Amerigroup RealSolutions® in healthcare

Provider Manual Addendum

Behavioral Health

800-454-3730

provider.amerigroup.com/GA

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Georgia Families
Choices for a Healthy Life

Georgia Families 360°SM

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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 **provider.amerigroup.com/GA**. To request a free, printed copy of this manual, call Provider Services at **800-454-3730**.

If there is an inconsistency between the 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 healthcare management at Amerigroup. Our mission is to coordinate the whole health needs, including 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.

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 (for example, 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 healthcare 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 providers 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 condition care 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 substance use 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 provider, member, or guardian.

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 their 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 **800-715-4225, 988 suicide hotline** 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).

Whole Health care

Whole Health program overview

We are committed to supporting the Georgia Department of Community Health's (DCH's) goals of integrating behavioral health care, physical health care, pharmacy needs, and social determinants of care 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:

- Maintain 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, behavioral, pharmaceutical, and social 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 **800-454-3730**, and members can call Member Services at **800-600-4441** for help with finding a provider.

At Amerigroup, our behavioral health care benefit is fully integrated with the rest of our healthcare programs. This coordination of healthcare 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
- Checking member eligibility regularly prior to delivering services through mmis.georgia.gov/.
- Seeking prior authorization for all services that require it
    - For more information on prior authorization, visit our provider website at provider.amerigroup.com/GA and:
        - Use our *Searchable Formulary* to search for drugs requiring prior authorization
        - Use our *Prior Authorization Lookup Tool* to search for services and drugs under the medical benefit 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:
        - 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.
        - Please note that as of 7.1.24, the CANS/ANSA are no longer required for authorization and reauthorization requests for services. However, the CANS will continue to be utilized to measure treatment outcomes as a part of programmatic evaluation for Apex, IC3, MC3, and Youth Mental Health Resiliency Support Clubhouses.
        - Please also note that the Trauma Assessment which is a requirement component of all newly eligible foster care members will continue to include the CANS as a mandatory component.
    - Medical assessment including:
        - Screening for medical problems
        - Medical history
        - Current 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 referrals to appropriate medical or social support professionals have been made.

A provider who discovers a gap in care is responsible for helping 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
- Frequency service(s) will be delivered
- Individualized steps for prevention and/or resolution of crisis, which includes:
    - Identification of crisis triggers (in other words, 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 (for example, behavior, intervention, response and plan [BIRP], subjective, objective, assessment and plan [SOAP], etc.)
- Support for the amount of units used
- Name, signature, and credentials of the person providing the service
- The date the note was signed (time and date stamped)

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. For members who have other conditions that may be adversely impacted by psychotropic medications, additional monitoring is needed. If obesity is a problem, the medical record needs to reflect that a weight loss diet and exercise plan have 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 any coordinated efforts with that provider as well. The documentation is expected to reflect such conversations that have occurred. The medical record is expected to indicate that the medication prescribed 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 the side effects and risks of medications and regularly check and monitor 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

- Blood glucose tests or hemoglobin A1c 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 a risk for significant QT-prolongation
- Ongoing checks for movement disorders related to antipsychotic use and other co-morbidities

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 newly prescribed medication, see the child at least once within 30 days of prescribing the medication, 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 testing noted above and follow-up care are provided by the American Psychiatric Association, among others. Summary guidelines are referenced in our clinical practice guidelines located on our provider website at **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.

Behavioral health quality management

Amerigroup works in collaboration with the Clinical Practice Management (CPM) team to assist in educating providers on applicable best practice healthcare policies and identifying instances of incorrect usage of codes and/or medically unnecessary or inappropriate services. The Clinical Practice Management (CPM) team outreaches to providers post a review of claims patterns, trend analysis, and comparative data reporting to support provider education and prevent/reduce the risk of inappropriate utilization and/or billing practices. The telephonic outreach meetings 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 collaboration with the Clinical Practice Management (CPM) team is essential to ensure compliance with state and federal requirements to prevent fraudulent or abusive healthcare billing practices and support clinical best practices. Providers will be outreached to schedule a real time

collaborative teleconference call. Member records and/or specific member names will not be referenced during the call. That real time collaboration itself is a best practice regarding utilization management and quality care of members.

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 the assumption of a 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 via 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 (for example, T2038 Community Transition Planning). Other services do require prior authorization (PA) (for example, 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.

Pharmacy prior approval

Prescriptions written for preferred and non-preferred antipsychotic medications in children aged 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 as outlined in the Amerigroup provider manual under *Pharmacy Services*. Visit our *Preferred Drug List* (*PDL*) and searchable formulary at **provider.amerigroup.com/GA** > Resources > Pharmacy information for more information on drugs requiring PA.

Psychological testing

Providers should initiate PA service requests by filling out the form. The form can be found at provider.amerigroup.com/docs/gpp/GA_CAID_PsychologicalTestingRequestForm.pdf?v=202108132119 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; SA IOP that is not done within a facility, in other words, a Community Service Board, can be submitted through GAMMIS. The exception services should be submitted via Availity Essentials.

Service requests should be submitted only for the number of units 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), Intensive Customized Care Coordination (IC3), which are authorized for 30 days and require subsequent concurrent review ongoing when indicated. Service authorizations will start on the date of receipt of the request.

- 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 checkboxes 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.

For any questions regarding outpatient requests email GABHUM@amerigroup.com.

For any questions regarding ABA requests email AGPAutism@amerigroup.com.

While reconsiderations can be made through GAMMIS, providers can email requests for reconsiderations to GABHOPRECON@amerigroup.com.

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 the submission of authorization requests:

- Precertification is required for Behavioral Health Inpatient, PHP, IOP, and PRTF requests. This means a request for service authorization must be received prior to admission, but at minimum within 24 hours of admission.

- Initial and Continued Stay requests should be completed via the secure self-service site by logging in at provider.amerigroup.com/GA within 24 hours of a member's admitting into the facility or one calendar day of admission. Exception: providers can request precertification for residential treatment on the DCH portal via mmis.georgia.gov.
- 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, determine whether the member's medications need prior approval.
- 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.
- Upload the discharge clinical to Availity 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. Discharge clinical should also be sent to the step-down provider for continuity of care.

Frequently asked questions: acute hospitalizations (inpatient or crisis stabilization unit admission)

When should a referral be made for evaluation and possible admission for an acute hospitalization?
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 (in other words, hearing voices or seeing things that are not 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, an emergency department, or a mobile crisis team.

What is the role of Amerigroup in determining and approving admission for an acute hospitalization?
The acute hospital 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 acute hospital staff of the treatment recommendations for the member. If the recommendations do not include admission to the acute hospital based on medical necessity criteria for admission, a denial letter is released to the provider and the 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 acute hospital) 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 acute hospitalization services?
The acute hospital 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 healthcare 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 an acute hospital, 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 continue to meet medical necessity criteria for continued services or is stabilized and ready for discharge from the acute hospital.

During the youth's stay at the acute hospital, what is the role of Amerigroup in providing care coordination services?
The Amerigroup UM staff will work in conjunction with the acute hospital 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 acute hospital 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 healthcare 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 acute hospital. 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 acute hospital treatment team. When the youth no longer meet 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 an acute hospital, but the DFCS CM/DJJ JPPS has not been able to locate placement for the member, will the member remain in the acute hospital 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 acute hospitalization services to our Provider Services team at **800-454-3730**.

Frequently asked questions: psychiatric residential treatment facilities

Initiating a PRTF request

Who can submit PRTF service authorizations?
Any licensed independent provider (psychiatrist, psychologist, licensed social worker (LSW), licensed professional counselor, licensed marriage and family therapist (LMFT), or advanced practice registered nurse) who is currently treating the member.

How does the provider submit an authorization for PRTF services?
Providers should visit provider.amerigroup.com/georgia-provider and:

- Select **Forms**
- Expand **Behavioral Health** and select the *Standard PRTF Referral Form*
- Fill out the required information on the form and label it with Georgia Member 360°
- Use the Availity Essentials platform for submission and upload the completed form

When should I submit a PRTF request?
As soon as the treating provider determines that PRTF level of care is clinically appropriate, it is advised to submit the request to Amerigroup immediately. Waiting for an acceptance facility is not necessary and may negatively impact the member's clinical well-being.

What information should be included in the PRTF request/submission?
All fields on the initial review form must be completed accurately and verified as such before submission. Attach any available clinical documentation supporting the PRTF request, particularly focusing on the past three months, including symptom frequency and severity, their impact on daily life, and the role of the support system.

When documenting the treatment history, consider the member's response and compliance, current outpatient provider details, session frequency, and any barriers to increasing services. Supporting documentation may include a recent psychiatric evaluation, DFCS/Department of Juvenile Justice (DJJ) records, a psychosocial report covering treatment history, psychosexual assessment, previous psychiatric/substance use disorder treatment, school records/individualized education plan (IEP), and any relevant assessment information essential for processing the PRTF request.

What is the Amerigroup approval process for PRTF service requests?
Requests are reviewed within three business days by the clinical team and the Medical Director with Amerigroup. The provider is then informed of the decision through Availity. The care coordinator for Georgia Families 360°SM will inform the DFCS or DJJ case manager of the decision.

If the request is not approved, denial letters are also mailed to the provider and guardian. In addition, the care coordinator will provide the guardian with alternative service options based on clinical recommendations.

It is important to note that approved PRTF authorizations are granted based on meeting medical necessity criteria. Receiving an initial prior authorization (PA) does not guarantee continued stay coverage.

What happens after my PRTF request is approved?
The submitting provider or guardian is responsible for seeking admission to a PRTF. Care coordinators with Amerigroup assist in identifying suitable facilities. It is expected that providers send clinical information to multiple in-network PRTFs simultaneously for timely admission decisions. Amerigroup will follow up and should be informed of any updates or reasons for denial, if applicable.

Who identifies the PRTF for the approved youth to be admitted?
The requesting provider, in collaboration with the DFCS case manager/DJJ CCM, and the care coordinator with Amerigroup identifies the appropriate PRTF facility that meets the clinical needs of the youth. Bed availability and acceptance is at the discretion of the facilities.

When can out-of-state or out-of-network PRTFs be considered?
Once all in-network (INN) PRTFs have been tried and Amerigroup has been provided with the denial reasons and/or the wait for a bed is exceptionally long, the clinical team will give permission for out-of-state (OOS) or out-of-network (OON) facilities to be explored.

Does an approved PRTF request expire if no accepting facility is found?
Initial authorization is valid for 30 days. If a PRTF is not secured within that time, the

authorization closes. If the member is accepted to a PRTF after closure, the case will be staffed with the clinical team to assess the case for reopening the authorization. Alternatively, a new PRTF request may be necessary based on the member's current condition.

What is the process for submitting a PRTF application for youth in regional youth detention center custody awaiting admission?
Youth in regional youth detention center (RYDC) custody awaiting admission in a residential program are not necessarily members of Georgia Families 360°SM. Providers should verify coverage through the state eligibility website.

Medical director reviews and appeals

What is a medical director review or peer-to-peer review?
A medical director review (MDR), also known as a peer-to-peer review, allows the provider to discuss the request for authorization with the medical director for Amerigroup. It provides an opportunity to provide additional information and clarify any questions before a decision is made. If the provider declines or does not respond, the medical director will render a decision based on the available clinical documentation.

What is a reconsideration?
A reconsideration is a request for a review of an adverse decision by the medical director based on added information. It can be requested within five business days of receiving an adverse decision, and it is only available in the absence of a peer review. However, it is important to note that the medical director who rendered the decision may decline the reconsideration request, at which time the facility must request an appeal.

What is an appeal?
An appeal is a review by a third-party medical doctor of Amerigroup, not the medical director who made the initial denial. An appeal can result in upholding the original decision, a partial overturn, or a total overturn. It provides another opportunity to review clinical information and medical necessity.

Who can submit an appeal?
The member, requesting provider, or their legal guardian or legal representative may initiate the appeal process with appropriate consent.

How do I initiate an appeal request?
Appeals can be submitted through standard or expedited processes. The timing and method depend on the urgency of the situation. The request for an appeal must be received by Amerigroup within 60 days of the date of the denial letter. It is recommended that the request for an expedited appeal be received by Amerigroup within 24 hours of the denial notification.

All appeals may be made orally or in writing and can be accompanied by the following forms:

- *Request for Administrative Review Form*
- *Request for Continuation of Benefits Form*
- *Authorized Representative Form*

Oral requests for an appeal can be made through the Georgia Families 360°$_{SM}$ intake line at **855-661-2021**:

- Additional clinical documents should be faxed to **877-842-7183**.

A written request may be emailed, mailed, or faxed:

- Emailed to ga1quality@amerigroup.com:
  - Emailed requests for expedited appeals should have **EXPEDITE** in the subject line.
- Mailed (not recommended for expedited appeals):

  Medical Appeals
  Amerigroup Community Care
  P.O. Box 62429
  Virginia Beach, VA 23466-2429
- Faxed:
  - **877-842-7183**
  - Fax requests for expedited appeals should have **EXPEDITE** clearly marked on top of the first page. No fax cover page is required.

What happens after an appeal request?
When an appeal is initiated, the provider can submit supporting clinical notes or request a peer-to-peer review. It is important to note that a request for a peer-to-peer review is not guaranteed, so it is highly recommended that the provider also submits detailed clinical notes to support their appeal. In the case of a peer-to-peer review, it is strongly advised that the PRTF medical director or nurse practitioner from the member's clinical team participate. They should be prepared to explain the reasons for the appeal and provide supporting evidence. The time required for resolution varies depending on whether it is an expedited or standard appeal.

An expedited appeal will be resolved within 72 hours from the date of notification or as expeditiously as the member's health condition requires.

A standard appeal will be resolved no more than 30 calendar days from the date Amerigroup receives the request for appeal or as expeditiously as the member's health condition requires.

You can appeal a decision only once. If the appeal outcome confirms the initial decision, any concerned party (such as the member, their representative, or guardian) has the right to request a State Fair Hearing, otherwise known as an administrative law hearing. The provider is permitted to request a State Fair Hearing on behalf of the member with explicit written consent from the member or guardian.

If the final resolution of the State Fair Hearing confirms the original decision, Amerigroup retains the right to seek reimbursement for the services rendered to the member during the appeal process, following the policy outlined in §431.230(b).

PRTF treatment and discharge planning

What is expected of the PRTF provider while a member is in PRTF?
The PRTF treatment team is expected to conduct thorough assessments that address the member's comprehensive treatment needs, including medical, substance use disorder, psychiatric, and behavioral needs, both upon admission and throughout the stay.

They should develop an individualized plan of care within 10 to 14 days of admission and review it every 30 days, updating it based on observed behaviors and outcomes. This plan should be guided by a board-certified psychiatrist and focus on achieving safe and enduring stabilization in the shortest possible time.

The treatment plan should also consider the need for diagnostic reviews and testing, with an emphasis on completing these as soon as possible to ensure the best possible treatment outcome and aftercare service provision.

The treatment team should also ensure that family sessions are occurring on a weekly basis. The treatment team should also provide regular updates to the member's guardian, utilization management and case management team with Amerigroup, on the member's progress, expected progress, recommendations, and discharge dates. Efforts should be made to identify the need for and recommend visits and passes with the member and guardian.

The provider must address short-term and long-term needs in discharge planning, collaborating with Amerigroup when necessary. This includes creating a Hospital Aversion Plan and identifying and engaging outpatient providers and supports to ensure continuity of care for the member post-discharge.

What is expected of the member's guardian while a member is in PRTF?
Member guardians play a vital role in the PRTF treatment process, starting with providing essential information at admission and continuous feedback throughout the stay. Effective communication and engagement with the treatment team are essential for optimal treatment outcomes. Weekly updates on the treatment plan, progress, and barriers are expected, alongside attending scheduled family sessions, and facilitating passes as directed by the PRTF Treatment Team.

Guardians are expected to maintain contact and collaboration with the assigned case manager throughout the treatment process. Early initiation of discharge planning is crucial to address all concerns and barriers, ensuring the case manager’s inclusion in the final plan upon discharge. This encompasses verifying medication prior authorizations and prescriptions according to formulary guidelines and confirming outpatient services and follow-up appointments.

Furthermore, guardians are urged to keep existing providers informed about treatment planning and changes during the member's PRTF stay. It is advisable that the guardian request a comprehensive treatment summary and discharge plan from the PRTF provider, which can be shared with outpatient providers to ensure continuity of care when the member resumes services with them.

For members in DFCS and/or DJJ custody who require placement, it is important to collaborate with the treatment team and promptly submit universal packets to explore placement alternatives. Monthly case worker visits and sessions are expected for members without identified placements, facilitating discharge planning, and readiness assessments.

Upon securing placement, it is recommended to initiate family sessions, guardian education, visits, and passes with the identified placement guardian promptly.

How are non-formulary psychotropic medications managed for youth in PRTF?
While in PRTF, the coverage of medication is included as part of the contracted services. However, to prevent issues with the member receiving medication after discharge, the PRTF provider should submit a prior authorization form for approval by Amerigroup. This step is essential in ensuring continuity of care.

How are discharges from PRTF supported by Georgia Families 360°$_{SM}$?
Discharge planning should be initiated upon admission, with active involvement from care coordinators in monitoring the member's clinical progress. They actively participate in PRTF treatment team meetings and discharge planning sessions, serving as a liaison between different agencies and the guardian. If a continued stay denial is rendered, the Care Coordinator is responsible for conveying the discharge date and/or the last day of coverage to the appropriate

stakeholders.

What happens if a member is discharged from PRTF, but no placement is found?
Amerigroup covers medical treatment and not placement services. The member's stay in a PRTF is based on medical necessity. Coverage does not extend in the absence of placement.

What is needed when a member is discharged from PRTF?
The PRTF provider should submit and obtain prior authorization for medication before the discharge. In addition, the PRTF provider must collaborate with the guardian to ensure all aftercare appointments are in place within seven days of discharge, including a psychiatric appointment within 30 days of discharge. The PRTF provider should submit discharge clinicals through Availity within 24 to 48 hours post-discharge.

I still have questions, who can I talk to?
Providers should direct all questions regarding PRTF services to Provider Services or your contracting representative at **800-454-3730**. For care coordination inquiries, call the Georgia Families 360°$_{SM}$ Member Services line at **855-661-2021**.


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