Amerigroup RealSolutions in healthcare

Provider update

This is an update about information in the provider manual. For access to the latest provider manual, go online to https://providers.amerigroup.com.

Behavioral health authorization submission

Summary of change: To ensure timely notification and determination of services, providers must submit outpatient behavioral health authorizations through the Alliant Georgia Medical Care Foundation (GMCF) prior authorization website at https://www.mmis.georgia.gov.

Beginning March 1, 2017, providers will no longer be able to submit outpatient behavioral health service requests via the Amerigroup Community Care provider website. Providers will need to follow the requirements below:

- Service requests must be submitted by the servicing provider with all supporting documentation on the GMCF website.
- Supporting clinical information must be attached for review to the authorization on the website.
- Reconsiderations may be submitted via GABHOPRecon@anthem.com within two business days of denial notification, or providers may submit an appeal as indicated in the *Letter of Proposed Action* within 30 days of the denial notification.
- All approvals and denials can be verified on the GMCF or Amerigroup website.
    - Notice of the *Letter of Proposed Action* (denial letters) will continue to be mailed to the member and the requesting and servicing providers per contractual and National Committee for Quality Assurance requirements.
- This requirement affects all outpatient behavioral health services with the exception of:
    - Partial hospitalization programs, intensive outpatient programs, psychological testing and any higher level of care. These exceptions will continue to be processed via the Amerigroup website.
- Please note:
    - Faxed or telephonic clinical information will not be accepted for medical necessity review.
    - If the online questions are answered in full when entering information, no additional documentation is required.

Why are these changes necessary?

All requests will be reviewed within 14 business days for standard requests and 24 hours for expedited requests. Expedited requests are contractually defined as any services for which following the standard time frame could seriously jeopardize the member's life or health. In these cases, an expedited authorization determination is made within 24 hours. Clinical information to support the need for an expedited request, as defined by the contract, must be submitted as part of the authorization request.

What are the impacts of these changes?

Failure to follow this process could result in service denials due to failure to preauthorize or provide clinical information. This process update will improve:

- Electronic tracking of requests.
- Peer-to-peer and reconsideration requests.

What if I need assistance?

If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

https://providers.amerigroup.com