Amerigroup RealSolutions in healthcare

Provider update

Behavioral health assessment and service plan development authorization update notification

Summary of update:

Effective April 1, 2022, all members will be allowed up to 16 units of behavioral health assessment, and 16 units of service plan development, per provider, per member, during a calendar year, before prior authorization is required.

Why is this change necessary?

Amerigroup Community Care is committed to ensuring our members receive high-quality, clinically appropriate services.

The purpose of the behavioral health assessment process is to gather information needed to determine the youth's problems, symptoms, strengths, needs, abilities, resources, and preferences. The information gathered should support the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders. Reassessments should be utilized to ensure treatment plans are updated as goals are completed and/or new goals need to be added.

Service plan development should include information from the behavioral health assessment and ultimately be used to develop with the individual an individualized recovery plan that supports recovery and is based on goals identified by the individual.

What is the impact of this change?

Beginning April 1, 2022, once a member has exhausted 16 units of mental health assessment and/or 16 units of the service plan code, all additional sessions will require the provider to follow the prior authorization process. Please note:

- The affected CPT® codes are H0031 and H0032. Each provider has 16 units of each code, per member for a calendar year. On January 1 of each year, all members will start the year with 16 units of each code.
- Any unused units in the current year will not extend into a new calendar year.
- The provider is responsible for tracking units billed and knowing when a prior authorization is required for either code.
- This change will not impact trauma assessments for newly enrolling or re-enrolling Georgia Families 360°SM foster care members age 5 years or older when billed with the following code and modifier:
    - H0031 plus provider descriptor (U3, U4, etc.) and TJ modifier.
    - The TJ modifier should not be used for a standard behavioral health assessment, only for trauma assessments.
    - Only the actual number of units used to complete the face-to-face assessment should be billed.
- The provider is responsible for tracking units billed and knowing when a prior authorization is required for either code.

- Prior authorizations submitted for either code before the member reaches the limit will only become effective after 16 units of either of the requested codes are exhausted.
- The requesting or servicing provider must submit all prior authorization requests with all supporting clinical documentation, to the Alliant Georgia Medicaid Care Foundation website (**www.mmis.georgia.gov/portal**). Please note that faxed clinical information will not be accepted.
- If the items on **www.mmis.georgia.gov/portal** are completed with the most up-to-date clinical information; no attached documents are necessary.
- If the request for continuation of services is denied, an appeal may be submitted within 60 days of the denial notification. Appeals can be faxed to **877-842-7183** or can be mailed to:

  Amerigroup Community Care
  Medical Appeals
  P.O. Box 62429
  Virginia Beach, VA 23466
- This change will impact Georgia Families members and Georgia Families 360°$_{SM}$ members, outside of trauma assessments.
- Failure to follow this process may result in an adverse request decision after 16 units of each code have been exhausted in a calendar year.

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your assigned Provider Experience associate or call Provider Services at **800-454-3730**.