Amerigroup RealSolutions® in healthcare

Provider Manual Addendum

Behavioral Health

1-800-454-3730

https://provider.amerigroup.com/GA

Georgia Families
Choices for a Healthy Life

Georgia Families 360°SM

GA-PM-0034-20

Behavioral Health Services
Provider Manual Addendum

Updates and Changes

This provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. The most updated version is available online at https://provider.amerigroup.com/GA. To request a free, printed copy of this manual, call Provider Services at 1-800-454-3730.

If there is an inconsistency between information contained in this manual and the agreement between you or your facility and Amerigroup Community Care, the agreement governs. In the event of a material change to the information contained in this manual, we will make all reasonable efforts to notify you through web-posted newsletters, provider bulletins and other communications. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including but not limited to bulletins and newsletters.

Overview

At Amerigroup Community Care, we plan our approach to treatments and services in collaboration with the family and all organizations involved in the member's life. We aim to provide a comprehensive system of care that is community-based and promotes healthy outcomes for adults, children, youth and their families. We embrace the practice of family-driven, culturally and linguistically competent care utilizing, whenever possible, evidence-based or best practice-subscribed services and supports. Amerigroup always strives to use the least restrictive and least intrusive services that are condition-appropriate.

Behavioral health services are an integral part of health care management at Amerigroup. Our mission is to coordinate the physical and behavioral health care of members by offering a wide range of targeted interventions, education and enhanced access to care to ensure improved outcomes and quality of life for members. Amerigroup works collaboratively with hospitals, group practices and independent behavioral health care providers, as well as community agencies, Georgia's community service boards and other resources to successfully meet the needs of members with mental health and substance use conditions, and/or intellectual and developmental disabilities.

The goals of the Amerigroup behavioral health program are to:

- Ensure and expand service accessibility to eligible members
- Promote the integration of the management and delivery of physical and behavioral health services
- Achieve quality outcomes, including those related to Healthcare Effectiveness Data and Information Set (HEDIS®) and the National Committee for Quality Assurance (NCQA)
- Work with members, providers and community supports to provide recovery tools and create an environment that supports members' progress toward their recovery goals
- Ensure utilization of the most appropriate and least restrictive medical and behavioral health care in the right place and at the right time

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

The objectives of the Amerigroup behavioral health program are to:

- Promote continuity and coordination of care among physical and behavioral health care practitioners
- Enhance member satisfaction by implementing individualized and holistic support and care plans that allow members to achieve their recovery goals
- Provide member education on treatment options and pathways toward recovery
- Provide high-quality case management and care coordination services that identify member needs and address them in a person-centered and holistic manner
- Work with care providers to ensure the provision of medically necessary and appropriate care and services (e.g., inpatient care, alternative care settings and outpatient care), at the least restrictive level
- Enhance provider satisfaction and success through collaborative and supportive relationships built on mutually agreed upon goals, outcomes and incentives
- Promote collaboration between all health care partners to achieve recovery goals through education, technological support and the promotion of recovery ideals
- Use evidence-based guidelines and clinical criteria, and promote their use in the provider community
- Maintain compliance and accreditation standards with local, state and federal requirements
- Amerigroup contracted providers shall deliver behavioral health and substance use disorder services in accordance with best practice clinical guidelines, rules, regulations and policies and procedures set forth by the:
    - State of Georgia's Department of Community Health
    - Department of Behavioral Health and Developmental Disabilities Manual; specifically:
        - Utilization, Service Definition, Admission, Continuing Stay, Discharge Criteria, Service and Clinical Exclusions
        - Documentation requirements

Coordination of Behavioral Health and Physical Health Treatment

Key elements of the model for coordinated and integrated physical and behavioral health services include:

- Ongoing communication and coordination between primary medical providers and specialty providers, including behavioral health (mental health and substance use) providers
- Screening by primary medical providers for mental health, substance use and co-occurring disorders
- Discussions by behavioral health provider of physical health conditions
- Referrals to primary medical providers or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders and/or any known or suspected and untreated physical health disorders
- Development of person-centered treatment plans, involving members as well as caregivers and family members when appropriate
- Case management and disease management programs to support the coordination and integration of care between providers, as indicated by member needs

Fostering a culture of collaboration and cooperation helps sustain a seamless continuum of care between physical and behavioral health, and positively impacts member outcomes. To maintain

continuity of care, patient safety and member well-being, communication between behavioral health and physical care providers is critical; especially for members with comorbidities receiving pharmacological therapy.

Systems of Care

Services provided to people with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles, which are endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Mental Health Services (CMHS). Services should be:

- Person-centered and family-focused, with the needs of the person and family dictating the types and mix of services provided
- Community-based, with the focus of services as well as management and decision-making responsibility resting at the community level
- Culturally competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve
- Comprehensive, covering an array of services that address physical, emotional, social, educational and cultural needs
- Personalized, as evidenced by an individualized service plan formulated to meet the member's unique needs and potential
- Delivered in the least restrictive, most normative environment that is clinically appropriate
- Integrated and coordinated between agencies, including mechanisms for planning, developing and coordinating services inclusive of case management, or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the person and their family
- Delivered without regard to race, age, religion, national origin, sex, physical disability, sexual orientation or other characteristics
- Oriented to recovery, providing services that are flexible and evolve over time

Medically Necessary Behavioral Health Services

Medically necessary behavioral health services means those behavioral health services which:

- Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain or prevent deterioration of functioning resulting from such a disorder
- Are in accordance with professionally-accepted clinical guidelines and standards of practice in behavioral health care
- Are furnished in the most appropriate and least restrictive setting in which services can be safely provided
- Are the most appropriate level or supply of service that can safely be provided
- Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered
- Are not primarily for the convenience of the doctor or member

Behavioral Health Care Providers

Behavioral health licensed and paraprofessional staff can offer covered behavioral health and/or substance abuse services when:

- Services are within the scope of their professional license
- The licensed behavioral health specialist is a credentialed Medicaid provider and registered in the Amerigroup provider network
- The paraprofessional staff are employed by a behavioral health agency approved by the Department of Behavioral Health and Developmental Disabilities (DBHDD) as a CORE, Intensive Family Intervention (IFI), or Community Service Board (CSB) provider
- Services are within the scope of the benefit plan and contractual requirements

Behavioral Health Emergency Services

Behavioral health emergency services are recommended for members experiencing acute crises resulting from a mental illness. An acute crisis is an incident at a level of severity that meets the requirement for involuntary examination pursuant to *2010 Georgia Code Title 37, Chapter 3* and, in the absence of a suitable alternative or psychiatric medication, would require the hospitalization of the member.

Emergency behavioral health services may be necessary if the member is:

- Suicidal
- Homicidal
- Violent with objects
- Unable to take care of his or her activities of daily living due to suffering a precipitous decline in functional impairment
- Alcohol- or drug-dependent and experiencing severe withdrawal symptoms

In the event of a behavioral health and/or substance abuse emergency, the safety of the member and others is paramount.

Instruct the member to seek immediate attention at a behavioral health crisis service facility. In the event of a medical concern in conjunction with the behavioral health and/or substance abuse emergency, please instruct the member to seek treatment at the nearest emergency room.

Contact the Georgia Crisis and Access Line at 1-800-715-4225 or emergency dispatch services (911) if the member is in imminent danger to him or herself or others and is unable to get help on his or her own from a facility mentioned above or behavioral health agency, licensed psychiatrist, psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT).

Integration of Physical and Behavioral Health Services

Integration Program Overview

We're committed to supporting the Georgia Department of Community Health's (DCH's) goals of integrating behavioral health and physical health providers to provide the best care for the member.

The behavioral health provider will:

- Obtain the member's or the member's legal guardian's consent to send behavioral health status reports to the member's PCP/specialists.
- Send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the member's PCP/specialist(s). This can be in the form of a treatment plan, care plan, updated crisis plans and/or any other pertinent information.

- Utilize specific billing codes to document the time and effort spent on this task. This documentation can and will be audited for compliance.
- Upon being informed that a member who's been seen and billed by him/her within the last six months has an inpatient admission, confirm whether the member is still receiving services there, collaborate on the importance of the seven-day follow-up appointment following discharge, and address any barriers to treatment, past and present.

Amerigroup will:

- Add appropriate billing codes to the provider fee schedule to allow providers the opportunity to document the time and effort spent in engaging in integration with the member's PCP/specialist(s).
- Audit providers as necessary to review this documentation.
- Contact behavioral health providers when a member who's been seen/billed by that provider within the last six months has an inpatient admission.
- Assist providers in removing any barriers to successful discharge planning and continued step-down services.

Provider Roles and Responsibilities

We believe the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure that we jointly meet quality and recovery goals. Our commitment includes:

- Improving communication of the clinical aspects of behavioral health care to improve outcomes and recovery
- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person
- Simplifying precertification rules, referrals, claims and payment processes to help providers reduce administrative time and focus on the needs of members
- Monitoring the quality of the behavioral health provider network in accordance with the standards and expectations outlined in the Amerigroup provider manual
- A team of clinical care managers, case managers and support staff providing high-quality care management and care coordination services to our members, and striving to work collaboratively with all providers
- Amerigroup case management and care coordination teams acting as a liaison between the physical and behavioral health providers to ensure communication occurs between providers in a timely manner, and facilitating coordinated discussions (when indicated) to meet the health outcome goals of the member's care plan

Our experienced behavioral health care staff is available 24 hours a day, 7 days a week to help identify the closest and most appropriate behavioral health service provider. Providers can call Provider Services at 1-800-454-3730, and members can call Member Services at 1-800-600-4441 for help with finding a provider.

At Amerigroup, our behavioral health care benefit is fully integrated with the rest of our health care programs. This coordination of health care resources requires certain roles and responsibilities for behavioral health providers, including:

- Participating in the care management and coordination process for each Amerigroup member under their care
- Seeking prior authorization for all services that require it

    - For more information on prior authorization, visit our provider website at https://provider.amerigroup.com/GA and:
        - Use our *Prior authorization Lookup Tool* to search for services by code
        - See the *Precertification and Notification* section of the comprehensive provider manual, located under *Resources* > **Provider Manuals, Policies and Guidelines** section of the website.
        - Check your quick reference card, also available under *Resources* > **Provider Manuals, Policies and Guidelines** section of the website.
- Understanding the service definition of each available service and ensuring that those services with face to face component requirements (Intensive Family Intervention has 50% and Community Support Individual has 80%) are being met.
- Offering hours of operation that are no less than the hours of operation offered to commercial members

Member Records and Treatment Planning

The Georgia Health Information Network

The Georgia Health Information Network (GaHIN) helps providers close the information gap and improve the quality of patient care across the state. The electronic health record is structured to provide data in a summarized, user-friendly printable format and employs hierarchical security measures to limit access to designated persons. It is available 24 hours a day, 7 days a week, except during limited scheduled system downtime. Amerigroup encourages all providers to enroll and participate in the GaHIN.

For more information, please email info@gahin.org.

Comprehensive Assessment

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

- Information related to the provision of appropriate services, with documentation in a prominent place whether there is an executed declaration for mental health treatment.
- Providers must submit **a signed service order by an appropriately credentialed practitioner along with a comprehensive assessment** that provides a description of the member's physical and mental health status at the time of admission to services. It should include:
    - Psychiatric and psychosocial assessment including:
        - Child and Adolescent Needs and Strengths (CANS), Level of Care Utilization System (LOCUS) or other industry-recognized assessment scoring tool
        - Description of the presenting problem with specific information about behaviors from the most recent 30 days
        - Psychiatric history and history of the member's response to crisis situations
        - Psychiatric symptoms
        - Diagnosis using ICD-10
        - Mental status exam
        - Rating scales as indicated per clinical policy guidelines.
    - Medical assessment including:
        - Screening for medical problems
        - Medical history
        - Present medications
        - Medication history

- Substance use assessment including:
  - Frequently used over-the-counter medications
  - Current and historical usage of alcohol and other drugs reflecting the impact of substance use in the domains of the community functioning assessment
  - History of prior alcohol and drug use, as well as treatment episodes and their effectiveness
- Community functioning assessment or an assessment of the member's functioning in the following domains:
  - Living arrangements and daily activities (vocational/educational)
  - Social support
  - Financial
  - Leisure/recreational
  - Physical health
  - Emotional/behavioral health
- An assessment of the member's strengths, current life status, personal goals and needs

Personalized Support and Care Plan (Treatment Plan)
A patient-centered support and care plan based on the psychiatric, medical substance use and community functioning assessments found in the initial comprehensive assessment must be completed for any member who receives behavioral health services. There must be documentation in every case that the member and his or her family members, caregivers or legal guardian (as appropriate) participated in the development and subsequent reviews of the treatment plan.

The support and care plan must be completed within the first 30 days of admission to behavioral health services and updated as clinically appropriate or at a minimum annually, based on the member's progress toward goals or a significant change in psychiatric symptoms, medical condition and/or community functioning, or as required by the service definition.

There must be a signed release of information to provide information to the member's primary medical provider or evidence that the member refused to provide a signature. There must be documentation that referral to appropriate medical or social support professionals have been made.

A provider who discovers a gap in care is responsible to help the member get that gap in care fulfilled and documentation should reflect the action taken in this regard.

For providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written, and updated as appropriate, for each of the different services that are being provided to the member.

The treatment/support/care plan must contain the following elements:
- Identified problem(s) for which the member is seeking treatment
- Member goals related to each problem(s) identified, written in member-friendly language
- Measurable objectives to address the goals identified
- Target dates for completion of objectives
- Responsible parties for each objective
- Specific measurable action steps to accomplish each objective
- Service code(s) that will be used to address each objective
- Individualized steps for prevention and/or resolution of crisis, which includes:
  - Identification of crisis triggers (i.e., situations, signs and increased symptoms)

    - Active steps or self-help methods to prevent, de-escalate or defuse crisis situations
    - Names and phone numbers of contacts who can assist the member in resolving a crisis
    - The member's preferred treatment options, including psychopharmacology in the event of a mental health crisis
- Actions agreed to be taken when progress towards goals is less than originally planned by the member and provider
- Signatures of the provider completing the treatment plan, member, as well as family members, caregivers or legal guardian(s), as appropriate

Progress Notes

Progress notes should include the following items:

- Correct name and identification number of the member receiving the service
- Billing information including the:
    - Correct code for the service provided
    - Correct code for practitioner level providing the service
    - Beginning and ending time of the service
    - Total units/encounters used
- Intervention that ties to a corresponding goal and objective from the member's established treatment plan
- An established and structured note format (e.g., behavior, intervention, response and plan [BIRP], subjective, objective, assessment and plan [SOAP], etc.)
- Support for amount of units used
- Name, signature and credentials of person providing the service
- The date the note was signed

Discharge Summary

At the conclusion of services provided by the agency, a structured discharge summary should be developed and made available to the member within 14 days of the final session. The discharge summary should contain the following items:

- Medications at the time of discharge
- Review of the member's plan of care
- Review of the member's involvement and engagement in the treatment process
- Any follow-up appointments by date, time and name of practitioner
- Any recommendations for ongoing care and services for the member
- Signature of the member and their respective family/caregiver, treating physician and/or clinician

For any member with an unplanned discharge, a discharge summary should still be created by the provider and submitted to the member's medical record.

Psychotropic Medications

Prescribing providers must inform all members considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications and other forms of treatment. If obesity is also a problem, the medical record needs to reflect that a healthy diet and exercise plan has been prepared and given to the member, or if appropriate, a referral to a nutritionist or obesity medical professional. If diabetes is a problem, the medical record needs to reflect a discussion with the member about their condition, and their treating provider should be identified in the documentation and coordination efforts with that provider as well.

The documentation is expected to reflect such conversations as having occurred. The medical record is expected to indicate the prescription data has been shared with the member's primary medical provider.

Members on psychotropic medications may be at increased risk for various disorders; the expectation is that providers are knowledgeable about side effects and risks of medications and regularly inquire about and look for them. This especially includes:

- Following up to inquire about suicidality or self-harm in children placed on antidepressant medications as per Food and Drug Administration and American Psychiatric Association guidelines
- Regular and frequent weight checks and measurement of abdominal girth, especially for those on anti-psychotics or mood stabilizers
- Glucose tolerance test or hemoglobin A-1C tests, especially for those members on anti-psychotics or mood stabilizers
- Triglyceride and cholesterol checks, especially for those members on anti-psychotics and mood stabilizers
- Electrocardiography (ECG) checks for members placed on medications with risk for significant QT-prolongation
- Ongoing checks for movement disorders related to anti-psychotic use and psychotic disorders

Appropriate follow-up for children prescribed ADHD medications is essential. Providers should:

- Ensure that children are appropriately diagnosed using rating scales (completed by parents and the school)
    - Note: Several tools, such as the Vanderbilt ADHD Diagnostic Rating Scale, are available online at no charge
- For a first-time user; see the child at least once within the first month, and twice more during the next nine months

Routine antidepressant medication management involves:

- Confirming the patient understands that some people need to remain on medication for several months or years (maintenance therapy).
- For a first-time user, encouraging members to follow up with you for medication refills as needed.

On initiation and engagement of alcohol and other drug dependence, the following standards should be facilitated:

- Every time a patient receives a primary or secondary diagnosis indicating abuse of alcohol or other drugs, schedule a follow-up visit within 14 days.
- During the second visit, schedule two additional visits and/or schedule the patient to see a substance abuse treatment specialist within the next 14 days.

Guidelines for such testing and follow-up are provided by the American Psychiatric Association, among others. Summary guidelines are referenced in our clinical practice guidelines located on our provider website at https://provider.amerigroup.com/GA. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure that these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions must be documented in the member's medical record.

Quality Monitoring, Record Audits and Provider Communication Initiative

Amerigroup has established a partnership with Alliant Health Solutions to assist in validating provider compliance with applicable health care policies, and identify instances of incorrect billing and/or medically unnecessary or inappropriate services. Through the use of proprietary software, Alliant Health Solutions includes employee roster review, desktop audits, claims patterns and trend analysis, statistical summary and comparative data reporting to support provider education and prevent/reduce risk of inappropriate utilization and/or billing practices. Utilizing systematic sampling methodology and a broad range of algorithms, the audits will be customized to support Amerigroup-specific policies and expectations as outlined in the Amerigroup provider manual, this addendum (see the *Member Records and Treatment Planning: Psychotropic Medications* section), clinical practice guidelines, medical necessity criteria and the general requirements of the state licensing agencies.

Provider cooperation with the Amerigroup Behavioral Health Quality Management program is essential to ensure compliance with state and federal requirements to prevent fraudulent or abusive health care billing practices. Providers will be notified 14 business days in advance of record retrieval requests. Member records can be provided by mailing hard copy records or through electronic media at the provider's preference, assuming the provider has confirmed with the audit vendor that the media used will be compatible with the Alliant/GMCF systems. Alternatively, providers may request to submit electronic copies by contacting the Behavioral Health Review Helpline at 1-888-507-0709 to request electronic uploading access.

All records must be available by the scheduled record retrieval timeline. Failure to include documentation for service(s) rendered may result in recoupment. Failure to respond timely to certified record requests received via certified mail will result in assumption of lack of available documentation, and the deficiency will be noted in the audit report and subsequent request for recoupment. Amerigroup is targeting approximately 45 business days from the time of review completion for provider follow-up meetings, including a comprehensive report outlining the audit findings. Please note this timeline is dependent upon review findings, provider availability and mutual scheduling needs. For audit reviews that do not require any additional processing, provider follow-up meetings may take place in person or teleconference. Corrective action plans will be due 14 calendar days after the provider follow-up meeting. Recoupment, re-auditing and termination from the network may be required when indicated by audit findings.

Guidelines for Submitting Outpatient Service Requests

Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can help expedite and ensure appropriate service requests are successfully approved. We encourage providers to use the secure Amerigroup provider website to request services.

Free training webinars are available for providers. You can access live and on-demand webinars, online demonstrations and tip sheets. For a list of upcoming webinars, visit rsvpbook.com/Amerigroup.

Different types of services require provider communication of different clinical information to Amerigroup. Some services do not require authorization before delivery (e.g. H0031 behavioral health assessment). Other services do require prior authorization (PA) (e.g., H2015 Community Support Individual, H2014 group skills).

Prior Authorization (PA) is a prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical

history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. Prospective means the coverage request occurred prior to the service being provided.

If PA is required, you **must** get prior approval from Amerigroup before rendering the requested service. Prescriptions written for preferred or nonpreferred antipsychotic medications in children age 17 and under will also require a PA. Prior to discharge from a hospital or inpatient behavioral health facility, providers should check the formulary status of all new drugs started that will be continued as an outpatient. If PA is required, the request should be submitted prior to discharge. Visit our *Preferred Drug List* (*PDL*) and *Prior Authorization Lookup Tool* at https://provider.amerigroup.com/GA for more information.

Providers should initiate PA service requests by filling out the form at https://provider.amerigroup.com/GA > *Resources* > **Forms** > **Behavior Health** > ***Psychological Testing Request Form - Medicaid***. Once complete:

1. Log on to the secure provider self-service website.
2. Select **My Payer Portal**.
3. Select **Precertification** from the left-hand navigation.
4. From the *Precertification* tab, select **Precertification Type**.
5. Complete the *Request Info* tab.

Completing an Outpatient Service Request

All outpatient prior authorization requests, except for psychological testing, IOP and PHP, should be submitted through the Centralized Authorization Portal on the GAMMIS website. The exception services should be submitted via the Availity portal.

Service requests should be submitted only for the number and type of services indicated by the individualized recovery plan (IRP) and are expected to be utilized in the next six months, with exceptions for intensive family intervention (IFI) services, assertive community treatment (ACT), substance abuse intensive outpatient programs (SA IOPs) and Intensive Customized Care Coordination (IC3), which are authorized for 30 days and require subsequent concurrent review ongoing when indicated.

- When completing the OTR, the first section is demographic information.
    - When submitting using the secure website, this section does not need to be completed; the secure site automatically connects to the specific member.
- Complete the *Provider Info* tab.
    - Provider information for Core services providers and community service board (CSB) agencies should be noted as the *Agency Name*, not the individual practitioner who will be providing the services. Provider information for individually-credentialed practitioners should reflect the individual provider's name.
- Complete the *Diagnosis* tab.
    - A full ICD-10 diagnosis is needed; please use diagnosis codes for easy identification.
- Complete the *Supporting Files* tab.
    - Please create a **current** symptom table, designed to give a quick, **current** overview of the members' symptoms.
    - Mark the check boxes to represent the severity of the symptoms as mild, moderate, severe, acute or chronic.
- The *Medications* section should note the type, dosage, frequency and the prescribing provider.
- Complete the *Review and Submit* tab.
- Select the **Submit Auth Request** button.

Please note: Amerigroup makes every effort to process requests as soon as possible, up to the allowed 3 business days. Please be sure to keep a copy of the submission confirmation number for reference.

Provider Guidelines for Submitting Inpatient/Crisis Stabilization Unit/Psychiatric Residential Treatment Facilities Service Requests

Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can help expedite and ensure service requests are successfully approved. Please see the directions below for submission of authorization requests:

- Submit via the secure self-service site by logging in at https://provider.amerigroup.com/GA within 24 hours of a member admitting into the facility or one calendar day of admission.
- Submit concurrent review clinical information to support authorization for continued stay in the inpatient setting via the secure site.
    - Discharge planning begins at admission and should be noted in the member record.
- Schedule family sessions as soon as possible for all members.
- Prior to discharge, coordinate with family and care coordinators as appropriate to schedule a member appointment within seven days with a psychiatrist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT) or psychologist.
- Prior to discharge, determine whether the member's medications need prior approval.
- Fax the discharge clinical information within 24 hours of discharge, to ensure case managers have the opportunity to follow up with members in a timely manner and ensure compliance with discharge appointments.

Frequently Asked Questions: Crisis Stabilization Units

When should a referral be made for evaluation and possible admission to a crisis stabilization unit (CSU)?
When a youth is experiencing a psychiatric emergency and a licensed behavioral health professional has determined imminent risk of self-harm, harm to others and/or the youth is experiencing signs of psychosis (i.e., hearing voices or seeing things that are not really there). The referral can be made by a licensed professional who may work, for example, in a local community mental health program, a private practice, emergency department or mobile crisis team.

What is the role of Amerigroup in determining and approving admission to a CSU?
The CSU staff will provide an evaluation of the member and contact Amerigroup upon completion of their initial assessment. The completed assessment will be presented to the Amerigroup Utilization Management (UM) team for review, to determine the appropriate treatment services for the member based on medical necessity criteria. This review may include the Amerigroup medical director.

At the time of the review, the member must currently meet the medical necessity criteria for approval for continued stay. The turnaround time for Amerigroup to review and make a determination for approval or denial is 24 hours.

For Georgia Families 360°$_{SM}$ members, how will service approvals and denials be communicated to the Division of Family and Children Services (DFCS) case manager or Department of Juvenile Justice (DJJ) juvenile probation/parole specialist?
The Amerigroup UM team will notify the CSU staff of the treatment recommendations for the member. If the recommendations do not include admission to the CSU based on medical necessity criteria for an

admission a denial letter is released to provider and to guardian. The Amerigroup care coordinator will work in conjunction with the DFCS CM/DJJ JPPS and the CSU social worker (or designated staff of the CSU) to coordinate care and assist the member in receiving the most appropriate treatment level.

For Georgia Families 360°$_{SM}$ members, who identifies treatment options if the youth has been denied for CSU stabilization services?
The CSU staff will provide treatment recommendations for the member that meets their treatment needs. The Amerigroup care coordinator will work to assist the DFCS CM/DJJ JPPS with coordination of health care services, including behavioral health treatment services and medical services for the youth to access those services that best fit their treatment needs. Some examples of these possible treatment alternatives could be, but are not limited to: partial hospitalization, an intensive outpatient program, a Core services provider, an intensive family intervention program, etc.

If a member is admitted to the CSU, what is the role of Amerigroup for the length of stay?
The Amerigroup UM team will conduct continued stay reviews to ensure the member is receiving the most appropriate treatment. Through a medical necessity review, a determination will be made on whether or not the youth continues to meet medical necessity criteria for continued services, or is stabilized and ready for discharge from the CSU.

During the youth's stay at the CSU, what is the role of Amerigroup in providing care coordination services?
The Amerigroup UM staff will work in conjunction with the CSU UM staff on a daily basis to stay abreast of the youth's condition, need for continued stay or readiness for discharge. The Amerigroup care coordinator will attend (in person or by phone) all scheduled discharge planning meetings set by the CSU treatment team. For Georgia Families 360°$_{SM}$ members, the Amerigroup care coordinator will provide continuing stay information to the DFCS CM/DJJ JPPS on a daily basis and will work to assist them in coordinating any needed health care services the youth will require following discharge.

For Georgia Families 360°$_{SM}$ members, what is the time frame for Amerigroup to notify the DFCS CM/DJJ JPPS that the youth is ready for discharge?
Plans for discharge begin upon admission to the CSU. Once the youth is stable and ready for discharge, the discharge plan that was developed will be implemented in conjunction with the DFCS CM/DJJ JPPS and the Amerigroup care coordinator, based on recommendations by the CSU treatment team. When the youth no longer meets medical necessity for the CSU level of care, it is expected the youth will be discharged to the DFCS CM/DJJ JPPS by the next calendar day.

For Georgia Families 360°$_{SM}$ members, when a youth is being discharged from a CSU but the DFCS CM/DJJ JPPS has not been able to locate placement for the member, will the member remain in the CSU until a placement is located?
No. Amerigroup benefits cover stabilization services and cannot be used to pay for placement beyond the approval period for which medical necessity has been determined.

I still have questions about this. Who can I talk to?
Please direct all questions regarding CSU services to our Provider Services team at 1-800-454-3730.

Frequently Asked Questions: Psychiatric Residential Treatment Facilities

Q1: Are CORE Providers the only provider type able to submit an authorization for PRTF services?

A1: No, requests for PRTF services are not limited to CORE providers. Any licensed independent provider (Psychiatrist, Psychologist, Licensed Social Worker, Licensed Professional Counselor Licensed Marriage and Family Therapist, Advanced Practice Registered Nurse) credentialed with Amerigroup may submit an authorization request to Amerigroup for PRTF services that is currently in treatment with the member. PRTF providers who are currently treating an Amerigroup member can submit a request for authorization for that member.

Q2: How do I submit an authorization for PRTF services?
A2: For youth enrolled in Georgia Families 360°SM, providers should go to www.provider.amerigroup.com/GA and select **Forms** under the *Resources* tab. On the *Forms* page, find the Behavioral Health section and select the "+" button to expand, and then select the **Behavioral health psychiatric residential treatment facilities initial review form**. Complete the required information requested on the form and write "Georgia Member 360°" across the top of the request. Please utilize the Availity system to submit requests and upload completed form.

Q3: What information should be included in the PRTF request/submission?
A3: All fields on the Behavioral health psychiatric residential treatment facilities initial review form should be addressed and be verified as 'accurate and complete' prior to submission. Additionally, any available clinical documentation supporting the PRTF request should be attached and submitted along with the completed form.

Supporting Documentation can include (but is not limited to) a psychiatric evaluation completed by a MD within the past (30) days; current DFCS /DJJ records; a psychosocial or similar document with an outline of the youth's treatment and placement history, family history, history of offenses; a psychosexual assessment; history of psychiatric / substance abuse treatment; school records or IEP, any other needed assessment information deemed applicable and pertinent to the processing of the PRTF request

Q4: **What is the Amerigroup (AGP) approval process for PRTF service requests?**
A4: Once a completed Behavioral health psychiatric residential treatment facilities initial review form and supporting clinical documentation is received by Amerigroup, the request will be staffed with the Amerigroup Medical Director and be processed within 3 business days. A decision based on the Amerigroup designated Medical Necessity Criteria will be made within three (3) business days from receipt of the request.

The decision made by the Amerigroup Medical Director will be communicated to the requesting provider via (Availity Portal, E-mail and/or telephonic update).

If the decision results in a denial or split decision, a denial letter is mailed to the provider.
The Utilization Management (UM) Team will also notify the assigned Amerigroup Care Coordinator for Georgia Families 360°SM of the decision.

The Amerigroup Care Coordinator for Georgia Families 360°SM will contact the DFCS Case Manager or the DJJ Community Case Manager (CCM) with the decision information. If the authorization request was not approved, the Amerigroup Care Coordinator for Georgia Families 360°SM will present the clinically recommended alternative service options.

All approved PRTF authorizations for the Georgia Families 360°SM members are based on clinical necessity. A prior authorization does not guarantee continued stay coverage or reimbursement for the entire period of authorization. PRTF approval does not immediately constitute admission to a facility. Bed availability and admission is solely up to the treating facility.

If approved, all in-state PRTF facilities must be exhausted before looking into out of state facility treatment beds.

The PRTF initial authorization is valid for 30 days. If a PRTF is not found within those 30 days, the authorization will be voided and another precertification request will have to be submitted for review as a member's presentation can change over time.

Q5: Who identifies the PRTF for the approved youth to be admitted?
A5: The requesting provider or acute facility looks for the appropriate PRTF facility to meet the clinical needs of the youth. Taking into consideration the preferences of the parent (regardless of who is fulfilling that role), this would be a collaborative discussion via conference call between the DFCS Case Manager/DJJ CCM, the requesting facility / provider, and when clinically appropriate the Amerigroup Care Coordinator within 24 hours of prior authorization approval. Once a facility has been identified, continued stay is based upon medical necessity criteria. Bed availability is at the facilities discretion.

It is also imperative for all legal guardians/ DJJ CCM be available for contact for medication consent, treatment planning, and discharge planning once a member is approved/admitted into a PRTF facility. Discharge planning begins upon admission.

Q6: How will the approval/denial be communicated to the DFCS CM/DJJ CCM/Caregiver?
A6: The Amerigroup UM team will notify the provider of the approval/denial decision and last covered day for youth at the PRTF level of care. For youth in the custody of DFCS and/or committed to DJJ, the Amerigroup UM team will notify state DCH, DFCS and DJJ leadership of the denial decision daily (Mon-Fri) via email by 10 am with a notice of the expected discharge date. The Amerigroup Care Coordinator for Georgia Families 360°SM will notify the DFCS Case Manager and/or DJJ CCM regarding treatment and service decisions by email. The Amerigroup Care Coordinator for Georgia Families 360°SM will email a copy of the denial letter to the DFCS CM or DJJ CCM, appropriate state DFCS and DJJ leadership and designated PRTF facility representatives. For Adoption Assistance youth, a letter will be mailed to the parent regarding decisions for treatment services. The assigned Care Coordinator will receive a copy of the denial letter to notify parents of the decision, and address planning for aftercare.

Q7: **What is a Medical Director Review (MDR) or "Peer to Peer" review?**
A7: A Medical Director Review (MDR), also known as a "peer to peer" or "doc to doc," is a process in which the provider (the facility Medical Doctor, state licensed therapist, nurse or APRN responsible for the member) has the opportunity to speak with the Amerigroup Medical Director to provide information to support the request for authorization. This occurs once the primary reviewer determines that there is not enough information to support medical necessity for continued stay and sends the case for a Medical Director Review (MDR). At that point, the provider will be provided with the opportunity to speak with the Medical Director before a decision is made. If the provider declines the opportunity to speak with the Medical Director or does not provide a

response within the allotted time, the Medical Director will make a decision based on the clinical documentation provided. The benefits of a peer to peer is that it allows the provider an opportunity to provide additional information that may not be clear or present in the written documentation. It also allows the Amerigroup Medical Director an opportunity to ask any questions that may need to be clarified prior to the decision being rendered. If the MDR results in an adverse decision, the provider will then have the opportunity to request a reconsideration or an appeal.

Q8: What is a reconsideration?
A8: A reconsideration is a request for the opportunity to speak with the Medical Director who rendered the initial denial in light of new information that may support medical necessity. A reconsideration can be made within five business days of receiving an adverse decision and before the member is discharged. Reconsiderations are only available in the absence of a peer review. If a peer review has been completed, an appeal needs to be requested instead of a reconsideration. **Please also note that the Medical Director who rendered the decision may decline the reconsideration request, at which time the facility must request an appeal**. Requests for reconsideration should be made by the provider directly to the primary reviewer via email or phone.

Q9: What is an appeal?
A9: An appeal is conducted upon the request of the provider once a MDR is completed and an adverse decision is made. An appeal is completed by a 3rd party Amerigroup medical doctor meaning it will not be completed by the same physician who rendered the initial denial. An appeal is considered "expedited" when the member remains in that same level of care and has not yet discharged.

An appeal gives the provider another opportunity to have the clinical information reviewed to determine if medical necessity is met. The appeal can result in the original decision being upheld (no additional time provided), in a partial decision (some additional time is allowed up until a specified date but the remainder of the time is denied), or in a total overturn of the original decision (in which case the facility must submit clinical documentation to be reviewed by the primary reviewer for continued stay on the last covered day if the member is still being provided with services).

Q10: What is the process for submitting an appeal to Amerigroup?
A10: Upon notification of a denial or adverse action related to the medical necessity determination for PRTF by Amerigroup, an appeal request (referred to as an Administrative Review) can be made in one of two ways: the standard appeal processes or expedited appeal processes:
Standard Appeal:

- The member or their representative (DFCS WPAC Unit/DJJ CCM, PRTF treatment program or parent as appropriate) may initiate the appeal process with appropriate consent.
- The written request for a standard appeal must be received by Amerigroup within 60 days from the date of the denial letter.
- A written request for appeal can be accompanied by the following forms:
    - Request for Administrative Review Form
    - Request for Continuation of Benefits Form
    - Authorized Representative Form

- A written request may be mailed or faxed
  - Mailed to:
    Medical Appeals
    Amerigroup Community Care
    P.O. Box 62429
    Virginia Beach, VA 23466-2429
  - Faxed to 877-842-7183

Expedited Appeal:
Expedited requests for appeal may be made a) orally or b) in writing.
a) Oral requests for expedited review can be made through the Georgia Families 360°SM Intake line at (855) 661-2021.

- The member or their representative (DFCS System of Care Unit Well Being Specialist/DJJ CCM, PRTF treatment program or parent as appropriate) may initiate the appeal (referred to as an Administrative Review) process.
- The actual review will take place with the PRTF Provider that is providing the services to the member.
- Once the review is initiated then it is recommended that the PRTF medical director take part in the review of the member's clinical presentation. If the Medical Director is not able/available, a delegate from the clinical PRTF team would be a preferred alternate.
- When the review takes place, the person speaking with the Amerigroup reviewer (PRTF Medical Director or their designee) should be prepared to address the rationale for the request and provide evidence to justify the request.
- Oral requests for expedited review must be made within 24 hours of the denial or termination notification, and must be followed up in writing. This can be submitted to 877-842-7183.
- Additional clinical documents should be faxed to 877-842-7183.

b) Written requests for expedited review should be faxed

- The provider, member or their representative (DFCS System of Care Unit Well Being Specialist/DJJ JPPS, PRTF treatment program or parent as appropriate) may initiate the appeal (referred to as an Administrative Review) process.
- The written request for expedited appeal may be submitted in letter form (on letterhead as appropriate) or may use
  - Request for Administrative Review Form
  - Fax written request to (877) 842-7183 with "EXPEDITE" clearly marked on top of first page. No fax cover page is required.
- Once the written request is received, then a review will be scheduled with the PRTF provider that the youth is receiving services for.
- Once the review is initiated then it is recommended that the PRTF medical director take part in the review of the member's clinical presentation. If the Medical Director is not able/available, a delegate from the clinical PRTF team would be a preferred alternate.
- When the review takes place, the person speaking with the Amerigroup reviewer (PRTF Medical Director or their designee) should be prepared to address the rationale for the request and provide evidence to justify the request.

- Additional clinical documents can be submitted to 877-842-7183.

If the final resolution of the appeal upholds the original decision, Amerigroup has the right to recover the cost of the services provided to the member during the appeal process in accordance with the policy set forth in §431.230(b.).

Q11: How does the appeals process work?
A11: Upon receipt of the appeal, the **provider** will be contacted for additional clinical information as appropriate.

- The appeal, along with the clinical information and medical necessity criteria, is sent to the appropriate clinical reviewer for determination.
- The Amerigroup total time for acknowledgment, investigation, resolution and written notification for:
    - An expedited appeal will be resolved within seventy-two (72) hours from the date of notification or as expeditiously as the member's health condition requires.
    - Pre-service appeal review is no more than thirty (30) calendar days from the date Amerigroup receives the request for appeal or as expeditiously as the member's health condition requires.
    - Post-service appeal review is not more than thirty (30) calendar days from the date Amerigroup receives the request for appeal or as expeditiously as the member's health condition requires.
- There is only one level of medical necessity appeal, which can be expedited to accommodate the clinical urgency of the situation or standard.
    - If the appeal results in an upheld decision, any involved party (i.e. the member, the member's representative or guardian) may request an administrative law hearing.
    - The provider cannot request an administrative law hearing on the member's behalf.

Q12: Does the appeal process differ between a denial for admission versus a denial for continued stay?
A12: No, the processes are the same.

Q13: How are discharges from PRTF supported by Georgia Families 360°SM?
A13: Amerigroup will review the member's clinical progress as part of the continued stay review process. Amerigroup Care Coordinators for Georgia Families 360°SM will work to attend PRTF treatment team meetings and/or discharge planning meetings, in person when clinically appropriate, or via conference call in order to communicate between the agencies and parents. The Amerigroup Care Coordinator for Georgia Families 360°SM is responsible for notifying the DFCS Case Manager, Office of Provider Management (OPM), DJJ Regional Placement Specialist (RPS) and/or the parents of the last covered day provided by Amerigroup.

Q14: A member is being discharged from a PRTF but the DFCS Case Manager or the DJJ Regional Placement Specialist has not located a placement for the member. Will the member remain in the PRTF until a placement is located?
A14: Amerigroup benefits cover medical treatment and will be used to pay for medically necessary services provided by a PRTF for a designated period of time based on the member's clinical condition. Medical benefits do not cover placement services.

Q15: **What is the process for submitting a PRTF application for youth currently in a RYDC or YDC awaiting placement?**
A15: Youth in a RYDC or YDC awaiting placement in a residential program are not members of the Georgia Families 360°SM program. These youth are fee-for service so the completed PRTF application should be submitted to Beacon through a CORE provider.

Q16: What is the plan for youth who are in a PRTF and may be taking non-formulary psychotropic medications while in a PRTF level of care?
A16: While youth are receiving treatment in an authorized PRTF, this is not a benefit coverage issue because coverage of their medications is part of the contracted services provided by the program. Providers/prescribers are encouraged to utilize the Amerigroup formulary when selecting medication(s) for Amerigroup members. As a youth prepares for transition from the PRTF level of care, and medications are identified as not being on the AGP formulary, the PRTF treatment team would be notified by the AGP Care Coordinator and/or the AGP UM team about the process to request continuation of the off-formulary medication. If the PRTF team believes that the medication should be maintained after the member's discharge; then the PRTF team would submit a Prior Authorization (PA) request prior to the youth's discharge to ensure continuity of care is followed. This open discussion is important in making sure youth may remain on a medication that is effective for them. Consents for all medications must be obtained from the legal guardian.

Q17: What is expected of PRTF PROVIDER/TREATMENT TEAM while a member is in PRTF?
A17: Amerigroup expects that the **PRTF treatment team will assess all members in a manner that will address comprehensive treatment needs** (ex.-dual medical, substance abuse and/or psychiatric-behavioral needs) prior to and throughout the PRTF stay. **A current, thorough, active, and individualized plan of care is to be created within 10-14 days of admission and reviewed every 30 days thereafter**. The treatment plan is also expected to be updated in a manner that reflects ongoing active and effective treatment interventions, based on observed behaviors, needs and outcomes noted throughout the member's stay.

An Interdisciplinary Treatment Team Plan, as guided by a board eligible/certified Psychiatrist, is required. The Treatment Plan should remain focused on allowing for safe and enduring stabilization of the member within the most timely duration period, to minimize length of stay in this restrictive setting. The Treatment Plan should take into consideration the need for review of existing diagnosis and current medications, as well as the need for potential supplemental testing (psych testing etc.) as part of the treatment process.

Efforts should be made to identify need and complete any clinical reviews/testing as soon as possible during treatment process. This will help to assure the best possible treatment outcome and provision of aftercare service/ supports, based on results as noted.

The Treatment Plan should include consideration of both **short term and long-term** needs. Both should be addressed in DC planning for the member, in collaboration with Amerigroup when appropriate. This includes formulating an effective Hospital Aversion Plan and identifying/securing the most appropriate outpatient providers, services and supports that can best assist member in succeeding upon discharge, based on needs observed during the member's PRTF stay. Discharge planning should be initiated at time of admission, and updated throughout the member's stay. It is

expected that the Treatment Team closely and continuously collaborate with the member, the member guardian(s) and with the Amerigroup Utilization Management and Case Management Staff regarding discharge planning. When possible and appropriate, outpatient providers (existing psychiatrist, intensive family intervention providers, behavioral analysts, PCP, psychiatrist, therapist) should be incorporated into the treatment and/or advised of the active treatment and discharge plan, to assure a smooth transition and best effective continuity of care for the member upon discharge.

Clinical Updates regarding progress/barriers/active treatment interventions/ adjustments and DC planning should consistently be provided for utilization review (via the Georgia Portal) within the time frame as requested by **Amerigroup** (typically on the last covered day of service, unless otherwise specified).

Updates should include **dated** Attending MD notes, RN notes, Therapist/Social Work notes (to include updates regarding completed individual and family sessions).
Updates should completely address any question and/or concerns as noted by the assigned Utilization Manager throughout the clinical review process.

Q18: What is expected of the MEMBER GUARDIAN while a member is in PRTF?
A18: Amerigroup expects that a member's LEGAL GUARDIAN (parents, DFCS, DJJ Case worker or Agency Representatives, etc.) actively engage in the PRTF Treatment process throughout the duration of the members stay. Engagement includes being available/accessible to the treatment team, in order to provide collateral information upon a member's admission to PRTF, as well as ongoing feedback throughout the PRTF stay. This assures that best possible treatment planning and adjustments can be implemented for the member.

At minimum, weekly communication with the facility treatment team is anticipated, in order to provide and receive updates regarding treatment plan, progress, barriers, psychiatric discharge plan and placement. Ongoing and consistent attendance of scheduled family sessions and completion of passes if also expected, as directed by the PRTF Treatment Team. Consistent, proactive communication and engagement in the treatment planning and implementation process is needed between the member, guardian and treatment team, so that the best treatment outcome can be realized. This includes returning calls, presenting concerns and questions, attending scheduled Treatment Team meetings, collaborating with the Treatment Team and following through on recommended Treatment Team interventions, as discussed during interactions with the Team throughout the PRTF stay. Contact and collaboration with the assigned Amerigroup Care Manager, throughout the treatment process is also expected and highly beneficial.

A focus on discharge planning should be initiated as soon as member is admitted and should be maintained throughout the member's stay. This is to assure that all concerns and barriers are effectively addressed during the stay and included in the final plan, as implemented at time of discharge. Effective discharge planning engagement includes member's guardian inquiring and assuring that **any and all medication prior authorizations and prescriptions are in place** (as per Amerigroup Formulary guidelines as found on https://provider.amerigroup.com/GA > **Resources** > **Pharmacy Information** > **Amerigroup PDL (Formulary) in Printable Format**. Additionally, it should be verified that appropriate outpatient services are secured (as discussed during treatment) and that outpatient psychiatric and therapy follow up appointments (within 7 days of discharge) are

confirmed to be in place prior to member's date of discharge. Guardians can contact Amerigroup should additional questions regarding provider/service referrals be needed.

It is highly encouraged that the member's guardians keep existing providers informed of current treatment planning and significant treatment plan changes noted throughout the member's PRTF stay. Additionally, guardians are encouraged to request a thorough treatment summary and discharge plan, to provide to the member's outpatient primary care physician, psychiatrist and other providers for review upon PRTF discharge. This will assist in assuring that that effective continuity of care can be assured once member initiates/resumes services with these providers
For members in DFCS and/or DJJ custody in need of placement, it is vital that collaboration with the treatment team be completed at least weekly during the member's stay. This helps assure that timelines and rationales regarding medical necessity based projected lengths of stay are effectively communicated for planning purposes. This also allows for discussion of placement recommendations with the member and Treatment Team, based on behaviors, requests and needs noted.

Universal Packets to explore placement alternatives should be submitted in a timely manner, particularly once a member shows signs of sustained improvement in the treatment setting.
At minimum, monthly Case Worker visits and sessions with members who have no placement / additional supports identified is expected. This is to promote progress and member inclusion in the treatment and discharge planning process, as well as facilitate passes to assess readiness of member for discharge and placement. If/when placement is secured, immediate initiation of family sessions, guardian education, visits and passes with the identified placement guardian is strongly encouraged.

Q19: What do I need when my member is discharged from PRTF?
A19: 1) Ensure that all aftercare appointments are in place (appointment with outpatient provider should be within 7 days of discharge). 2) Ensure that all necessary prior authorizations are submitted and authorized to prevent any issues with the member receiving their medications.

Q20: I still have questions about this. Whom can I talk to about it?
A20: Please direct all questions regarding PRTF services to Provider Services or your contracting representative at 1-800-454-3730. For other questions related to coordination of a member's care, please call the Georgia Families 360°SM Member Services line at 1-855-661-2021.

To stay current on all the latest updates, be sure to visit our provider website at https://provider.amerigroup.com/GA often.


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