission -Within three months of the month the denial occurred
- Crossover claim -Within 12 months of MOS
- Secondary/TPL claim -Within 12 months of MOS

One Year (365 Days) Claim Submission New

Edit: 515 for DTL and 516 for HDR

Example:

	Original Submit Claim	1st Resubmit	2nd Adjustment
DOS	**Denied Date:**	**Adjustment**	**(365 days)**
July 1, 2020	December 30, 2020	March 31, 2021	June 30, 2021

- All claim submissions and adjustments to denied claims are to be completed according to policy by 365 days. Other timely submission and resubmission system edits will remain in GAMMIS according to policy (there is no time limit for adjusting a claim that reverses payment back to the Department of Community Health).
- Please refer to the Georgia Medicaid Part 1 - Policies and Procedures Manual, Chapter 200. The Timely Resubmission policy outlined in Section 204 will still be enforced to include this new one year or 365 days guideline.

*Banner Message posted April 12, 2018

Working Your Denied Claims

Claims Management Tips

Reviewing, correcting, and re-submitting denied claims is central to your revenue management.

- Assign dedicated staff person to denials if possible.
- Document receipt of denials, reasons for denied payment and deadline for resubmission.
- Always review denial reasons (read twice, act once.)
- Make corrections involving missing or inaccurate information.
- Review clinical reasons for denial (service, diagnosis, etc.) with treating provider.
- Make any corrections possible.
- Re-submit claims in a timely manner.

Denials = revenue delay, revenue loss

Georgia Field Territories

Territory 1 N GA
Bartow, Catoosa, Chatooga, Cherokee, Dade, Dawson, Fannin, Floyd, Forsyth, Gilmer, Gordon, Habersham, Hall, Lumpkin, Murray, Pickens, Rabun, Stephens, Towns, Union, Walker, White, Whitfield

Territory 2 Atlanta
Fulton

Territory 3 NE GA
Banks, Barrow, Clarke, Elbert, Franklin, Gwinnett, Hart, Jackson, Madison, Oconee, Walton

Territory 4: NW GA
Carroll, Cobb, Douglas, Haroldson, Paulding, Polk

Territory 5: SE Metro
Clayton, DeKalb, Rockdale

Territory 6: Middle GA
Butts, Chattahoochee, Coweta, Fayette, Harris, Heard, Henry, Jasper, Jones, Lamar, Marion, Meriwether, Monroe, Muscogee, Newton, Pike, Spalding, Talbot, Taylor, Troup, Upson

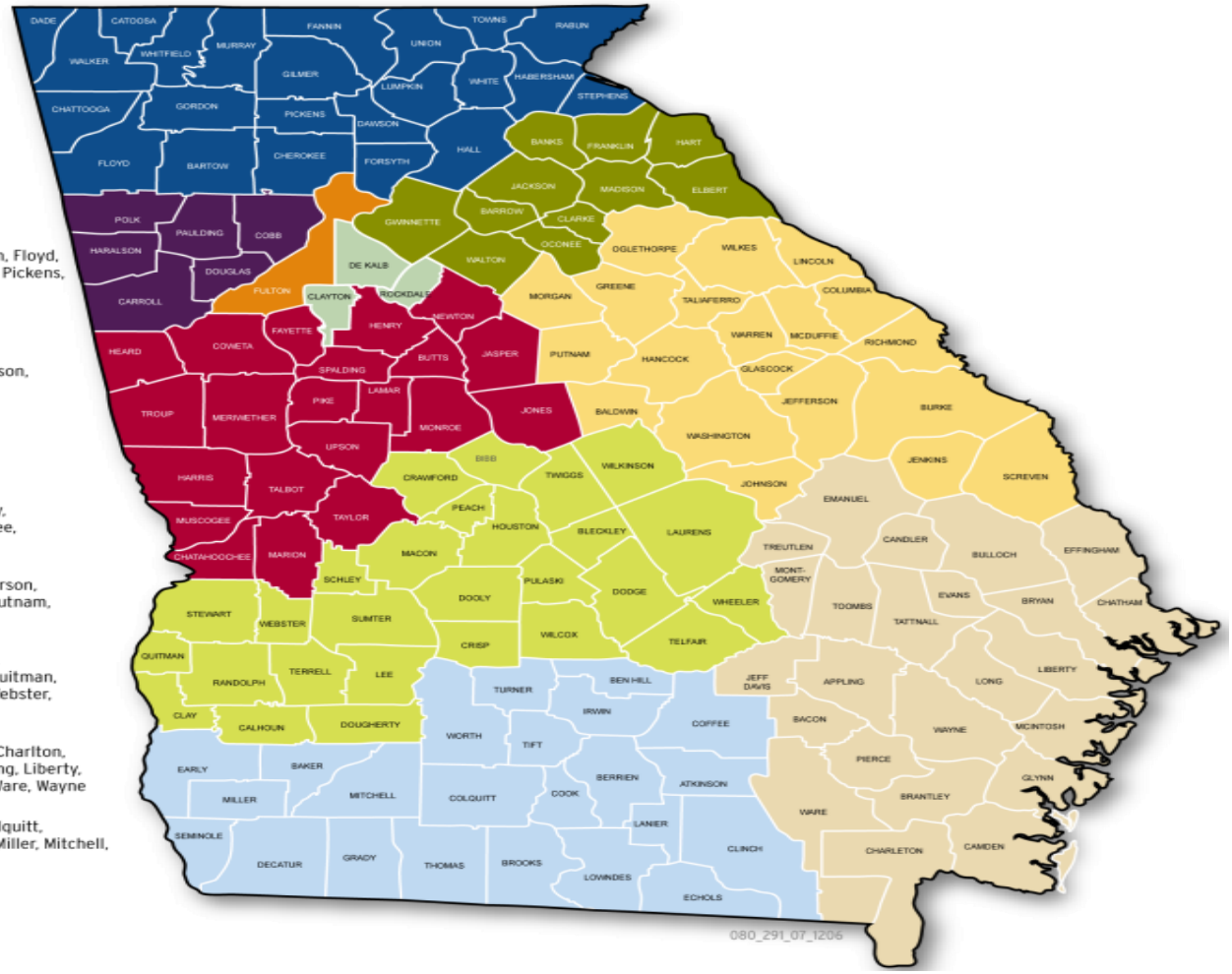
Territory 7: Augusta
Baldwin, Burke, Columbia, Glascock, Greene, Hancock, Jefferson, Jenkins, Johnson, Lincoln, McDuffie, Morgan, Oglethorpe, Putnam, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes

Territory 8: SW GA
Bibb, Bleckley, Calhoun, Clay, Crawford, Crisp, Dodge, Dooly, Dougherty, Houston, Laurens, Lee, Macon, Peach, Pulaski, Quitman, Randolph, Stewart, Schley, Sumter, Telfair, Terrell, Twiggs, Webster, Wheeler, Wilcox, Wilkinson

Territory 9: SE GA
Appling, Bacon, Bryan, Bulloch, Brantley, Camden, Candler, Charlton, Chatham, Effingham, Emanuel, Evans, Glynn, Jeff Davis, Long, Liberty, McIntosh, Montgomery, Pierce, Tattnall, Toombs, Treutlen, Ware, Wayne

Territory 10: South GA
Atkinson, Baker, Ben Hill, Barrien, Brooks, Clinch, Coffee, Colquitt, Cook, Decatur, Early, Echols, Grady, Irwin, Lanier, Lowndes, Miller, Mitchell, Seminole, Thomas, Tift, Turner, Worth

Territory 11 State Wide
Hospital Field Representative



Provider Relations Field Services Representatives

Territory	Region	Rep
1	North Georgia	Mercedes Liddell
2	Fulton	Deandre Murray
3	NE Georgia	Carolyn Smith
4	NW Georgia	Tierra Johnson
5	SE Metro	Ebony Hill
6	Middle Georgia	Shawnteel Bradshaw
7	Augusta	Jessica Bowen
8	SW Georgia	Jill McCrary
9	SE Georgia	Kendall Telfair
10	South Georgia	Anitrus Johnson
North	Hospital Rep	Sherida Banks
South	Hospital Rep	Janey Griffin

Provider Relations Field Services Representatives

State-Wide Consultants

Sharée C. Daniels
Brenda Hulette
Danny Williams

What's New…. Chatbot

In our effort to implement innovations that will benefit the overall productivity and quality of our provider and member call center experience, we will be implementing a Chatbot feature as early as October 27, 2021.

Location

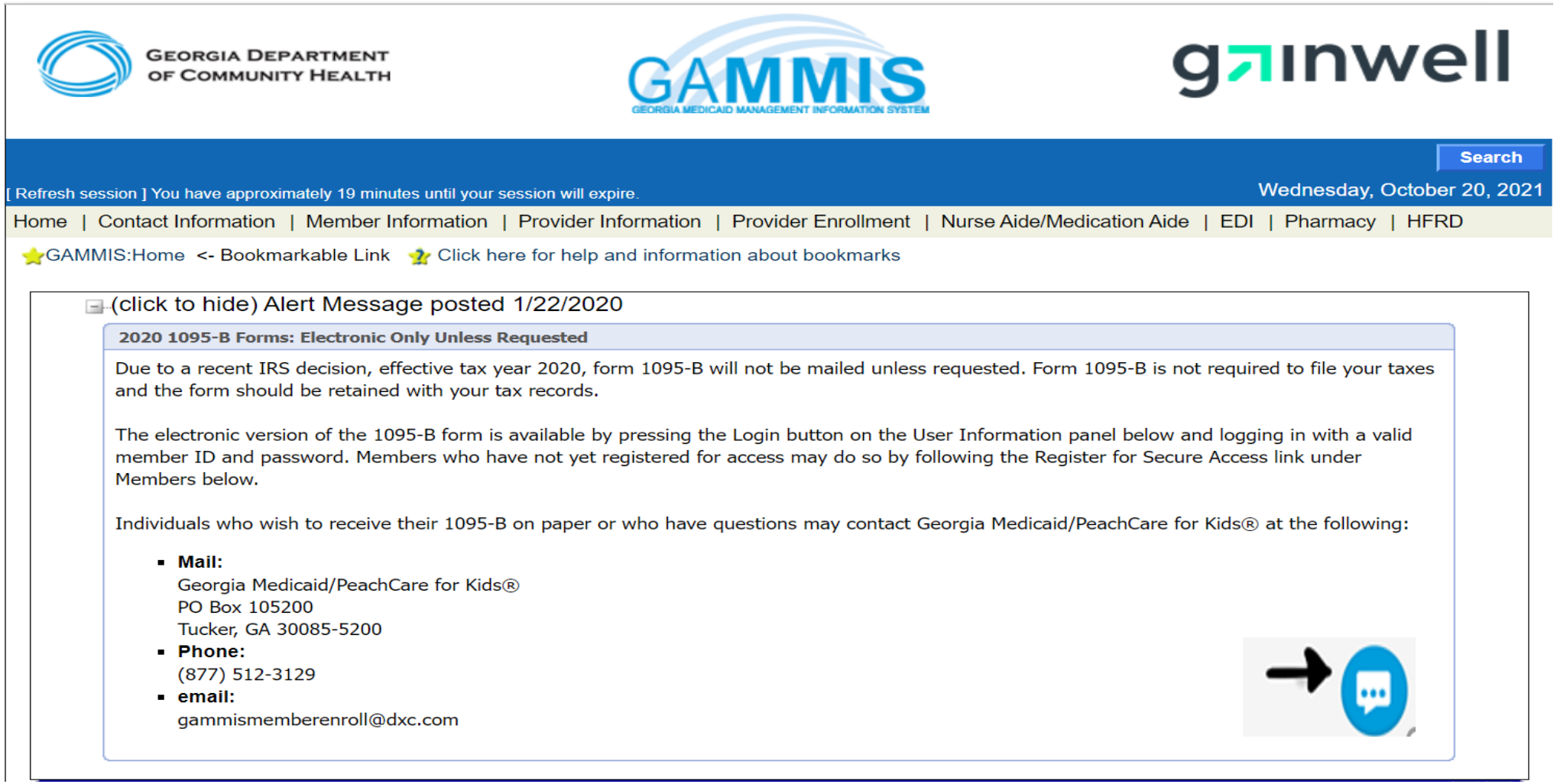
- This enhancement will be located and accessed from the Georgia Medicaid Management Information System (GAMMIS) and will be available 24/7.

Goals/Benefits

- The Chatbot will enhance the users experience by offering site visitors an option to get quick answers to frequently asked questions, which will eliminate the need to speak with a live agent.
- This will make a positive impact to the provider/member community by reducing call volumes and wait times.

What's New…. Chatbot

(continued) **Visit: www.mmis.georgia.gov**



IVRS Overview

The Interactive Voice Response System (IVRS) allows users to call and conduct inquiries or transactions on the Georgia Medicaid Management Information System (GAMMIS) using a touch-tone telephone.

800-766-4456	
Option 1	Member Eligibility
Option 2	Claims Status
Option 3	Payment Information
Option 4	Provider Enrollment
Option 5	Prior Authorization
Option 6	GAMMIS website password reset, Pharmacy Benefits, the Nurse Aide Registry or Nurse Aide Training program, PeachCare for Kids® EDI submission or electronic claim submission, or a system overview

Contact Us

Our Provider Services Contact Center (PSCC)

can be reached at

800-766-4456

and is available 7 a.m. to 7 p.m. EST

Monday through Friday (except state holidays) for service inquiries**.**

Please note the Web Portal is available 24/7

You should now know…

- ASD Service Benefits
- Who qualifies for ABS Services
- Therapy Request Guidelines
- Billable Procedure Codes
- When to submit a Change Request for a PA
- Time limits for PA Reconsideration
- Common Claim Denials
- How to contact your Gainwell Field Representative

Questions?

Thank you

Contact
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