GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner *Sonny Perdue, Governor*

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

Georgia Medicaid Children's Intervention Services
Frequently Asked Questions

Q. Why is the state changing its policy on CIS?

A. DCH wants to ensure the right care is provided for the right children at the right time. A child's need for therapy can change over time, and by standardizing the PA process and assuring medical necessity, we can be more certain that each individual child's needs are met.

Q. How will the CIS therapy change?

A. The change in the policy is that the Georgia Medical Care Foundation, which provides medical reviews for DCH, will be reviewing whether therapy services are medically necessary earlier than before and across multiple disciplines. In the past, a medical review submitted by the therapy provider was completed after 20 units of any one therapy per month, or 20 units of combined therapies per month. Beginning September 1, 2006, prior authorization was required for over eight units per month per member for any therapy specialty. These units include the evaluation visit. Prior authorization is based on medical necessity and is effective for up to 90 days.

Q. Why has Georgia Medicaid chosen to change the level at which Prior Authorizations (PAs) must start?

A. The Legislature mandated that the Department implement a care management model, including a gate-keeping function. On retrospective review of claims, CIS providers often billed up to and above the previous 20 unit per month threshold, far above that allowed by other health plans. The Department determined that it would adjust the threshold for prospective medical review, rather than have retrospective audits of medical necessity result in recoupments.

Q. When can I begin to submit PAs?

A. PAs may be submitted up to 30 days before the date that services are to begin.

Q. Will submitting a PA delay a child's therapy?

A. No, there should be no interruption of care if the provider submits a complete PA packet to Georgia Medical Care Foundation (GMCF) in a timely fashion. Providers will be notified by GMCF in a communiqué of any incomplete PA packets, which might delay the decision.

Q. Can therapists split PA requests?

A. Yes. PA requests may be split between two providers or one provider may receive all approved PA units for the child.

Q. How long are PAs good for?

A. PAs are effective for up to 90 days.

Q. I provide therapy for children eligible for Medicaid under the Katie Beckett/Deeming waiver. Does this policy change apply to them?

A. Yes. This new policy of medical review ensures that prescribed therapies are in fact medically necessary for children with this waiver.

Q. What if no PA is given for additional services?

A If a service is determined to not be medically necessary, it is considered a non-covered services. If a condition or situation changes, the PA may be resubmitted with updated documentation.

Q. What is a medical review process?

A. The review is based on confirmation from the patient's physician that he/she approves the plan of care and the proposed therapy is medically necessary. Once completed, the medical review team will review medical documentation to determine if the prescribed therapy service is medically necessary and is based on the needs of the member. The **medically necessary therapy** can be prescribed for three months at a time. Continuation of care beyond that the initial 3 months is assessed in the same manner each quarter. The prior authorization process can be obtained in advance at least 30 days before therapy services are rendered (for the next three months) to avoid interruption of care - if additional months of care are anticipated.

The review is based on confirmation from the patient's physician that the proposed therapy is medically necessary. Once completed, there is **no limit on the type or frequency of medically necessary therapy** that can be prescribed for the following three months of care. Continuation of care beyond that is assessed in the same manner each quarter. Prior authorization can be obtained for the next three months in advance to avoid interruption of care - if additional months are anticipated.

Q. Who performs the medical review or prior approval?

A. The revised medical review process will be conducted by the state's clinical review organization utilizing a team of Medical Directors including a Pediatrician and Pediatric Neurologist, Bachelor, and Master prepared pediatric nurses, and therapists representing the three disciplines (Occupational Therapy, Physical Therapy and Speech and Language Pathologist).

Q. Where can I find out more information about the policies and procedures for the CIS changes?

A. You can go to the Georgia Health Partnership web portal at https://www.ghp.georgia.gov, click on the Provider tab and look at the section marked Medicaid manuals. The Children's Intervention Services manual is among those listed. You may also contact the Maternal and Child Health Section of the Georgia Department of Community Health at: 404-651-5785 or toll free at 800-377-3557.

Q. How does Georgia compare with other health plans in the state?

A. According to the surveys and reviews the state has conducted, Georgia falls within the

high end of service limits for states and private pay providers.

Q. Can a member be seen by an enrolled Medicaid provider and a school therapist?

A Therapy services can be rendered under both the CIS and the CISS programs to the same member. Medicaid reserves the right to review the members' Individualized Education Plan (IEP) to avoid duplication of services.

Important reminders in submitting PAs:

Services Available Without Prior Authorization:

a. 8 units per month per member for each therapy specialty (Inclusive of the evaluation)

Note: The policy change of 16 units per month for more than one therapy specialty is **no longer applicable** for September 1, 2006. The Department will pursue an external vendor to provide case management to assist children with complex needs.

b. Units in **excess** of 8 units per month for any member per therapy specialty will require Prior Authorization.

Note: Providers should note that some codes and specialties have other existing limitations and restrictions; please refer to the CIS policy sections, Chapter 900 [scope of services] and Chapter 1000 [reimbursement], for code limits.

Procedures for Obtaining and Billing Prior Approval Units:

a. Refer to the current Prior Authorization procedures in the CIS policy manual in Section 802.2. Any units above the limit as specified in 1.a. (above) will require a prior authorization before providing the additional services.

Note: Providers could begin submitting PA's for medically necessary services as of August 1, 2006, for service dates beginning in September.

- The provider must specify the requested start date on the PA.

- PA's should be submitted no sooner than 30 days prior to date that services are to begin (**new policy**).

- If a member requires more services **beyond** the 8 units for a single therapy specialty (even if involving more than one therapist), it is the responsibility of those providers to decide who requests and receives the additional PA units requiring prior authorization.

- Requests for PA should include the total number of units requested for each specific procedure code requested; i.e., 12 units 97533; 6 units 92609.

- A PA number is required only after you have used the maximum units allowed in policy as stated above. Do not use a PA number if the member is within the limits established by policy.

The following items are required for medical review and approval of additional services requiring prior authorization:

- A copy of the written service plan must be submitted with each request for additional therapy services, including children serviced under BCW. The written service plan must include the member's diagnosis or condition requiring services; a complete description of the services requested, including frequency and duration of services along with the name and specialty of the provider. Plan must include specifics of client's current level of function as well as goals to be achieved with additional therapies and time lines to reach projected goals. If the child also has an IEP/IFSP, in addition to the written service plan, it must be submitted with the request. If the child does not have an IEP/IFSP or is not available, please note this on the DMA-81 in Block #18 (additional comments).

- Provider's progress notes showing details of previous therapy interventions and member's response to said therapy sessions.

- Requestor is required to document where services are to be provided.

- Letter of Medical Necessity is required with detailed information which includes, but is not limited to the following:

  1) Child's current diagnosis and/or condition requiring therapy.
  2) Child's progress to date.
  3) Expected outcomes with timeframe to achieve said outcomes.
  4) Relevant medical information supporting need for therapy.
  5) Physician's original signature and date.

  All PA approvals will be based solely on medical necessity.

- Providers can either fax the above required items to GMCF at (678) 527-3001 or mail them to Gmcf at:

  GMCF PreCert
  GHP
  P.O. Box 7000
  McRae, GA 31055

  Note: When mailing or faxing documents, place the member's ID# on each page and a PA# so the pages can be matched should they become separated.

- For web questions, contact the ACS Customer Interaction Center (CIC) at (404) 298-1228 or (800) 766-4456.

If all requirements are not submitted as outlined above, the provider will be notified by a communiqué from GMCF. Approvals will be approved no sooner than the date reviewed by GMCF.

For further information, contact Sherri Collins at (404) 463-6096 or scollins@dch.ga.gov.