

Centralized Prior Authorization Process for Georgia Medicaid Providers Frequently Asked Questions September 27, 2013

Answers to your most common questions regarding the Centralized Prior Authorization (PA) process have been listed below. Contact the specific CMO Provider Services department if your question is not listed.

Services Covered

1. What services are included in this Centralized PA Process?

Services include Newborn Delivery Notifications and Pregnancy Notifications, plus all inpatient and outpatient services performed only in a hospital setting, including ambulatory surgery requests. These inpatient and outpatient services have a Place of Service (POS) code of 21, 22 and 24, respectively. These eligible services, as well as PAs for in-state transplants, hospital outpatient therapy, reconsideration requests and submission of initial and additional clinical data should be submitted through the Georgia Medicaid Management Information System (GAMMIS) at www.mmis.georgia.gov.

2. Who should submit a Prior Authorization request using the Centralized PA process beginning on 7/1/2013?

Any participating Georgia Medicaid provider requesting Newborn Delivery Notifications and Pregnancy Notifications, or inpatient or outpatient hospital or an ambulatory surgery service PA (Place of Service (POS): 21, 22, 24 respectively) should submit their requests using this new mechanism. PAs for in-state transplants, hospital outpatient therapy, reconsideration requests and submission of initial and additional clinical data should be submitted using the process on the Georgia Medicaid Management Information System (GAMMIS) at www.mmis.georgia.gov. The individual CMO web portals should not be used after 7/1/2013 to submit the PA types listed.

We have enhanced the functionality of GAMMIS to process both notifications and prior authorization requests as of 7/1/2013. When you log into GAMMIS, you must follow the steps outlined below:

- Select Prior Authorization
- Select Provider Workspace
- Select Enter a New Authorization
- Select the Appropriate Form
- Complete All Required Information

Note: The admit date in the Newborn Delivery Notification is the actual date that the mother was admitted to the hospital. All of the newborn delivery information will be located under the heading "Baby#: New." If the mother delivered more than one baby, you can simply select "add another baby," located on the right side of the screen.

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3. Are there any PA submission exceptions for any service types or POS 21, 22, 24?

The exception to this process is for inpatient and outpatient Behavioral Health (BH) services including services handled by CMO third-party vendors (dental, vision, radiology, etc). You will need to go to the individual CMO's web portal to enter BH requests or the vendor's portal to enter these types of PA requests. BH and vendor services are not a part of the Centralized PA process implementation at this time.

When To Use This Process

1. Will I be able to determine if a service requires a PA by a specific CMO before submitting my request?

Yes. When you enter the Georgia Centralized PA area of GAMMIS, you will have an opportunity to review the CMO's specific prior authorization rules by selecting the CMO's hyperlink option located directly on the site. As a reminder, all CMO out-of-network providers must obtain a Prior Authorization before providing non-emergency services even if you are a participating Georgia Medicaid provider.

2. When requesting a PA for therapy services, other than behavioral, using GAMMIS, am I required to submit the same CMO-specific forms that were applicable for use prior to 7/1/2013?

Yes. You must still submit all forms required by the member's assigned CMO along with your PA request.

3. When a PA number was obtained from the assigned CMO before the member was re-assigned to a new CMO and the service was not yet performed, will the original PA number provided by the initial CMO be accepted by the newly assigned CMO? Or do I have to obtain a new PA number from the newly assigned CMO?

This would be considered a transition of care matter because the member has been reassigned to a different CMO after receiving Prior Approval for a service that had not yet been performed. The initial CMO is not able to transfer a PA to another CMO.

You should review the CMO's current policy as outlined in their Provider Handbook for specific guidance. During the first thirty (30) days of enrollment, Prior Authorization is not required for certain members with previously approved services by DCH or another CMO. However only notification via phone or fax is necessary to properly document these services and determine any necessary follow-up care.

4. If I have previously submitted a Newborn Notification for a well-baby but the newborn suddenly became ill and was admitted to NICU, must I do anything in GAMMIS to update

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the CMO of the inpatient status? Or does it require a new inpatient admission PA request to be submitted?

The Newborn Delivery Notification form is only used to notify the CMO that a maternal delivery event occurred, regardless of whether the outcome was a well or sick infant. Infants who are admitted directly or subsequently to the Newborn Intensive Care Unit (NICU) or have a continued length of stay (LOS) beyond routine delivery standards (i.e., 2-day LOS for vaginal; or 4-day LOS for C-section) would require a separate and distinct authorization. If the provider does not have the NICU newborn's unique Medicaid ID, then the provider should notify the CMO directly and timely via phone or fax to be informed of the change of inpatient status.

5. Am I allowed to submit a Hospital Outpatient Therapy (HOT) PA request for physical and occupational therapy under the same submission? Or must I submit two separate HOT PA requests in this case?

Yes. It is acceptable to submit one HOT PA request for physical and occupational therapy for the same member and same dates of service. Specify CPT codes that are applicable for each discipline by providing remarks in the "Comments" section of the PA request to outline the plan of care that includes, but is not limited to, the frequency and total number of visits and the expected duration of care to be rendered.

When Not To Use This Process

1. If I need to request a PA for radiology or other services where the CMO has a contracted vendor (vision, dental, behavioral health) and the service is performed in an outpatient hospital setting, should I use this Centralized PA process?

No. You should visit to the individual CMO's website to identify its specific vendor responsible for administering services and follow the published protocols for submitting a request for Prior Authorization related to these vendor contracted services. These services are not currently included.

2. What number should I use if my PA was denied and I want to submit an appeal?

You should use the "Reference Number" listed on the Centralized PA site or the number listed on the denial letter that is sent to you by the CMO. Do not use the Centralized PA site to submit your appeal. Follow the CMO's currently outlined appeal submission process.

Timing For Use Of The Process

1. Is there a standard timeframe in which the inpatient/observation notification must be entered into GAMMIS for it to be considered timely? Is there a grace period established for weekend and/or holiday admissions?

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You must still adhere to the CMO's specific notification of admissions (i.e., inpatient and observation) requirement as currently established; there are no exceptions with the implementation of this new process. Please consult your Provider Handbook for the respective CMO to review the policy concerning notification requirements.

2. If a member is admitted through the emergency department (ED), can notification be done via GAMMIS or via fax to the CMO? And can clinical information be provided at a later time?

Yes. If the member was admitted via the ED to an inpatient status, then the PA request can be initiated via GAMMIS followed by subsequent submission of all clinical documents attached to the PA request within the required notification and clinical submission guidelines established per the respective CMO. Notification may be made through GAMMIS or via fax.

3. Can I submit a Prior Authorization request using the Centralized PA process if I am not a participating network provider with any of the CMOs?

Yes. CMO out-of-network providers who are participating in Georgia Medicaid can submit PAs using this process. Approval of these requests is not guaranteed. The CMO may opt to steer the requested service to an in-network provider, if applicable. If prior authorization is not obtained for out-of-network services, reimbursement will be denied.

4. What is the expected turn-around time to receive an approved or denied authorization status from the CMOs?

As it is today, the CMOs are obligated to provide a PA determination within the state-established timeframes. For instance, if the PA request meets the criteria for an expedited review, then a determination will be made within 24 hours of receipt. All standard PA requests may not exceed fourteen (14) calendar days following receipt of the request for service.

5. What types of PAs are appropriate to be submitted via fax or telephone?

PA telephone or fax requests are appropriate to facilitate hospital discharge, to maintain the health and well-being of the member, or when emergency services are required. Telephone or fax PAs are not appropriate for services that can otherwise be processed and authorized by using the Georgia Medicaid Centralized PA process.

6. What if the CMO requests additional information related to a PA that was entered on the Georgia Medical Care Foundation (GMCF) portal?

The individual CMO PA reviewer will determine if a service or procedure is medically reasonable and necessary and may request more information from the provider via fax or phone. The provider must respond to the CMO with this information within 24 to 48 hours of the request, unless otherwise specified, or the PA request is systematically denied.

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Benefits And Eligibility

1. Must I verify member eligibility prior to the delivery of health care services?

Yes. You must verify eligibility whenever a Medicaid member presents to your office or facility. You can check member eligibility by going to the GAMMIS portal at www.mmis.georgia.gov.

2. The member eligibility information that I have differs from the message provided by the PA system in GAMMIS. How should I proceed?

If this occurs, please contact the member's CMO directly for your request. If you are a Fee-for-Service provider, contact your local Provider Relations Representative at GMCF.

Claims

1. If there is coordination of benefits applicable, what insurance coverage is primary?

Medicaid is always the payer of last resort. Worker's Compensation, automobile coverage and any other liability insurance or payment is always primary.

2. If Medicaid is secondary, is it necessary to get authorization from the CMOs?

Yes. The CMOs require that you obtain an authorization from our Prior Authorization department through GAMMIS regardless of whether the CMO is the member's primary or secondary insurance.

3. Why didn't I get paid correctly for services that have been authorized?

There are a number of possible answers. In some cases, the services authorized are different than the services billed. This can occur because individual CPT or HCPCS codes differ between authorization entry and claims billing.

Also, dates of service authorized may vary from the dates of service shown on the form. It is important to make sure that both the persons calling for Prior Authorization and the billing staff have a common understanding about exactly what services have been authorized and when they are to be delivered.

4. When, if ever, am I allowed to bill the member for balances due?

The general rule to follow for the CMO Medicaid line of business is that the member cannot be balance billed. If you disagree with a claim payment decision, you should appeal the claim decision to the CMO and not attempt to collect any monetary funds directly from the member. The member may be billed only if the member knows that the service he or she is requesting is not a covered benefit and agrees to have the service performed by the provider.

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FAQ

5. If a member has other insurance, what is Medicaid's payment liability?

Medicaid is always the payer of last resort. If a member has other active coverage, such as Medicare or Blue Cross, the Medicaid liability is limited. Specifically, payment will be made only up to the contracted Medicaid rate. So if a primary insurer has paid more than Medicaid would have paid if its coverage were primary, then no additional reimbursement from Medicaid will be made.

Further Information

1. Who can I contact to get additional information about the Centralized PA process?

You may go to the DCH provider portal – GAMMIS – at www.mmis.georgia.gov to obtain more information. You can contact the specific CMO using the contact information listed below if you have specific questions related to policy and procedures.

CMO Name	Provider Services	E-mail	Web Site
WellCare	1-866-300-1141	GAPR@wellcare.com	https://georgia.wellcare.com/provider/resources
Peach State	1-866-874-0633	PSHPproviderservices@centene.com	http://www.pshpgeorgia.com/provider-quick-reference-information/
Amerigroup	1-800-454-3730	jewelmarie.simmons@amerigroup.com	https://providers.amerigroup.com/pages/ga-2012.aspx