Georgia Department
of Behavioral Health
& Developmental
Disabilities

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IDD ALL- STATE PROVIDER MEETING

BE D·B·H·D·D

Georgia Department of Behavioral Health & Developmental Disabilities

Presented by DBHDD, Division of IDD
February 10, 2022
9:00am – 12:00pm

Today's Agenda

Welcome everyone to the February 10, 2022, IDD All-State Provider Meeting!

D·B·H·D·D		
	Meeting:	DBHDD ALL STATE IDD Provider Meeting
	Date:	February 10, 2022 (virtual)
	Time:	9:00 am – 12:00 pm
	Location:	WebEx

Topic	**Time**	**Presenter**
Opening Welcome and Updates	9:00 am-9:15 am	Ronald Wakefield, Division Director IDD, DBHDD
QEPR Revisions	9:15 am-9:30 am	Nancy Over-Ikard, Director of Quality for IDD, Qlarant
American Rescue Plan Appendix K COMP Renewal Tiers/Additional Staffing Training	9:30 am-9:55am	Ashleigh Caseman, Director of the Office of Waiver Services, DBHDD
Bed Board Reminder	9:55 am-10:00 am	LaTonya Williams, State Transition Specialist, Office of Waiver Services; DBHDD
Adult Therapy Services- PA development	10:00 am-10:15 am	Ron Singleton, IDD Division Budget Manager, DBHDD
GAMMIS Billing Presentation	10:15 am-10:45 am	Gainwell Representative, TBA
Belton Updates	10:45 am-11:00 am	Kelly Sterling, Director of the Office of Deaf Services, DBHDD
Mandated Reporting	11:00 am-11:15 am	Anna Thomas, CACTS Manager, Forensic Special Initiatives Unit (FSIU), GBI Crimes Against Disabled Adults and Elderly Task Force
Question and Answers	11:15 am -12:00 pm	All

Opening Welcome and Updates from Ronald Wakefield, Division Director IDD, DBHDD

D·B·H·D·D

Quality Enhancement Provider Review (QEPR) Changes Overview

Effective January 1, 2022

Training conducted December 14,2021. Presenters: Marion Olivier, ASO, Virginia Sizemore, DBHDD, Ashleigh Caseman, DBHDD

Provider Record Review

Key Changes

- Updated scoring guides
- Removed indicators not included in Manuals or that were redundant
- Moved indicators to other tools that made more sense
- Updated some Not Met Reasons
- Updated some indicators to match, verbatim, the manuals/policy
- Removed Quality Indicators

https://www.georgiacollaborative.com/providers/intellectual-developmental-disabilities-providers/

QEPR Report Changes:
Exit, Summary, and External Reports

Quality Enhancement Provider Review
Final Assessment Report
Provider Name, LLC

Provider Address: 2222 Main St., Example, GA 00001	**Region:** 3	**Review Method:** Remote Quality Review - Paper Records
Review Date(s): 9/6/2021 - 9/9/2021	**Individual Records Reviewed:** 2	**Staff Records Reviewed:** 2
Services Reviewed: Community Residential Alternative, Nursing		
Lead Assessor: Joe Smith		

The Quality Enhancement Provider Review (QEPR) is conducted by Qlarant as part of the Georgia Collaborative ASO, under contract with the Department of Behavioral Health and Developmental Disabilities. The Overall Score is based on indicators measuring the compliance and quality of your organization's systems and practices, and adherence with the Provider Manual for Community Developmental Disability (DD) Providers. Results, shown in the following table, are derived from a sample of individual and employee records maintained by your organization.

	Review Components	Percent Met	Weight[1]	Weighted Score
Provider Record Review	Safety	100%	0.20	20%
	Whole Health	60%	0.15	9%
	Person Centered Practices	76%	0.15	11%
	Community Life	0%	0.12	0%
	Rights	40%	0.12	5%
	Choice	33%	0.10	3%
	Staff Qualifications & Training	69%	0.10	7%
	Service Guidelines	59%	0.06	4%
	Overall Score			**59%**

[1] Explanation: The Provider Record Review (PRR) is organized around six Focused Outcome Areas (FOA), as shown in the table. The Percent Met is the number of indicators scored met over the total number scored. The Weight is the proportion of the total score attributed to each review component (for example, the Weight for Safety is .20, or 20% of the Overall Score). To calculate the Weighted Score, multiply the Weight times the Percent Met. The sum of the Weighted Scores is equal to the Overall Provider Score. Note:

Exit and Final Summary Report: Key Area Changes

General Information and Demographics

Overall Scoring Table
- Introduction
- Scoring methodology

QEPR Highlights

Provider Record Review
- Reorganized findings
- Recommendations
- Quality Indicators

Service Guidelines
- Reorganized findings
- Recommendations
- Quality Indicators

Staff Q&T
- Reorganized findings

Administrative Review
- Moved to end of report
- Scoring
- Not met reasons

QTAC Section

General Information and Demographics

- Moved several sections around, removed the "Review Period".
- Added "Services Reviewed" so they are identified at the beginning of the report.

Provider Address: 2222 Main St., Example, GA 00001	Region: 3	Review Method: Remote Quality Review - Paper Records
Review Date(s): 9/6/2021 - 9/9/2021	Individual Records Reviewed: 2	Staff Records Reviewed: 2
Services Reviewed: Community Residential Alternative, Nursing		
Lead Assessor: Joe Smith		

QEPR Highlights

- Updated the "QEPR Highlights" section with a new title (previous title was "Strengths") to better define good organizational systems and practices identified by review component (i.e., provider record review, service guidelines, staff qualifications and training, and administrative review). This section focuses on practices the provider has developed that promote quality services.

Practices Demonstrating Quality Supports and Services
Provider Record Review • Documentation indicated individuals served were regularly offered opportunities to learn about human rights and safety, and were then provided an opportunity to teach their peers about the knowledge they had gained. This practice supports ongoing education about human rights and responsibilities and topics around self-preservation. • Progress notes for Community Access Individual (CAI) were replete with person-centered information regarding community interactions and decision-making; they contained meaningful details about preferences, conversations with staff and community members, as well as individuals ' served responses to activities.
Administrative Review • Emergency drill forms provided detailed information in the sections related to problems encountered and improvements needed. • Quality improvement (QI) committee notes included evidence that subcommittees had addressed such areas as training, human rights, peer reviews, health and safety, and technology.
Staff Qualification & Training • Staff received additional hours of annual training beyond the required 16 hours.
Service Guidelines • Documentation included detailed information regarding individuals' responses to supports and services.

Review Components

When necessary, each review component will have the following sections:

- Key Findings
- Requirements to be Addressed based on indicators that scored below 75%
- Recommendations and Technical Assistance for Quality Improvement are also included if discussed during the review.

Provider Record Review: FOA Sections

- Reorganized the PRR FOA sections to now include (for each FOA):
  - Key Findings
  - Recommendations (retitled as "Requirements to Be Addressed (scored less than 75%)"
  - Recommendations and Technical Assistance for Quality Improvement.

Whole Health	Total Indicators Scored Met	Total Indicators Scored Not Met	Total Indicators Scored NA	Score
	21	14	19	**60%**

Key Findings

- Both records were missing documentation related to preventative healthcare, including dental, hearing, and vision screenings. They did not include documentation demonstrating individuals were provided information regarding their medications, including psychotropic medications.
- One record was also missing evidence the individual received an annual physical.

Requirements to Be Addressed (scored less than 75%)

- Ensure documentation includes evidence individuals receive preventative healthcare, if applicable, based upon their gender, age, and need (if individuals refuse treatment, this is documented): Dental
- Ensure documentation includes evidence individuals receive preventative healthcare, if applicable, based upon their gender, age, and need (if individuals refuse treatment, this is documented): Hearing
- Ensure documentation includes evidence individuals receive preventative healthcare, if applicable based upon their gender, age, and need (if individuals refuse treatment, this is documented): Vision
- Ensure documentation includes evidence individuals receive preventative healthcare, if applicable, based upon their gender, age, and need (if individuals refuse treatment, this is documented): Physical
- Ensure education on the risks and benefits of psychotropic medication(s) is provided to individuals.
- Ensure education for all medications prescribed is provided to individuals and families (as approved by individuals).

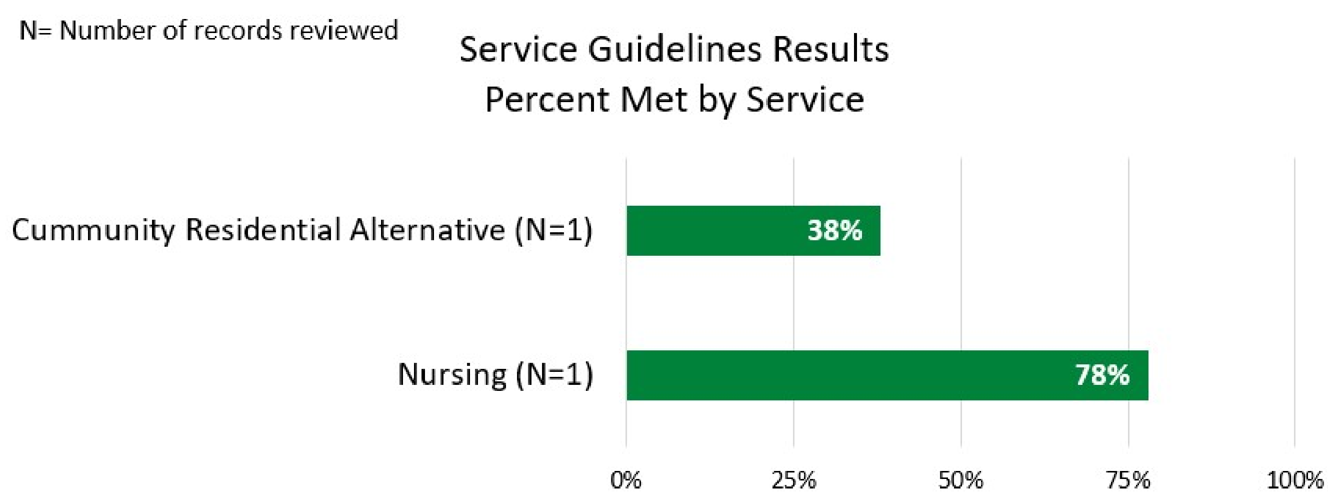
Recommendations and Technical Assistance for Quality Improvement

- Ensure nursing supervisory/progress notes are detailed and specific to the nursing services delivered. Include all health-related monitoring (glucose, bowel, skin, etc.), education provided, review of preventative health exams, follow-up, and next steps in the documentation.
- Consider capturing individuals' health-related preferences and choices, e.g., if cold water is preferred for taking medications, if female staff is preferred, or if individuals prefer medical visits to occur in the evenings rather than mornings. This information can be documented on the

Service Guidelines: Scores

New section with the Overall Score and Records Reviewed, and new bar graph.

Service Guidelines Percent Met: 59%	Total Records Reviewed: 2
The Service Guidelines (SG) results graphic shows the total number of records scored and the percent met by service. Key findings and Requirements to Be Addressed are based on any indicators that scored below 75%. Any technical assistance and recommendations for improvement discussed during the review are also included.	



Review Components: Quality Indicators

Removed all Quality Indicators from the Exit Conference, Final Summary, and detailed reports.

Staff Qualifications and Training: Scores

New section with the Overall Score and Records Reviewed, and new scoring table.

Staff Qualifications and Training Percent Met:96%		Total Records Reviewed: 4		
Staff Qualifications & Training (Q&T) results display the number of indicators scored met, not met or not applicable (NA) and the percent met by staff title. Any identified Key Findings Requirements to Be Addressed are based on indicators that scored below 75 percent. Any technical assistance and recommendations for improvement discussed during the review are also included.				
Staff Title	**Total Indicators Scored Met**	**Total Indicators Scored Not Met**	**Total Indicators Scored NA**	**Score**
Certified/Licensed Professional (SE, LPN, RN, BA, PT, OT, SLP, etc.)	18	0	48	100%
Developmental Disability Professional (DDP)	24	2	40	92%
Direct Support Professional (DSP)	34	1	97	97%

Administrative Review

Key Changes

- Updated Description
- Scoring
- Added “Not Met Reasons”

NOTE: Not included in the overall QEPR score

Administrative Review: Scoring

This table describes how the percentage was calculated.

Administrative Review	Total Indicators Scored Met	Total Indicators Scored Not Met	Total Indicators Scored NA	Score
	3	3	0	50%

Administrative Review: Not Met Reasons

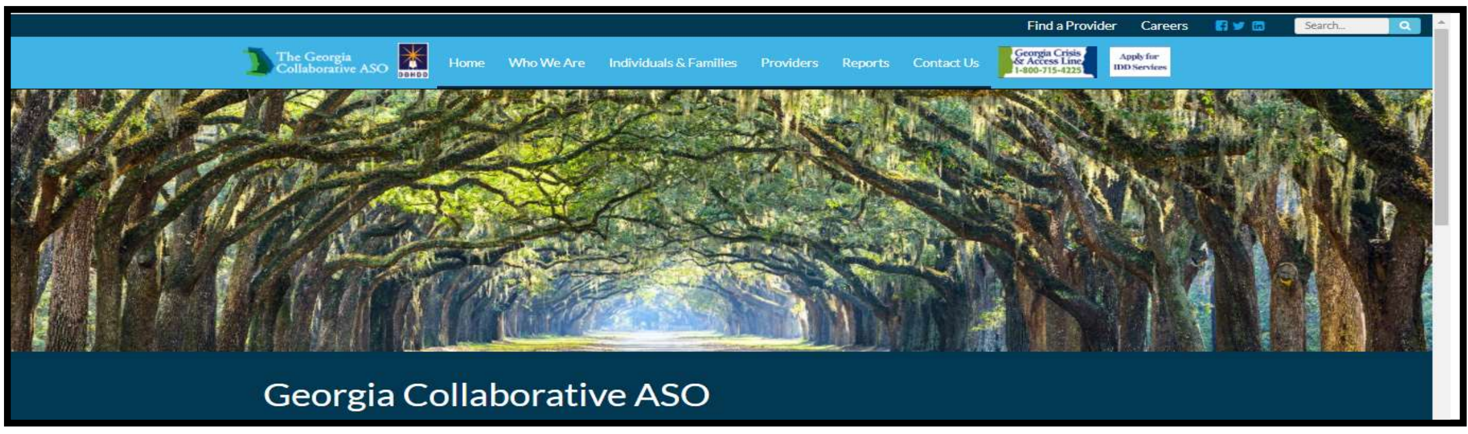
Indicator	Results
The provider locations have a current Medicaid license.	Yes
There is a well-defined quality improvement plan for assessing and improving organizational quality.	No
• The provider's does not show evidence of tracking and trending of outcomes.	
Areas of risk to individuals served and to the organization are identified and monitored based on services, supports, treatment, or care offered.	No
• The provider does not show evidence that areas of risk for people served are tracked.	
There is documented evidence of active oversight of the contracted provider/professional's capacity and compliance to provide quality care.	Yes
Developmental Disability Professional (DDP) services are rendered by a qualified DDP employed by or under contract with the provider.	Yes
The organization has a policy, by job classification, that describes the competency-based training procedures for orientation and annual trainings; additional trainings for professional level staff; and additional training/recertification (if applicable) required for all other staff.	No
• The organization's policy does not describe by job classifications the competency-based training procedures for annual trainings. • The organization's policy does not describe by job classifications the competency-based training procedures for orientation trainings. • The organization's policy does not describe by job classification how competency on training is validated and documented in the staff personnel record. • The organization's policy does not describe by job classifications the additional trainings required for professional level staff.	

Quality Technical Assistance Consultation (QTAC): Criteria

New Section added to address Quality Technical Assistance Consultation (QTAC) Criteria and explains when a QTAC is required.

Quality Technical Assistance Consultation (QTAC) Criteria
Scores from your QEPR determine whether a QTAC needs to occur, based on the following guidelines: 1. The provider will be required to participate in a QEPR Follow-Up QTAC review within 90 days of the Exit Conference: • If the Overall score is 84% or below • Scores for both Whole Health and Safety FOAs are 79% or below 2. The provider will be required to participate in a QCC QTAC review within thirty days from QEPR Exit Conference, regardless of the QEPR Overall score if there is an identified Quality of Care Concern or Immediate Action Item The provider may also request training or technical assistance through the QTAC process during the next twelve-month period.

Information on Review Processes, Tools, and Training



Review Processes and Tools:

https://www.georgiacollaborative.com/providers/intellectual-developmental-disabilities-providers/

QEPR Changes Training:

https://media.beaconhealthoptions.com/VIDEO/Georgia/Quality-Reviews-for-IDD-Providers-QEPR-Changes-12-14-2021.mp4

Thank You

Contact Us

855-606-2725

www.georgiacollaborative.com

GAQualityCollaborative@beaconhealthoptions.com

ARPA, APPENDIX K & COMP RENEWAL UPDATES

Ashleigh Caseman
Director of Waiver Services
Office of Waiver Services
Division of Developmental Disabilities

Georgia
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American Rescue Plan Act- Initial Spending Plan Proposal*

The American Rescue Plan Act was signed into law on March 11, 2021. It is the sixth COVID-19 relief bill enacted and provides approximately $1.9 trillion in federal assistance. It includes fiscal relief funding for state and local governments, education, housing, food assistance, and additional grant programs. The State of Georgia, through the Department of Community Health (DCH), submitted an Initial Spending Plan Projection and narrative to enhance, expand, and strengthen home and community-based services (HCBS) under the Medicaid program using funds associated with the increased Federal Medicaid Assistance Percentage.

** Note the spending plan is pending approval from the Centers for Medicare and Medicaid Services and is subject to change*

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DBHDD IDD Enhancements related to ARPA funding

While Georgia's Initial Spending Proposal has several initiatives, two main focuses related to DBHDD IDD include:

Temporary Rate Enhancements for specific services ***(the quick strike)***

- Community Residential Alternative
- Community Living Support Services
- Skilled Nursing Services
- Community Access Individual
- Supported Employment

Rate Study ***(the long game)***

- All NOW and COMP waiver services including but not limited to:
- Community Residential Refresh
- Community Living Support Services
- Skilled Nursing
- Community Access & Supported Employment
- Respite
- Adult Therapies
- Medical Equipment, Supplies

…And more!

Note: Georgia's initial spending plan has received partial approval and is pending additional approval from the CMS.

Georgia Department of Behavioral Health & Developmental Disabilities

DBHDD IDD Enhancements related to ARPA funding Cont.

In addition to the temporary rate enhancements and the rate study, DBHDD/IDD is also focusing on the following areas:

Addressing Workforce Challenges:

- Supporting Direct Support Professionals (DSPs) by way of certification, credentialing and/or training programs
- Engaging the broader Georgia workforce system to find solutions to DSP crisis by using community colleges and job centers to develop and invest in career training and credentialing for DSPs

Launch Supported Employment Pilot:

- Provide support to individuals on the planning list for supported employment to transition from school to competitive integrated employment.

Note: Georgia's initial spending plan has received partial approval and is pending additional approval from the CMS.

IDD COVID-19 Response: Appendix K

Appendix K is an important mechanism for ensuring people with intellectual and developmental disabilities have access to the home and community-based services they need to stay safely at home in their own community of choice.

IDD COVID-19 Response: Appendix K

- Telehealth Options
- Retainer Payments (3.1.20-3.1.21)
- Family Caregiver Hire
- Training & Background Check Modifications
- Service Rate Increases
- Alternate Settings
- Service Limitations Modifications
- Operational Guidelines
- Webinars/Technical Assistance

Appendix K & COMP Renewal Updates

In addition to the existing Appendix K modifications, DBHDD has requested a 5% provider rate increase from the FY22 Appropriations Bill [HB-81] for all NOW and COMP services to be included in an Appendix K amendment. If approved by CMS, this will serve as the temporary "vehicle" to aid the network and the individuals served until ARPA's initial spending plan and COMP renewal receive full approval from CMS.

Resources

To review the entire Georgia initial spending plan visit: https://dch.georgia.gov/programs/hcbs

To review the Appendix K Emergency Preparedness Response Plan:

https://dch.georgia.gov/announcement/2020-04-10/state-georgia-announces-approval-appendix-k-emergency-preparedness-response

Stay tuned for more information on ARPA and Appendix K funding!

Announcement: Tiered Rate & Additional Staffing Training

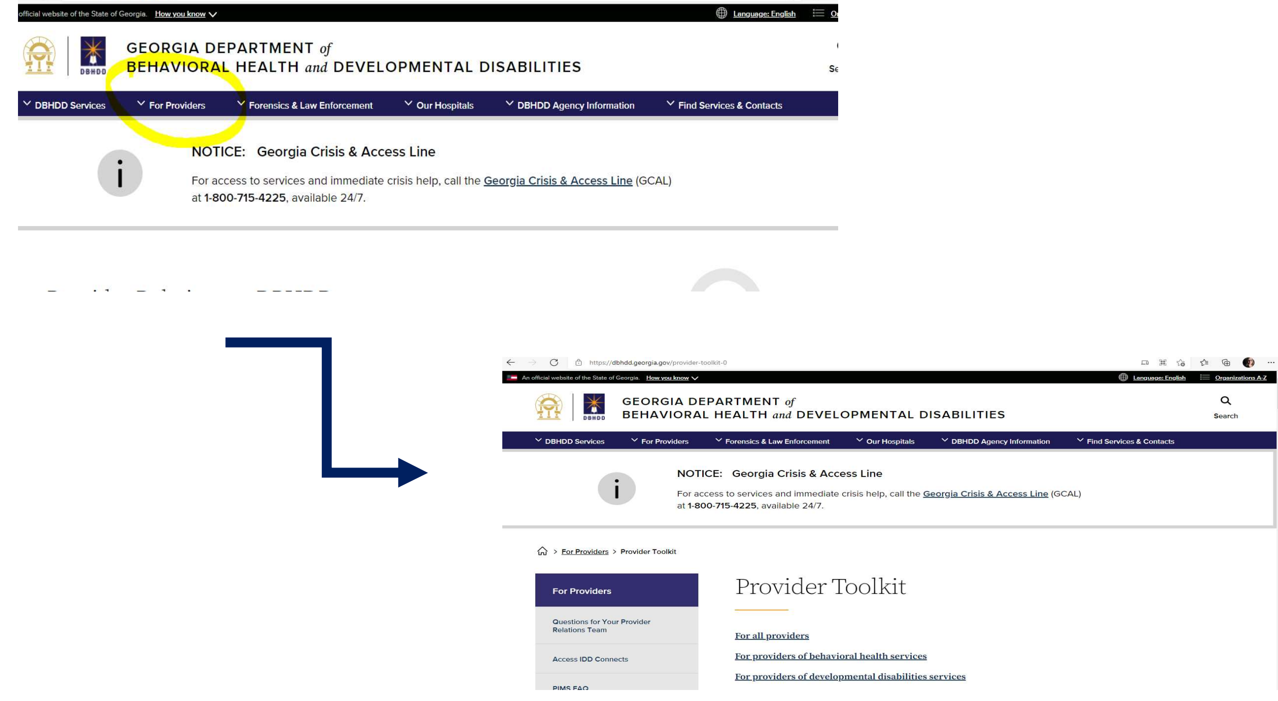
On December 10, 2021, The Division of IDD Conducted a training on the Tiers/Rate Category and Additional Staffing (AS) Process

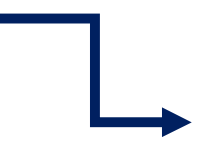
The training covers topics such as:

- ✓ How the tiered categories work – with calculations, staff matrices and calendar examples
- ✓ Additional Staffing eligibility and other requirements
- ✓ How to make a request for Additional Staffing

The training can be found here: https://dbhdd.georgia.gov/provider-toolkit-0

Announcement: Tiered Rate & Additional Staffing Training





Tiers Rate & Additional Staffing Services Webinar - December 10, 2021

Webinar / PDF Presentation

Stay Informed…

Publication	Monthly Cadence	Purpose
Network News	1st Business Day	To inform of new information, announcements, and updates.
Learning Corner	Business Day closest to 15th	Presents any findings and information based on trends seen by DBHDD.
Special Bulletins	As needed	Information that requires immediate attention.

Email DBHDD.Provider@dbhdd.ga.gov to be added to the distribution list for Provider Relations communications

IDD Residential Bed Board Updates

LaTonya Williams

State Transition Specialist

Office of Waiver Services

Georgia
Department of
Behavioral Health
& Developmental
Disabilities

IDD Residential Bed Board – For Residential Providers

The IDD Residential Bed Board is a very user-friendly application allowing (CRA) Providers to maintain their current capacity status along with vacancy availability to support referral activities. This system was designed to maintain basic Site-specific information about the capacity and vacancy of the Provider network across the state.

The Impact of Bed Tracking & Planning

The IDD Residential Bed Board provides useful information for tracking utilization in real time and planning for needed capacity, as well as a referral source for individuals and families by Support Coordination and DBHDD staff. They can use the information to engage Providers and locate available beds based on:

- Demographics (region, county, city)
- Accessibility
- Gender
- Medical Complexity
- Behavioral Challenges

IDD Residential Bed Board – Provider Responsibility

1. Provider Agencies should update the current bed availability in this system **<u>within 48 hours</u>** of any changes. Providers enter information on bed availability monthly or as changes occur into the "BHL Web Apps" portal under the "IDD Residential Beds" menu.

2. Providers select 1 -3 staff members within their organization to be responsible for entering information on bed availability. All user passwords **<u>will lapse</u>** if the system is not accessed monthly.

3. Providers work with DBHDD Bed Board manager to increase system utilization and management of agency sites (additions, inactive sites, correct capacity)

IDD Residential Bed Board – For More Information

1. Latonya Williams is the Division of DD contact for the IDD Residential Bed Board will respond directly to any requests submitted to this mailbox. Please contact the IDD Residential Bed Board directly via e-mail address: **ddresidential.boardrequests@dbhdd.ga.gov.**

2. The IDD Residential Bed Board can be found here: **https://bhlweb.com**.

3. Training for the IDD Residential Bed Board can be found here within the Provider Toolkit: **https://dbhdd.georgia.gov/document/document/idd-residential-beds-user-training/download**

Adult Therapy Services: Occupational, Physical and Speech and Language

Ron Singleton

IDD Division Budget Manager

Division of Developmental Disabilities

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Today's Topics

- Therapy Service "Bundle" Overview
- ISP Development (Service Summary)
- Prior Authorization Development

Therapy Service “Bundle” Overview

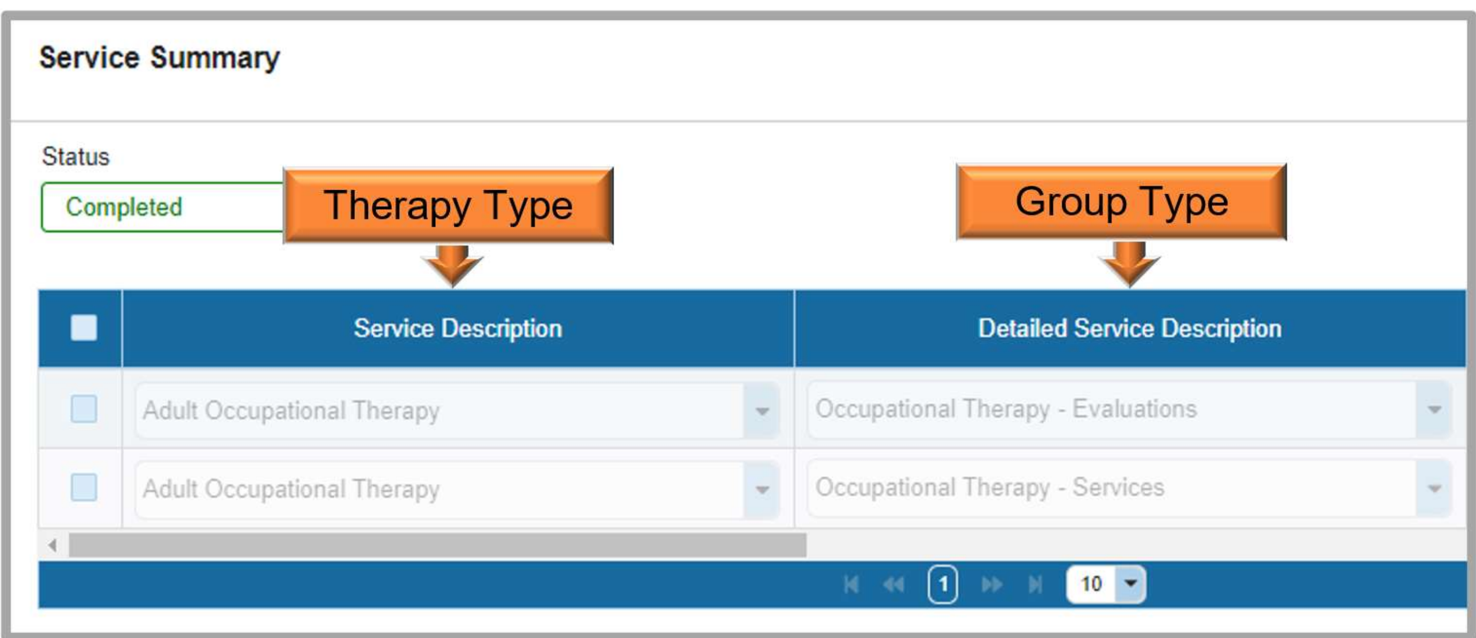
Adult Therapy Services will not be approved and authorized as independent services but within a “bundle” based on a unique ‘Therapy Type’ and ‘Group Type’.

Service Example: **Adult Occupational Therapy Services**

THERAPY TYPE	GROUP TYPE	SERVICE CODE	WAIVER SERVICE NAME
OCCUPATIONAL	Evaluation	97165	Adult OT Evaluation - Low Complexity
OCCUPATIONAL	Evaluation	97166	Adult OT Evaluation - Moderate Complexity
OCCUPATIONAL	Evaluation	97167	Adult OT Evaluation - High Complexity
OCCUPATIONAL	Evaluation	97168	Adult OT Re-Evaluation
OCCUPATIONAL	Service	97530-GO	Adult OT Therapeutic Services
OCCUPATIONAL	Service	97533-GO	Adult OT Sensory Integrative Techniques
OCCUPATIONAL	Service	97760-GO	Adult Orthotic and Prosthetic Fitting and Training
OCCUPATIONAL	Service	97761-GO	Prosthetic Training
OCCUPATIONAL	Service	97763-GO	Orthotic and Prosthetic Check Out

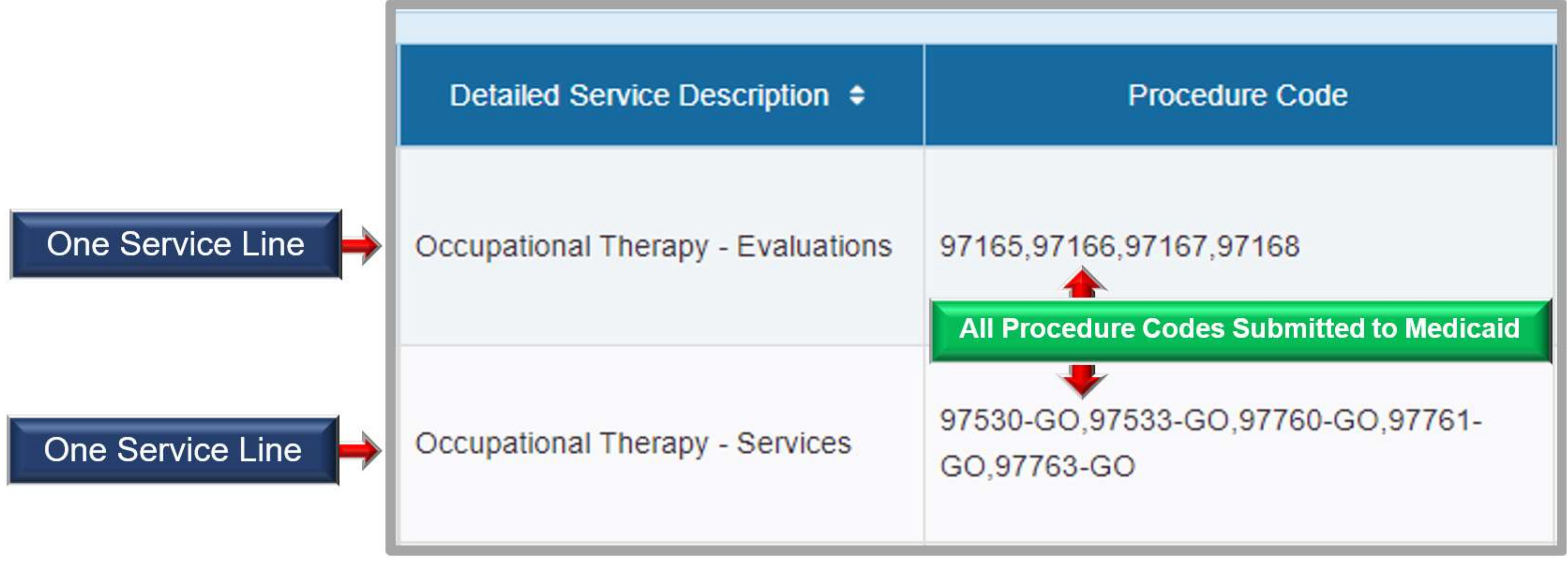
ISP Development (Service Summary)

Adult Therapy Services will not be approved and authorized as independent services but within a “bundle” based on a unique ‘Therapy Type’ and ‘Group Type’.



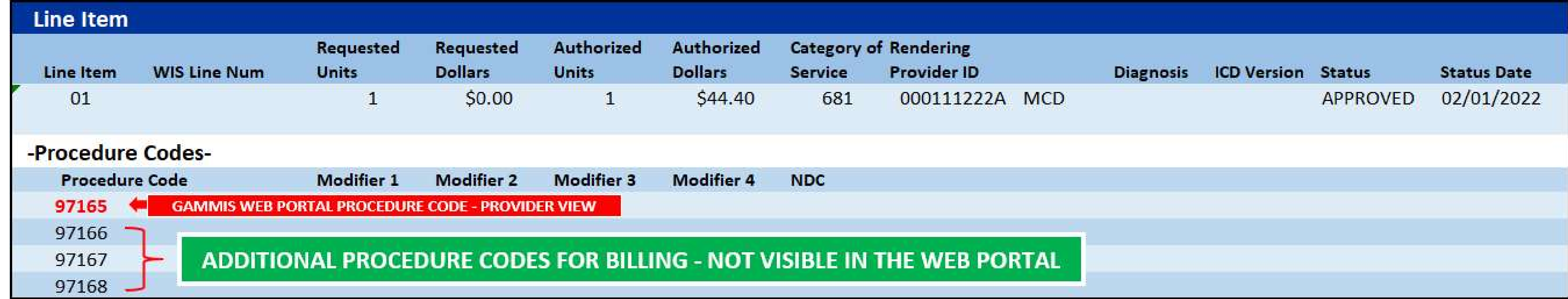
Prior Authorization Development

Each Adult Therapy Service line will contain all the procedure codes for the corresponding 'Group Type'. The procedure codes will be submitted to Medicaid (GAMMIS) and billable when rendered.



Prior Authorization Development

Medicaid/GAMMIS State View



Line Item

Line Item	WIS Line Num	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Category of Service	Rendering Provider ID		Diagnosis	ICD Version	Status	Status Date
01		1	$0.00	1	$44.40	681	000111222A	MCD			APPROVED	02/01/2022

-Procedure Codes-

Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	NDC
97165					
97166					
97167					
97168					

All 4 procedure codes visible to State users (GAMMIS)

Prior Authorization Development

Medicaid/GAMMIS Web Portal Provider View

Line Items

PA Line Item	1	Status	APPROVED	Rendering Provider	ACME THERAPY, LLC
		COS Code	681	Category of Service	CHSS/COMP
From DOS	02/10/2022			Tooth	
Through DOS	02/09/2023			Quadrant	
Most Recent DOS Paid				Surface	
Units Allowed	1	Amount Allowed	$44.40		
Units Used	0.000	Amount Used	$0.00		
Max Monthly Units	0	Max Monthly Amount	$0.00		
Max Daily Units	0	Authorized Rate	$67.21		

OCCUPATIONAL THERAPY - EVALUATIONS

Procedures

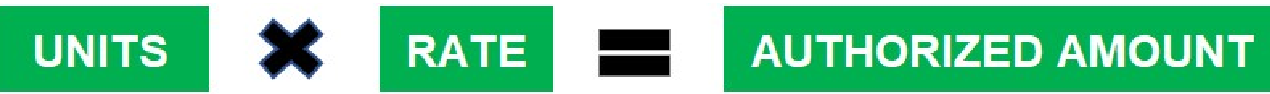
PA Line Item	(Procedure	Description)	(Modifier 1	Description)	(Modifier 2	Description)	(Modifier 3 Description)	(Modifier 3 Description)	NDC
01	97165	WAIVER SERVICE, NOS		M/CAID CARE LEV 4 STATE DEF					

OCCUPATIONAL THERAPY - EVALUATIONS

Only 1 of 4 procedure codes visible to providers (97165)

Prior Authorization Development: A Tale of Two Rates

IDD Connects uses two different rate methodologies for prior authorization development. For each therapy 'Group Type', the ***lowest*** rate within the "bundle" will be used to calculate the authorized amount. Only one rate can be associated with each "bundle".



OCCUPATIONAL SERVICES	
PROCEDURE CODE	UNIT RATE
97530-GO	$28.23
97760-GO	$27.38
97761-GO	$24.98
97533-GO	$24.46
97763-GO	$23.39

RATE USED FOR CALCULATION

Prior Authorization Development: A Tale of Two Rates

By using the ***lowest*** rate within the “bundle” we can maximize the highest amount of hours or sessions available within the annual maximum for Adult Therapy Services.

OCCUPATIONAL SERVICES				
PROCEDURE CODE	UNIT RATE	UNITS	HOURS	ANNUAL MAXIMUM
97530-GO	$28.23	191	47	$5,400.00
97760-GO	$27.38	197	49	$5,400.00
97761-GO	$24.98	216	54	$5,400.00
97533-GO	$24.46	221	55	$5,400.00
97763-GO	$23.39	231	57	$5,400.00

Prior Authorization Development: A Tale of Two Rates

To ensure that all the rates within the “bundle” are reimbursable, we’ll send the ***highest*** to Medicaid (GAMMIS). Providers will bill using the rate associated with the service rendered.

OCCUPATIONAL SERVICES		
PROCEDURE CODE	UNIT RATE	
97530-GO	$28.23	RATE SUBMITTED TO MEDICAID
97760-GO	$27.38	
97761-GO	$24.98	
97533-GO	$24.46	
97763-GO	$23.39	RATE USED FOR CALCULATION

Speech & Language Therapy: A Tale of Two Rates

SPEECH/LANGUAGE EVALUATIONS		
PROCEDURE CODE	UNIT RATE	
92523	$163.81	RATE SUBMITTED TO MEDICAID
92610	$117.54	
92607	$109.28	RATE USED FOR CALCULATION

SPEECH/LANGUAGE SERVICES		
PROCEDURE CODE	UNIT RATE	
92507-GN	$62.53	RATE SUBMITTED TO MEDICAID
92609	$54.75	
92526	$44.66	RATE USED FOR CALCULATION

Physical Therapy: A Tale of Two Rates

PHYSICAL THERAPY EVALUATIONS		
PROCEDURE CODE	UNIT RATE	
97161-GP	$69.34	RATE SUBMITTED TO MEDICAID
97162-GP	$69.34	
97163-GP	$69.34	
97164-GP	$47.14	RATE USED FOR CALCULATION

PHYSICAL THERAPY SERVICES		
PROCEDURE CODE	UNIT RATE	
97112-GO	$27.07	RATE SUBMITTED TO MEDICAID
97110	$25.91	RATE USED FOR CALCULATION

Occupational Therapy: A Tale of Two Rates

OCCUPATIONAL THERAPY EVALUATIONS		
PROCEDURE CODE	UNIT RATE	
97165	$67.21	RATE SUBMITTED TO MEDICAID
97166	$67.21	
97167	$67.21	
97168	$44.40	RATE USED FOR CALCULATION

OCCUPATIONAL THERAPY SERVICES		
PROCEDURE CODE	UNIT RATE	
97530-GO	$28.23	RATE SUBMITTED TO MEDICAID
97760-GO	$27.38	
97761-GO	$24.98	
97533-GO	$24.46	
97763-GO	$23.39	RATE USED FOR CALCULATION

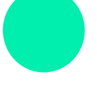
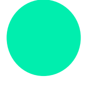
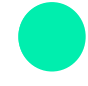
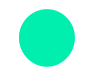
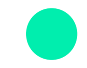
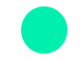
Adult Therapy Services: Policy & Rates

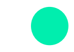
For additional information regarding Adult Therapy Services, please review Part III of the NOW/COMP policy. All waiver services rates are listed in Appendix A of the NOW/COMP policy:

- www.mmis.georgia.gov
- Provider Information
- Provider Manuals
- Comprehensive Supports Waiver Program Chapters 1300-3600
- New Options Waiver Program

DBHDD – GA Medicaid Web Portal Basics Web Portal Claim Submission

Common Claim Denials & Remittance Advice Presentation



To access the PDF version of this presentation, please visit our website: www.mmis.georgia.gov -> Provider Information -> Provider Notices – "Presentation – DBHDD – GA Medicaid Web Portal Basics.

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Agenda

- Overview of Georgia Medicaid
- Policy Information and Updates
- Common Denials
- Claims History Search
- Timely Filing Guidelines
- Accessing the Remittance Advice
- Contacting Gainwell Technologies
- Session Review
- Closing, Questions and Answers

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Georgia Medicaid Management Information System (GAMMIS), www.mmis.georgia.gov

• GAMMIS is the biller's 24-hour resource for Georgia Medicaid information.

• Non-secure information, such as policy manuals, provider alerts, forms, and training materials is available anywhere with Internet access.

With the use of the secure log-in available to each Georgia Medicaid provider, a biller can also verify HIPAA-related data and perform various functions on behalf of that provider, such as:

- Verifying member eligibility
- Reviewing prior authorizations
- Submitting, reviewing, adjusting, or resubmitting claims
- Reviewing remittance advice

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Policy Information and Updates

How to stay informed

Policy Information and Updates

- Provider Notices: Program Specific Presentations
- Provider Manuals: Program Specific Policy Manuals
- Provider Messages: Additional Policy and Program alerts

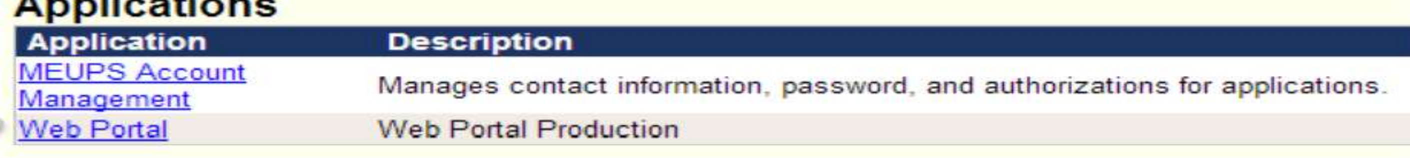
Logging into the Secure Web Portal

To get started, login to the secure GAMMIS Web Portal at www.mmis.georgia.gov.

Click the Login button.

1. Enter your Username and Password and click the Sign In button.

2. Click the Web Portal link.



NOTE: If acting as a billing agent, please select the appropriate provider ID from the Switch Provider panel to begin navigating on behalf of that provider.

GAMMIS Secure Web Portal

Welcome, callcenter

Search

[Refresh session] You have approximately 17 minutes until your session will expire.

Monday, November 15, 202

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy | HFRD

Account | Providers | Training | Claims | Eligibility | Presumptive Activations | Health Check | Prior Authorization | Reports | Trade Files

Home *Publication Search* *Site Map* *Site Settings* *Language Selection*

GAMMIS:Home <- Bookmarkable Link Click here for help and information about bookmarks

Eligibility Verification

- Eligibility verification is the first and most important step in billing any claim.
- Eligibility should be verified prior to each visit to the office or facility or dispensing of any equipment or treatment.
- The most common eligibility denials come from NOT checking the member's eligibility.

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Eligibility Verification

Verifying eligibility allows you to determine:

- Is the member currently eligible?
- Is the member eligible for *this* service?
- Does the member have other coverage?
- Has the member reached coverage limitations?
- Does the member have a spend-down or patient liability that will affect the claim?

Eligibility Verification

(continued)

There are **three ways** Georgia Medicaid provides verification of member eligibility:

- Provider Services Contact Center (PSCC) – 1-800-766-4456
- GAMMIS website www.mmis.georgia.gov
- Interactive Voice Response System (IVRS)

The IVRS and the GAMMIS website are available 24 hours a day.

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Common Medicaid Benefit Plans

Medicaid Benefit Plan	Plan Description
TXIX or Aged Blind Disabled	Provides Medicaid to individuals & families with low income - provided through DFCS
SSI	Provides Medicaid Benefits for those persons eligible for Supplemental Security Income benefits.
QMB	Provides payment for Medicare Part A premium. Co-insurance, deductible, and Medicare Part B premium only. QMB will not cover any medical services not covered by Medicare.
SLQI1	Provides payment for Medicare Part B Premium ONLY. No Medical Benefit. Aid Categories 446,661,662
Manager Care/Georgia Families	Benefits are received from 1 of the 3 CMO's: Peach State, Amerigroup, CareSource
Institutional Hospice	Providers Palliative Care to terminally ill Individuals.
Nursing Home	Providers coverage for Inpatient Nursing Home services.

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Eligibility Verification

(continued)

- [Medicaid ID and Date of Service Span]
- [Last Name/First Name, Gender, Birth Date, and Date of Service Span]
- [Birth Date, Social Security number, and Date of Service Span]
- [Last Name/First Name, Social Security number, Date of Service Span]

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Eligibility Verification

(continued)

"No" Medicaid Benefits

Eligibility by Service Type

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Inactive for Service Type Code selected.		09/08/2018	09/08/2018				

Eligibility Verification

(continued)

SLQI1/SLMB Medicare Premium Only "No" Medicaid Benefits

Aid Category 661 & 662 = No Medicaid Benefits

Benefit Plans

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	06/08/2018	06/08/2018	MC - Medicaid	661 - Spec. Low Income Mcre Benefic.	Provides payment of the monthly Medicare Part B premium only (SLMB-COE 466, 661 QI-COE 662)

Eligibility by Service Type

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Inactive for Service Type Code selected.	1 - Medical Care	06/08/2018	06/08/2018				
Inactive for Service Type Code selected.	33 - Chiropractic	06/08/2018	06/08/2018				
Inactive for Service Type Code selected.	35 - Dental Care	06/08/2018	06/08/2018				
Inactive for Service Type Code selected.	47 - Hospital	06/08/2018	06/08/2018				
Inactive for Service Type	48 - Hospital - Inpatient	06/08/2018	06/08/2018				

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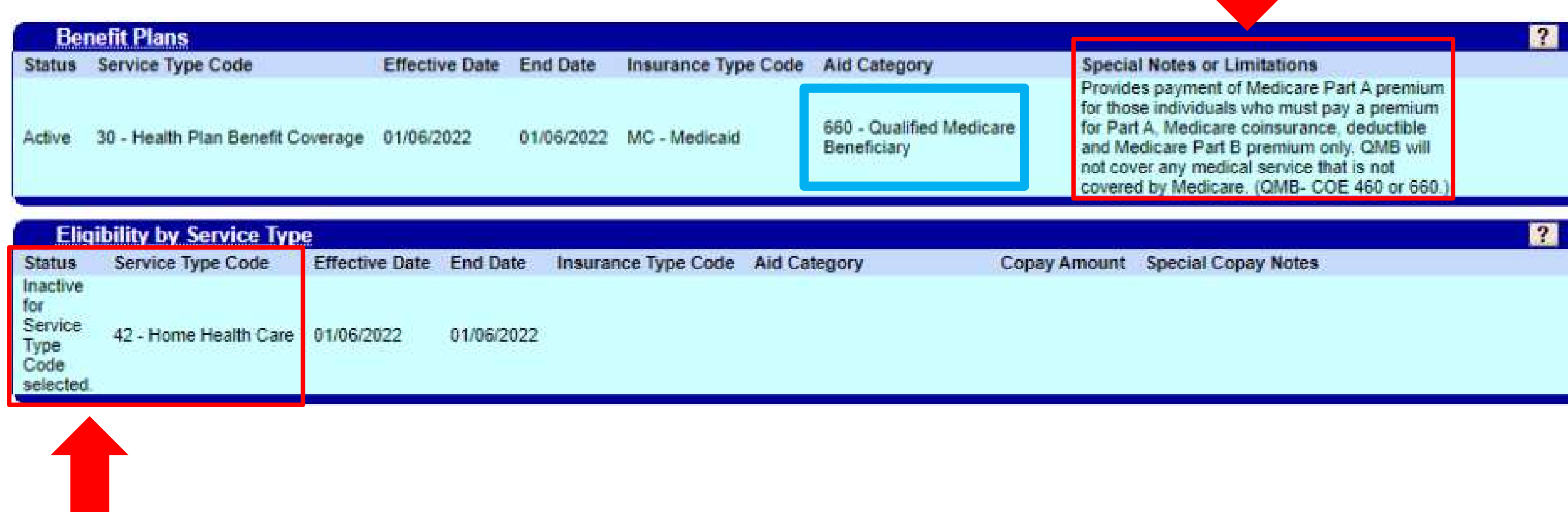
Eligibility Verification

(continued)

QMB Medicare Premium Only "No" Benefits for Home Health Care Services



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CCSP Medicaid & QMB Benefits

CCSP Benefits

Benefit Plans

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	06/08/2018	06/08/2018	MC - Medicaid	259 - Community Care Waiver	MEDICAID
Active	30 - Health Plan Benefit Coverage	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	Provides payment of Medicare Part A premium for those individuals who must pay a premium for Part A, Medicare coinsurance, deductible and Medicare Part B premium only. QMB will not cover any medical service that is not covered by Medicare. (QMB- COE 460 or 660.)

Benefit Plans

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	01/06/2022	01/06/2022	MC - Medicaid	259 - Elderly and Disabled Waiver	MEDICAID
Active	30 - Health Plan Benefit Coverage	01/06/2022	01/06/2022	MC - Medicaid	660 - Qualified Medicare Beneficiary	Provides payment of Medicare Part A premium for those individuals who must pay a premium for Part A, Medicare coinsurance, deductible and Medicare Part B premium only. QMB will not cover any medical service that is not covered by Medicare. (QMB- COE 460 or 660.)

Eligibility by Service Type

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Active	42 - Home Health Care	01/06/2022	01/06/2022	MC - Medicaid	259 - Elderly and Disabled Waiver	0.00	

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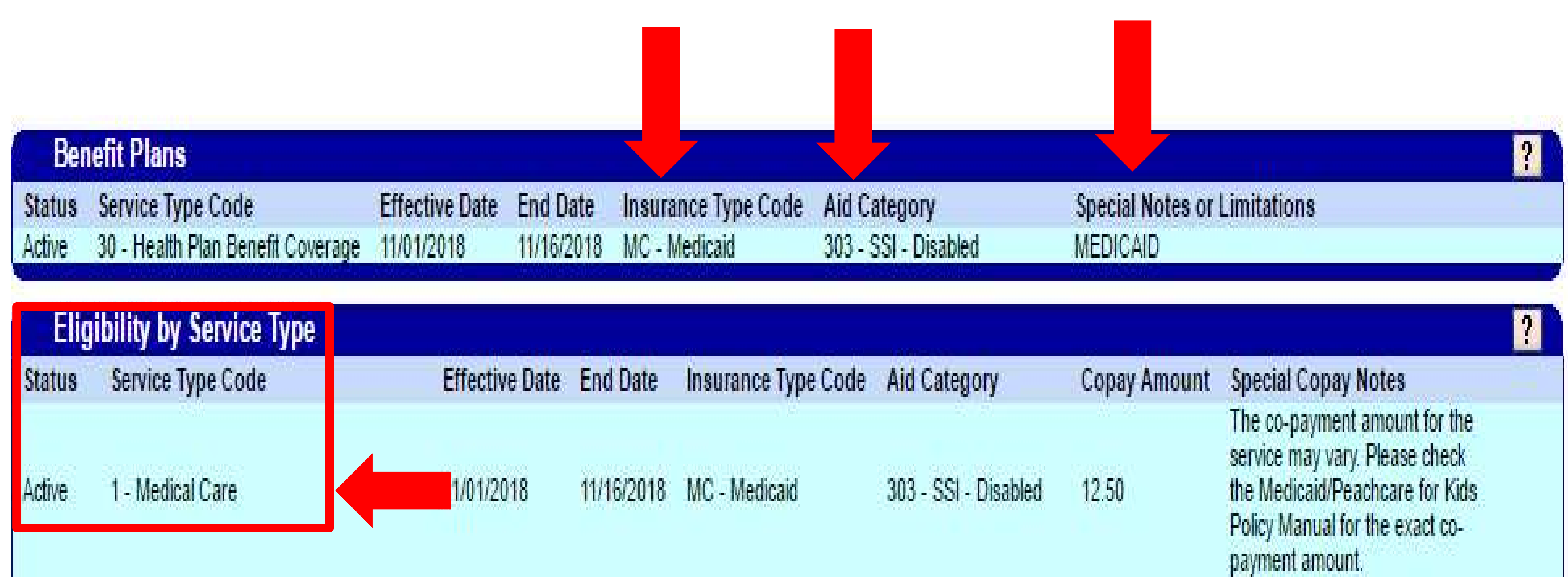
Eligibility Verification
(continued)

SSI Medicaid Benefits – Active



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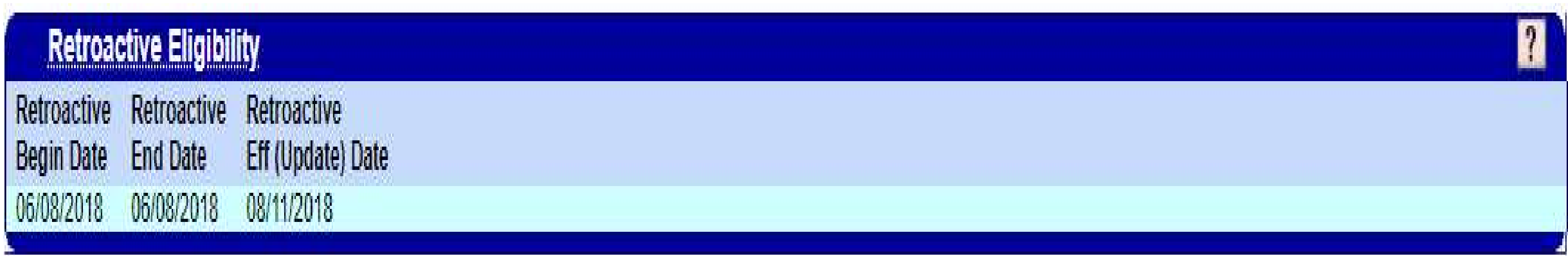
Eligibility Verification
(continued)

Retro Medicaid Benefits



Retroactive Eligibility

Retroactive Begin Date	Retroactive End Date	Retroactive Eff (Update) Date
06/08/2018	06/08/2018	08/11/2018

- **Claims must be received within six (6) months after the date in which the determination of retroactive eligibility was made.**

Prior Authorization Search

Prior Authorization Search

(continued)

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Prior Authorization Search

(continued)

Prior Authorization search can be done in either of the following ways:

- Enter the member's prior authorization number and select search
- Enter the Member ID and the requested from/through date of service and select search

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Prior Authorization Search

(continued)

Prior Authorization Search

(continued)

Line Items

PA Line Item	01	Status	APPROVED	Rendering Provider
		COS Code	660	Category of Service
From DOS	11/14/2016			Tooth
Through DOS	11/13/2017			Quadrant
Most Recent DOS Paid				Surface
Units Allowed	12	Amount Allowed	$2,240.04	
Units Used	0.000	Amount Used	$0.00	
Max Monthly Units	1	Max Monthly Amount	$0.00	
Max Daily Uniits	0	Authorized Rate	$0.00	
PA Line Item	02	Status	APPROVED	Rendering Provider
		COS Code	660	Category of Service
From DOS	11/14/2016			Tooth
Through DOS	11/13/2017			Quadrant
Most Recent DOS Paid	01/12/2017			Surface
Units Allowed	1160	Amount Allowed	$10,416.80	
Units Used	104.000	Amount Used	$933.92	
Max Monthly Units	110	Max Monthly Amount	$0.00	
Max Daily Uniits	0	Authorized Rate	$0.00	
PA Line Item	03	Status	APPROVED	Rendering Provider
		COS Code	660	Category of Service
From DOS	11/14/2016			Tooth
Through DOS	11/13/2017			Quadrant
Most Recent DOS Paid	01/11/2017			Surface
Units Allowed	676	Amount Allowed	$6,827.60	
Units Used	88.000	Amount Used	$886.45	
Max Monthly Units	60	Max Monthly Amount	$0.00	
Max Daily Uniits	0	Authorized Rate	$0.00	

Procedures

PA Line Item	(Procedure	Description)	(Modifier 1	Description)	(Modifier 2	Description)	(Modifier 3	Description)	(Modifier 4	Description)	NDC
01	T2022	CASE MANAGEMENT, PER MONTH	SE	STATE/FED FUNDED PROGRAM/SER							
02	T1021	HH AIDE OR CN AIDE PER VISIT	TF	INTERMEDIATE LEVEL OF CARE							
03	T1021	HH AIDE OR CN AIDE PER VISIT	U1	M/CAID CARE LEV 1 STATE DEF							

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Medicaid Claims

Acceptable Claim Types and Submissions

The provider can submit the following claim types:

- Professional – CMS 1500
- Institutional – UB 04
- Dental – 2006 ADA Dental claim

Claims, Claim adjustments, and Claim resubmissions can be submitted in two ways:

- Electronically through a clearinghouse
- Through the Georgia Medicaid Web Portal
- NetSmart – EVV Software Solution – (Personal Support Services)

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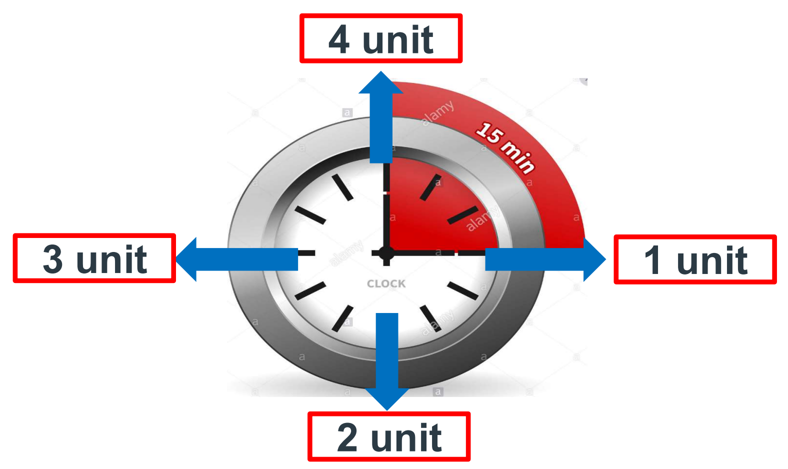
Billing and Unit Calculation Example

- **NOW/COMP Example:**

Description	Procedure Code	Modifier	Rate
Community Living Support	T2025	U5	$6.35 per 15 minutes
Community Access	T2025	HQ	$3.10 per 15 minutes Daily limit is 24 units, Monthly 504 units Annual Limit 5760 units



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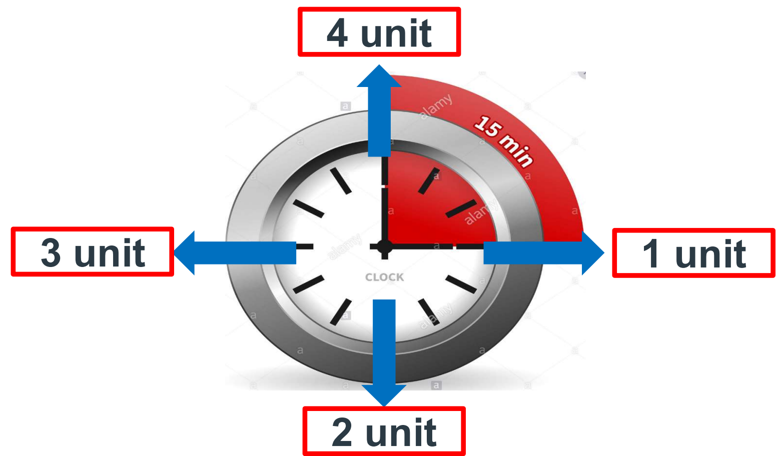
Billing and Unit Calculation Example

Prevocational Services:

Prevocational Services (T2015)
Unit = 15 minutes
Daily Limit = 24 units
Monthly Limit = 504 units
Annual Limit = 5760 units
Maximum rate per unit = $3.10



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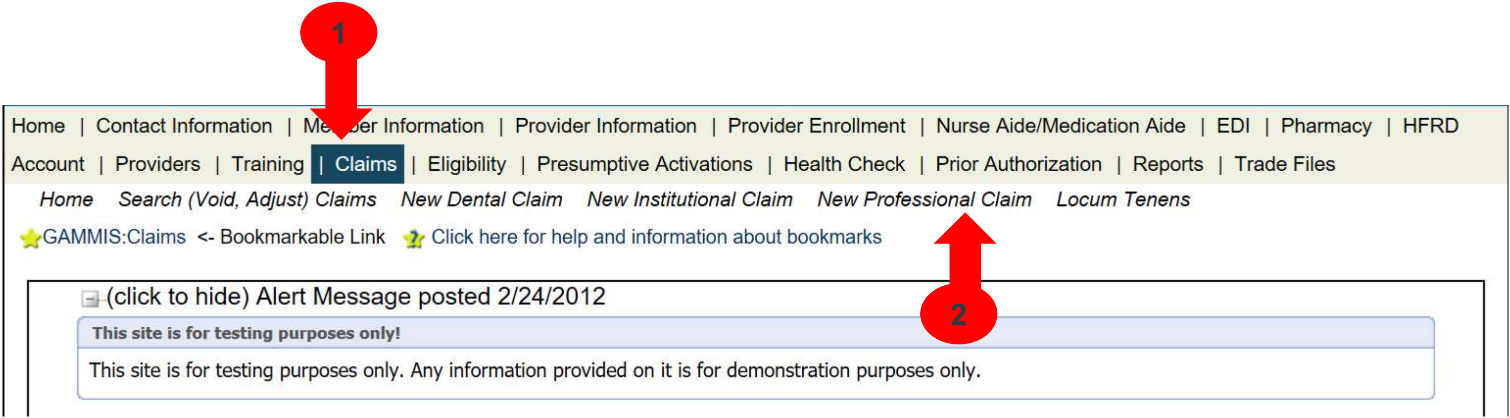
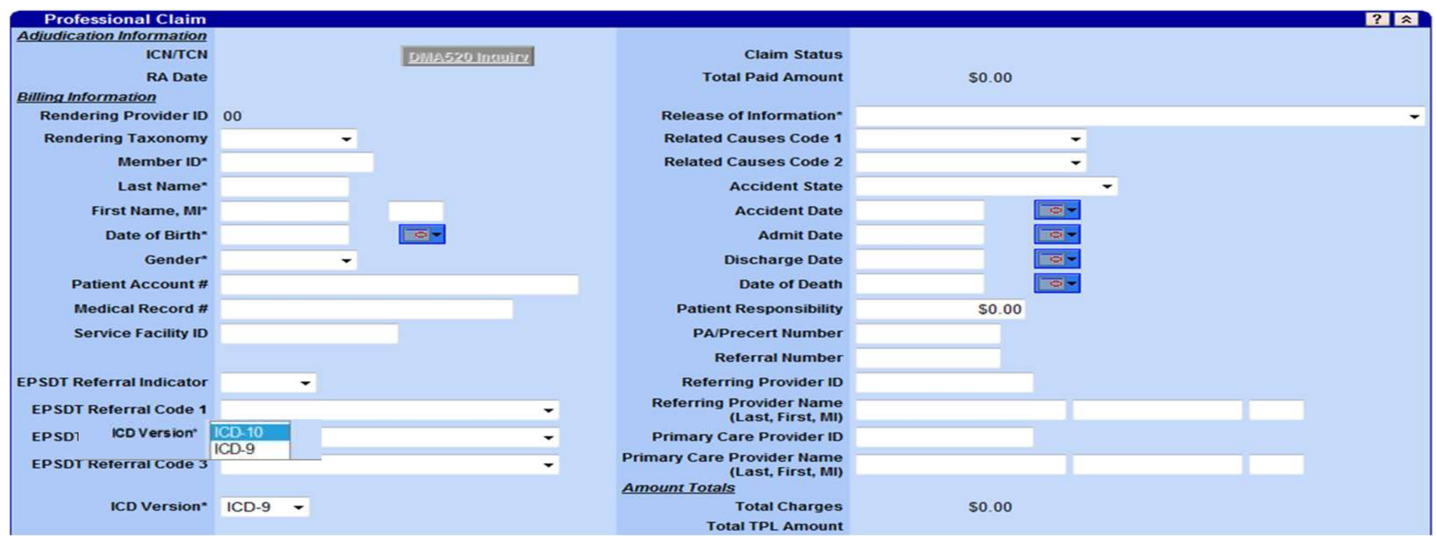
Professional Billing Information



Professional Claim

Header Panel 1

Enter the required information indicated by an asterisk (*) on each panel and as much optional information as possible.



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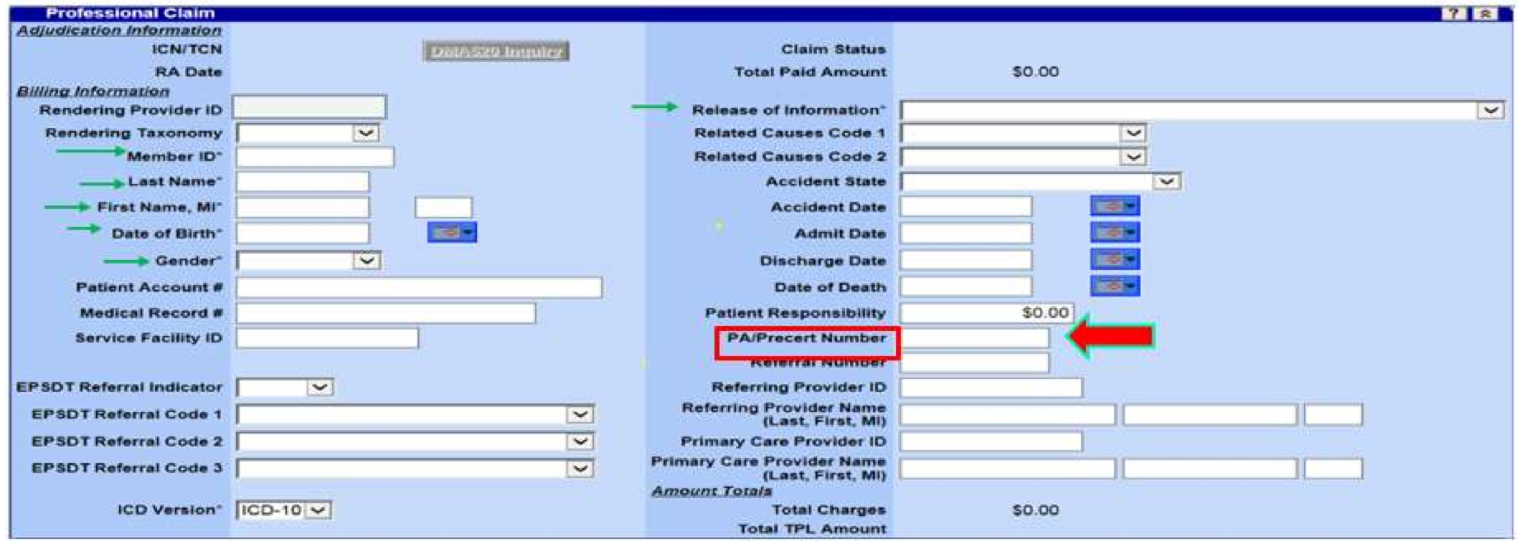
Professional Billing Information

Section 1

Enter the required information and as much optional information as possible (some required fields are the Member ID, Last Name, First Name, and Middle Initial).



Diagnosis

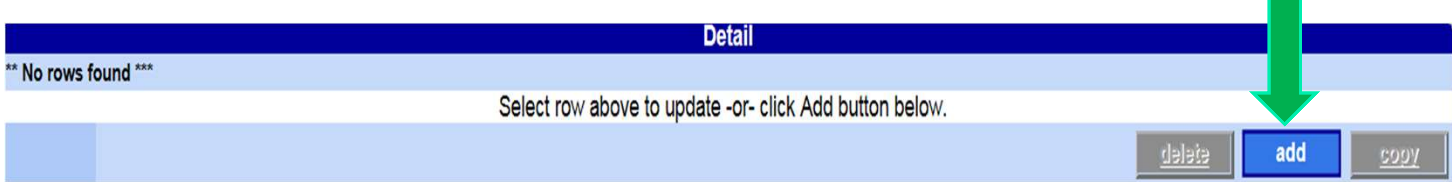
Section 2

Allows entry of up to 10 diagnoses

- Click add to activate the diagnosis section for **each additional diagnosis** to be entered.
- Enter the diagnosis (to find a diagnosis code, use the [Search] feature).
- Enter the sequence (diagnosis code pointer) number.

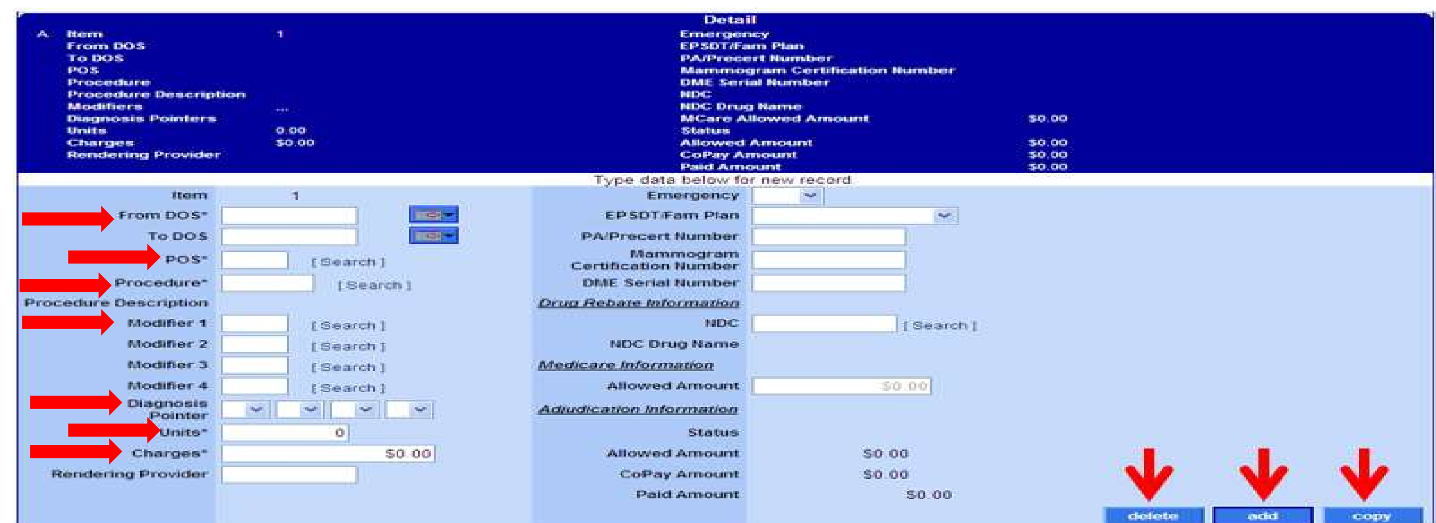
Detail

Section 3

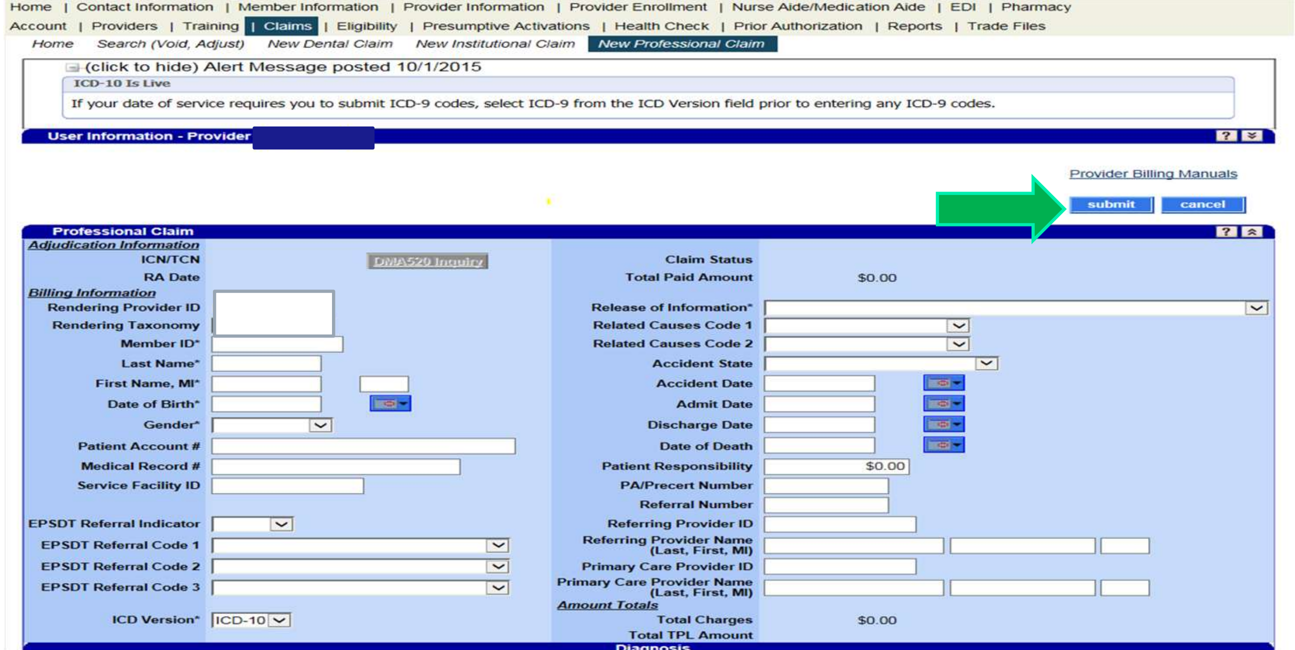


Claims Detail

Click add to add up to 50 lines > Click copy to duplicate information > Click delete to delete the details entered



Submit



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Internal Control Number (ICN) and/or Claim Number

The ICN is a 13-digit number that is unique to each claim, no matter the status.

20	12010	999	999
Region	Julian Date	Batch	Sequence
Claim Type	*Year and Day*	*Internal Use Only*	

- EVV claims will always start with 20 - Example: 2022123456789
- Web Portal keyed claims will start with 22 - 222212345678
- Corrected or Voided claims will start with 59 - Example: 5922123456789

Note The region or claim type is determined by how the claim was submitted.

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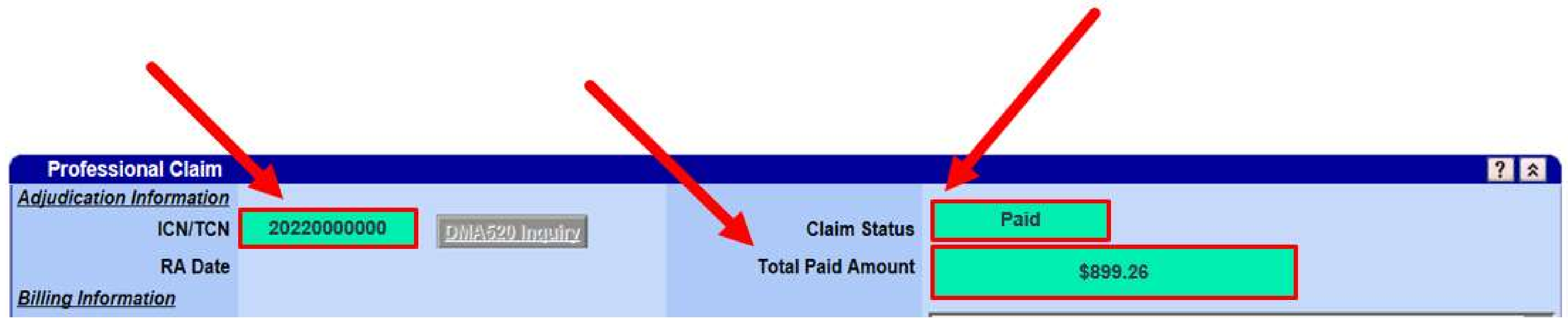
Claim Status

Once a claim has been processed, its status could be:

- **Paid:** Partially or fully paid. Void, Copy, or Adjust. (Adjustments must be made within 90 days of paid date.
- **Denied:** No part of the claim was found to be reimbursable.
- **Suspended:** Further processing is needed. The final determination may be dependent upon further review or receipt of additional information. (Check with your Field Rep. or call MMIS Call Center)

Claim Status – Top of the Claim

- ✓ **Claim number** – Internal Control Number (ICN)
- ✓ **Status** – Paid, Denied or Suspended
- ✓ **Total Paid amount**



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Claim Denial Reason

- Claim denial reason, move to the bottom of the claim for denial explanation.

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Timely Filing Guidelines

Timely Filing Guidelines

For most providers, timely filing is 6 months from the month the service was rendered by the provider. However, there are variations which you should be aware of:

- Claim submission -Within six months of the DOS
- Claim adjustment -Within three months of the month of payment
- Claim resubmission -Within three months of the month the denial occurred
- One Year (365 Days) Claim Submission Edit

A claim is considered a new claim if there are any changes made to the claim after the initial submission (total charges, dates of service, revenue codes, etc.). Therefore, the six months for timely filing will apply to the claim that has been edited. Regardless if the prior submitted claims were kept timely in the system.

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One Year (365 Days) Claim Submission

Example:

DOS	Original Submit Claim Denied Date:	1st Resubmit Adjustment	2nd Adjustment (365 days)
July 1, 2021	December 30, 2021	March 31, 2022	June 30, 2022

- All claim submissions and adjustments to denied claims are to be completed according to policy by 365 days. Other timely submission and resubmission system edits will remain in GAMMIS according to policy (there is no time limit for adjusting a claim that reverses payment back to the Department of Community Health).
- Please refer to the Georgia Medicaid Part 1 - Policies and Procedures Manual, Chapter 200. The Timely Resubmission policy outlined in Section 204 will still be enforced to include this new one year or 365 days guideline.

*Banner Message posted April 12, 2018

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Claims Billing Cycle Time Frames

Weekly Claims Submission Deadlines

EVV Claim submissions using the Netsmart System	Due Midnight each Thursday
MMIS Web Portal Claim corrections/submissions	Due Midday (12N) on Friday
Week Remittance Advices Availability	Monday
EFT Payment Deposits	Thursday

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Common Claim Denials

Common Claim Denials

- **0872**: First diagnosis code not on file
- **1072:** EVV Services mut be Submitted to EVV Vendor
- **1410:** 1st ICD-10 Diagnosis is a header or Parent Code
- **1430:** 1st ICD-10 Diagnosis is not specific
- **2697:** QMB Member – Bill Medicare First
- **3001:** Prior Authorization/Precert Not on File
- **3011:** DOS not within PA/Precert effective dates
- **3043:** Prior Authorization/Procedure Code Modifier Conflict
- **3052:** Prior Authorization Units/Amount have been exhausted
- **5115:** Service not allowed during Hospital stay

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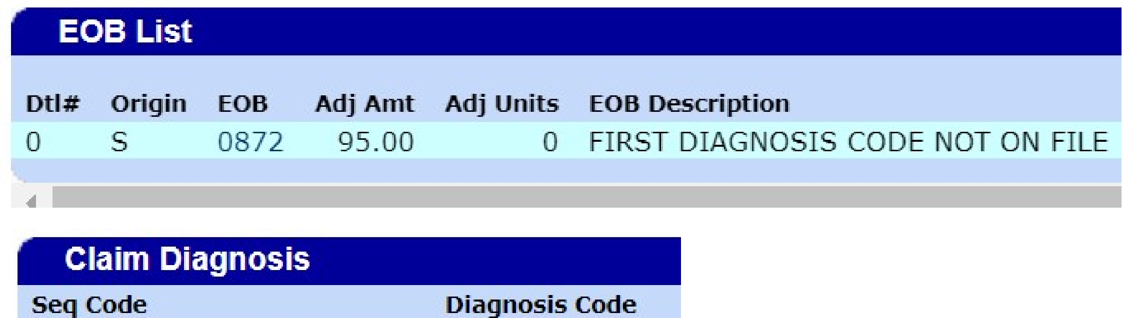
Common Claim Denials - EOB: 0872

(continued)



EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
0	S	0872	95.00	0	FIRST DIAGNOSIS CODE NOT ON FILE

Claim Diagnosis

Seq Code	Diagnosis Code
1	F71 F84

Method of Correction – Verify and resubmit claim with the correct diagnosis code.

Diagnosis Codes should be indicated within the members documentation or within the IDD Connect system.

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Common Claim Denials - EOB: 1072

(continued)

EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
3	S	1072	22.32	0	EVV SERVICES MUST BE SUBMITTED TO EVV VENDOR

Method of Correction - Submit all claims via the EVV Netsmart system.

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Common Claim Denials - EOB: 1410

(continued)

EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
1	S	1410	157.17	0	1ST ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE

Method of Correction - Resubmit a corrected claim via the Web Portal or EVV Netsmart system (if applicable) with the primary diagnosis code. The primary diagnosis should be indicated within the members documentation.

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Common Claim Denials EOB: 1430

(continued)

EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
1	S	1430	76.67	0	1ST ICD-10 DIAGNOSIS IS NOT SPECIFIC

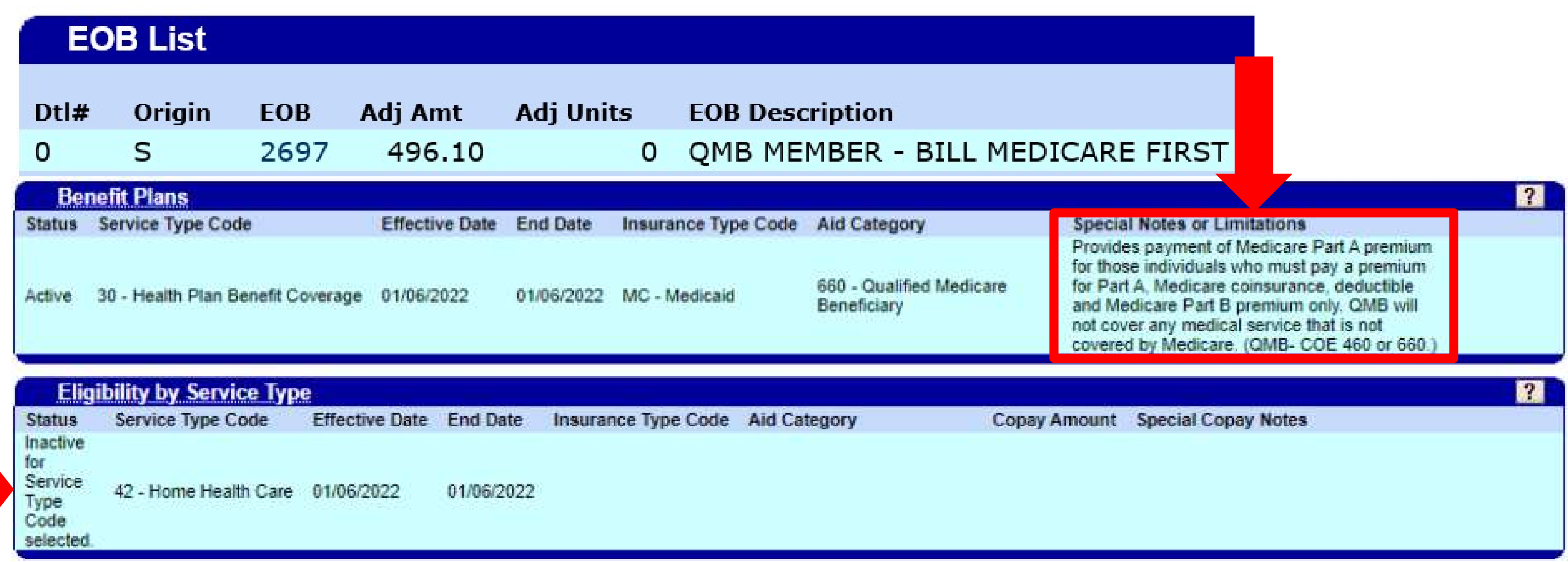
Claim Diagnosis

Seq Code	Diagnosis Code	ICD	Description
1	M19.90	ICD-10	UNSPECIFIED OSTEOARTHRITIS, UNSPECIFIED SITE

Method of Correction - Resubmit a corrected claim via the Web Portal or EVV Netsmart system (if applicable) with a more specific diagnosis code. The specific diagnosis should be indicated within the members documentation.

Common Claim Denials - EOB: 2697

(continued)


EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
0	S	2697	496.10	0	QMB MEMBER - BILL MEDICARE FIRST

Benefit Plans

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	01/06/2022	01/06/2022	MC - Medicaid	660 - Qualified Medicare Beneficiary	Provides payment of Medicare Part A premium for those individuals who must pay a premium for Part A, Medicare coinsurance, deductible and Medicare Part B premium only. QMB will not cover any medical service that is not covered by Medicare. (QMB- COE 460 or 660.)

Eligibility by Service Type

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Inactive for Service Type Code selected.	42 - Home Health Care	01/06/2022	01/06/2022				

Recommendation – if member is a CCSP members, check with care coordinator to see if CCSP benefits can be applied for.

All other members, check with DFCS to see if eligibility can be reviewed.

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Common Claim Denials - EOB: 3001

(continued)

EOB List
EOB Description
PRIOR AUTHORIZATION/PRECERT NOT ON FILE

Recommendation – Double check the Prior Authorization number to ensure is it validation PA number.

Method of Correction - Resubmit a corrected claim with a valid PA Number.

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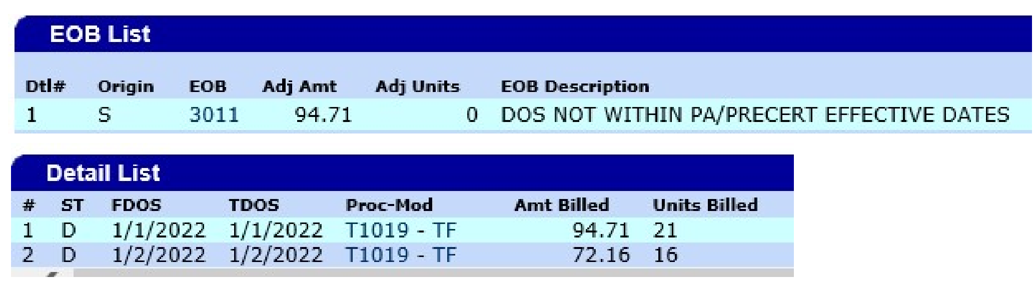
Common Claim Denials - EOB: 3011

(continued)



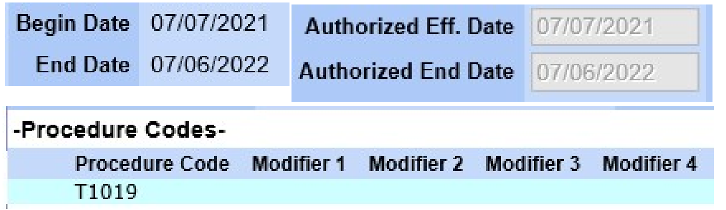
EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
1	S	3011	94.71	0	DOS NOT WITHIN PA/PRECERT EFFECTIVE DATES

Detail List

#	ST	FDOS	TDOS	Proc-Mod	Amt Billed	Units Billed
1	D	1/1/2022	1/1/2022	T1019 - TF	94.71	21
2	D	1/2/2022	1/2/2022	T1019 - TF	72.16	16

Prior Authorization Start and Ending date:



Begin Date	07/07/2021	Authorized Eff. Date	07/07/2021
End Date	07/06/2022	Authorized End Date	07/06/2022

-Procedure Codes-

Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4
T1019				

Recommendation - Cross reference date of service billed and Prior Authorization approval dates and ensure they are within range.

Method of Correction - Resubmit a corrected claim via the Web Portal or EVV Netsmart system (if applicable) with the correction.

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Common Claim Denials - EOB: 3043

(continued)

EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
1	S	3043	96.33	0	PRIOR AUTHORIZATION/PROCEDURE CODE MODIFIER CONFLICT

Detail List

#	ST	FDOS	TDOS	Proc-Mod	Amt Billed	Units Billed
1	D	12/22/2021	12/22/2021	T1019 -	96.33	19

Method of Correction – Resubmit a corrected claim via the Web Portal or EVV Netsmart system (if applicable) with the procedure and modifier as approved on the members Prior Authorization.

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Common Claim Denials - EOB: 3052

(continued)

EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
1	S	3052	81.18	0	PRIOR AUTHORIZATION UNITS/AMOUNT HAVE BEEN EXHAUSTED

Recommendation - Cross reference current Prior authorization and ensure that you have billed the current units on each date of service.
*(For accurate Prior Authorization result, verify PAs via the MMIS Web Portal)

Method of Correction – If corrections should be made, submit a newly corrected claim via the Web Portal or EVV Netsmart system (if applicable).

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Common Claim Denials - EOB: 5115

(continued)

EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
1	S	5115	376.07	0	SERVICE NOT ALLOWED DURING MEMBERS HOSPITAL STAY

Recommendation – member signed time sheet showing in and out time(s) may be requested to be attached to the claim via the MMIS Web portal. May also need hospital documentation to shows hospital visit.

Method of Correction – Must rebill and attach recommended documentation.

Claim History Search

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Claims History Search

(continued)

Ways to search for outstanding claims:

- ICN (Search)
- Member ID, FDOS -> TDOS, Claim Type (Search)
- Member ID, FDOS -> TDOS, Status Type (Search)
- Member ID, Claim Type, RA Date (Search)

Claim Type = Professional

Status Type Options = Paid, Denied, Suspended

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Claims History Search

Ways to search for outstanding claims

- ICN
- Member ID, FDOS – TDOS, Claim Type
- Member ID, FDOS – TDOS, Status Type
- Member ID, Claim Type, RA Date

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Claims History Search

(continued)

Claim Search

Top ?

ICN/TCN		From/Thru DOS	01/05/2009 01/29/2009
Member ID	11123456789	RA Date	
Rendering Provider ID	[Search]		
Claim Type	M - PROFESSIONAL CLAIMS	Status	D - DENIED P - PAID Q - QLTY CNTL R - RESUBMIT X - SUPER-SUSPEND S - SUSPENDED
		Records	

search

clear

English | Español | Accessibility

REPORT FRAUD

Search Results (13 rows returned)

ICN	TCN	Member ID	From DOS	To DOS	Claim Type	Status	RA Date	Amount Billed	Paid
4009	3090	111	01/05/2009	01/05/2009	PROFESSIONAL CLAIMS	PAID	01/12/2009	$67.97	$40.70
4009	2090	111	01/07/2009	01/07/2009	PROFESSIONAL XOVER CLAIMS	PAID	01/19/2009	$66.81	$48.20
4009	2090	111	01/09/2009	01/09/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/02/2009	$80.00	$0.00
4009	2090	111	01/12/2009	01/12/2009	PROFESSIONAL XOVER CLAIMS	PAID	01/26/2009	$67.97	$40.70
4009	2090	111	01/12/2009	01/12/2009	PROFESSIONAL XOVER CLAIMS	PAID	01/26/2009	$102.93	$62.71
4009	8090	111	01/12/2009	01/12/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/23/2009	$420.00	$107.31
4009	2090	111	01/13/2009	01/13/2009	PROFESSIONAL XOVER CLAIMS	PAID	01/26/2009	$66.81	$48.20
4009	8090	111	01/14/2009	01/14/2009	PROFESSIONAL XOVER CLAIMS	PAID	04/13/2009	$102.93	$0.00
4009	2090	111	01/23/2009	01/23/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/09/2009	$102.93	$59.71
4009	2090	111	01/27/2009	01/27/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/23/2009	$105.93	$0.00
4009	8090	111	01/27/2009	01/27/2009	PROFESSIONAL XOVER CLAIMS	PAID	04/13/2009	$79.61	$6.59
4009	2090	111	01/28/2009	01/28/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/23/2009	$144.01	$65.12
4009	2090	111	01/29/2009	01/29/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/23/2009	$102.93	$0.00

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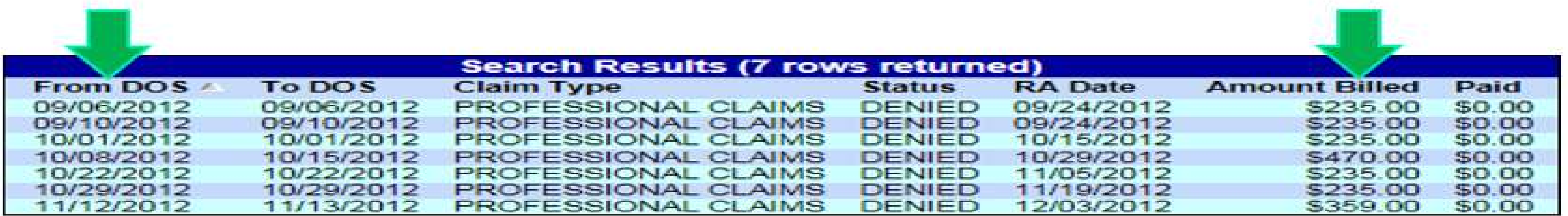
Claims History Search

(continued)

Sort Claims by DOS, RA Date, Billed, or Paid



Search Results (7 rows returned)

From DOS	To DOS	Claim Type	Status	RA Date	Amount Billed	Paid
09/06/2012	09/06/2012	PROFESSIONAL CLAIMS	DENIED	09/24/2012	$235.00	$0.00
09/10/2012	09/10/2012	PROFESSIONAL CLAIMS	DENIED	09/24/2012	$235.00	$0.00
10/01/2012	10/01/2012	PROFESSIONAL CLAIMS	DENIED	10/15/2012	$235.00	$0.00
10/08/2012	10/15/2012	PROFESSIONAL CLAIMS	DENIED	10/29/2012	$470.00	$0.00
10/22/2012	10/22/2012	PROFESSIONAL CLAIMS	DENIED	11/05/2012	$235.00	$0.00
10/29/2012	10/29/2012	PROFESSIONAL CLAIMS	DENIED	11/19/2012	$235.00	$0.00
11/12/2012	11/13/2012	PROFESSIONAL CLAIMS	DENIED	12/03/2012	$359.00	$0.00

Search Results (7 rows returned)

From DOS	To DOS	Claim Type	Status	RA Date	Amount Billed	Paid
11/12/2012	11/13/2012	PROFESSIONAL CLAIMS	DENIED	12/03/2012	$359.00	$0.00
10/29/2012	10/29/2012	PROFESSIONAL CLAIMS	DENIED	11/19/2012	$235.00	$0.00
10/22/2012	10/22/2012	PROFESSIONAL CLAIMS	DENIED	11/05/2012	$235.00	$0.00
10/08/2012	10/15/2012	PROFESSIONAL CLAIMS	DENIED	10/29/2012	$470.00	$0.00
10/01/2012	10/01/2012	PROFESSIONAL CLAIMS	DENIED	10/15/2012	$235.00	$0.00
09/06/2012	09/06/2012	PROFESSIONAL CLAIMS	DENIED	09/24/2012	$235.00	$0.00
09/10/2012	09/10/2012	PROFESSIONAL CLAIMS	DENIED	09/24/2012	$235.00	$0.00

Accessing and Understanding your Remittance Advice

Remittance Advice (RA)

Sections within the remittance advice

- Banner Messages
- Claims Type M – CMS 1500 Paid
- Claims Type M – CMS 1500 Denied
- Financial Transactions (Non-Claim Specific Payouts, Refunds & Account Receivable)
- Remittance Advise Summary Page (Indicates the total deposit to banking institutions)
- EOB Code Descriptions

- The Remittance Advices (RA) are generated each claims payment cycle. RAs are only received if there were claim activity during the claims cycle.

Accessing the Full Remittance Advice

- Select **Report**, then **Financial Reports** from the menu. Next, select **Remittance Advice** from the Report drop down menu.
- Enter the date span
- Click Search

*** For a full comprehensive remittance advice report including all page, please login and access using your payee ID user information.**
*** (For assistance, contact our EDI department at: 1-877-267-8785)**

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Remittance Advice (RA)

```
REPORT:   CRA-BANN-R                    GEORGIA DEPARTMENT OF COMMUNITY HEALTH                    DATE:
RA#:         8523480                    MEDICAID MANAGEMENT INFORMATION SYSTEM                    PAGE:
                                             PROVIDER REMITTANCE ADVICE
                                                  BANNER MESSAGES
```

```
PAYEE ID:
NPI ID:
PAYMENT NUMBER:
ISSUE DATE:
RECEIVER ID:
1

    ********************************************************************************
    ********************************************************************************
```

BANNER MESSAGE TO HCBS WAIVER COS PROVIDERS 590, 660, 680, 681 FINANCIAL MANAGEMENT, CASE MANAGEMENT AND SUPPORT COORDINATION PROVIDERS

THIS BANNER MESSAGE SHALL SERVE AS A SELF-DIRECTION (A.K.A. CONSUMER-DIRECTION, PARTICIPANT-DIRECTION) POLICY UPDATE TO HOME AND COMMUNITY-BASED WAIVER SERVICES FOR THE INDEPENDENT CARE WAIVER PROGRAM, COMMUNITY CARE SERVICES PROGRAM, NEW OPTIONS WAIVER, AND COMPREHENSIVE SUPPORTS WAIVER EFFECTIVE 11/1/15.

THIS COMMUNICATION IS AN UPDATE REGARDING THE U.S. DEPARTMENT OF LABOR FINAL HOME CARE RULE (EFFECTIVE JANUARY 1, 2015) EXTENDING THE MINIMUM WAGE AND OVERTIME PROTECTIONS OF THE FAIR LABOR STANDARDS ACT TO MOST HOME CARE WORKERS. THE FINAL HOME CARE RULE LABOR STANDARDS ACT WAS UPHELD BY THE U S. COURT OF APPEALS ON AUGUST 21, 2015. AS A RESULT, GEORGIA MEDICAID WILL BE MOVING FORWARD IMMEDIATELY TO COMPLY WITH THE RULE EFFECTIVE 11/1/15.

EFFECTIVE NOVEMBER 1, 2015 ALL PERSONAL SUPPORT AIDES MUST BE PAID OVERTIME FOR ANY HOURS THEY WORK THAT ARE OVER 40 IN A WORK WEEK. CURRENTLY AN AIDE WHO WORKS MORE THAN 40 HOURS A WEEK IS BEING PAID THE SAME HOURLY PAY RATE FOR THE OVERTIME HOURS AS THEY ARE FOR THE REGULAR HOURS. SERVICES ARE AUTHORIZED WITHIN THE WAIVER BASED ON MEMBER NEED WITHOUT PROVISIONS FOR OVERTIME. IT IS THE MEMBER'S RESPONSIBILITY AS THE EMPLOYER TO MAKE SURE HE/SHE HAS ENOUGH AIDES HIRED AND SCHEDULED SO THAT NO AIDE WILL WORK OVER 40 HOURS IN A WORK WEEK.

IF A MEMBER'S AIDE WORKS MORE THAN 40 HOURS IN A WEEK AFTER THIS CHANGE IS EFFECTIVE, THEY WILL HAVE TO BE PAID OVERTIME AT 1? TIMES THE NORMAL RATE BY THE FISCAL AGENT. THIS WILL AFFECT THE AMOUNT OF MONEY LEFT IN THE MEMBER'S BUDGET. IF ALL THE MONEY IN THE MEMBER'S BUDGET IS USED TO PAY O VERTIME, THE CARE COORDINATOR OR CASE MANAGER WILL NOT BE AUTHORIZED TO INCREASE THE BUDGET. IT WILL BE THE MEMBER'S RESPONSIBILITY AS THE EMPLOYER FOR PAYING THE AIDE FOR ANY ADDITIONAL SERVICES NEEDED. IF THE MEMBER DEMONSTRATES THAT HE OR SHE CANNOT STAY WITHIN THEIR SELF-DIRECTED BUDGET DUE TO LARGE AMOUNTS OF OVERTIME PAID OUT, THE MEMBER WILL RISK THEIR SELF-DIRECTED STATUS AND MAY BE REMOVED FROM THE SELF-DIRECTED PROGRAM AND REQUIRED TO RECEIVE PERSONAL SUPPORT SERVICES THROUGH A TRADITIONAL AGENCY.

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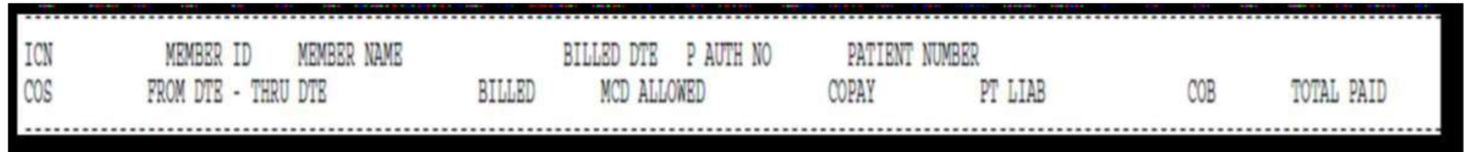
Remittance Advice (RA)

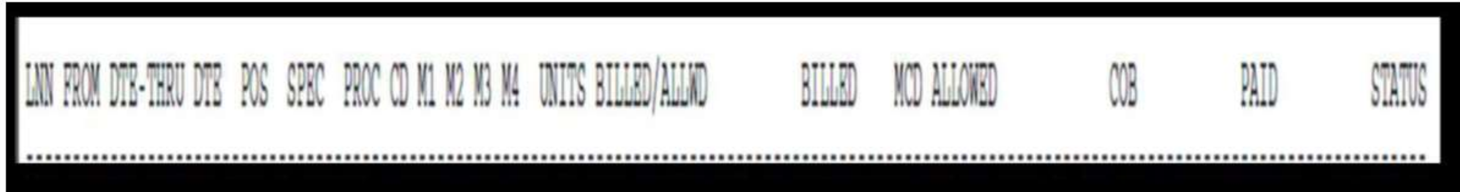
Claims data lines includes:

- ICN, Member ID, Member Name, Billed Date, Prior Auth No, Patient account number (if provided on claim), COS, FDOS-TDOS, Billed Amount, Medicaid Allowed Amount, Copay, Pt Liability, COB, Total Paid



ICN MEMBER ID MEMBER NAME BILLED DTE P AUTH NO PATIENT NUMBER
COS FROM DTE - THRU DTE BILLED MCD ALLOWED COPAY PT LIAB COB TOTAL PAID

- Detail Line Number, FDOS-TDOS, POS, Provider Specialty, Procedure Code, Modifiers, Units Billed/Units Allowed, Billed Amount, Medicaid Allowed Amount, COB, Total Paid, Claim Status



LNN FROM DTE-THRU DTE POS SPEC PROC CD M1 M2 M3 M4 UNITS BILLED/ALLWD BILLED MCD ALLOWED COB PAID STATUS

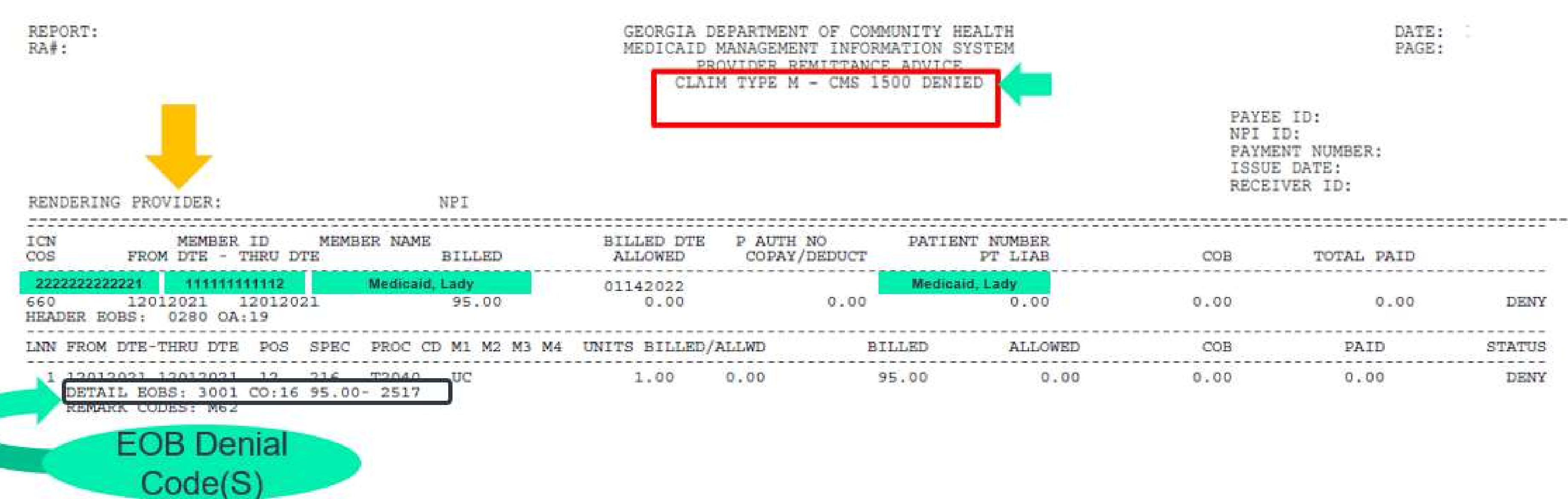
Remittance Advice (RA) – Paid Claims

```
REPORT:                                GEORGIA DEPARTMENT OF COMMUNITY HEALTH                          DATE:
RA#:                                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:
                                           PROVIDER REMITTANCE ADVICE
                                          CLAIM TYPE M - CMS 1500 PAID

                                                                                          PAYEE ID:
                                                                                          NPI ID:
                                                                                          PAYMENT NUMBER:
                                                                                          ISSUE DATE:
                                                                                          RECEIVER ID:
RENDERING PROVIDER: MCD  000000000A      NPI
------------------------------------------------------------------------------------------------------------
ICN              MEMBER ID      MEMBER NAME          BILLED DTE  P AUTH NO      PATIENT NUMBER
COS     FROM DTE - THRU DTE           BILLED         ALLOWED    COPAY/DEDUCT        PT LIAB         COB      TOTAL PAID
------------------------------------------------------------------------------------------------------------
2222222222221  111111111111   Medicaid, Man           01142022
660     11012021    11012021          95.00           95.00           0.00            0.00          0.00       95.00       PAID
HEADER EOBS:  0280 OA:19
------------------------------------------------------------------------------------------------------------
LNN FROM DTE-THRU DTE   POS  SPEC  PROC CD M1 M2 M3 M4 UNITS BILLED/ALLWD      BILLED      ALLOWED      COB       PAID      STATUS
------------------------------------------------------------------------------------------------------------
  1 11012021 11012021   12   216   T2040   UC              1.00     1.00        95.00       95.00       0.00      95.00      PAID
    DETAIL EOBS: 2517 CO:16
    REMARK CODES: MA64
```

Line Number

Remittance Advice (RA) – Denied Claims



REPORT:
RA#:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CLAIM TYPE M - CMS 1500 DENIED

DATE:
PAGE:

PAYEE ID:
NPI ID:
PAYMENT NUMBER:
ISSUE DATE:
RECEIVER ID:

RENDERING PROVIDER: NPI

ICN / COS	MEMBER ID / FROM DTE - THRU DTE	MEMBER NAME / BILLED	BILLED DTE / ALLOWED	P AUTH NO / COPAY/DEDUCT	PATIENT NUMBER / PT LIAB	COB	TOTAL PAID	
2222222222221	111111111112	Medicaid, Lady	01142022		Medicaid, Lady			
660	12012021 12012021	95.00	0.00	0.00	0.00	0.00	0.00	DENY

HEADER EOBS: 0280 OA:19

LNN	FROM DTE-THRU DTE	POS	SPEC	PROC CD M1 M2 M3 M4	UNITS BILLED/ALLWD		BILLED	ALLOWED	COB	PAID	STATUS
1	12012021 12012021	12	216	T2040 UC	1.00	0.00	95.00	0.00	0.00	0.00	DENY

DETAIL EOBS: 3001 CO:16 95.00- 2517
REMARK CODES: M62

Remittance Advice (RA) – Claim Adjustments

```
REPORT:                                   GEORGIA DEPARTMENT OF COMMUNITY HEALTH                          DATE:
RA#:                                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:
                                              PROVIDER REMITTANCE ADVICE
                                          CLAIM TYPE M - CMS 1500 ADJUSTMENTS
                                                                                                 PAYEE ID:
                                                                                                 NPI ID:
                                                                                                 PAYMENT NUMBER:
                                                                                                 ISSUE DATE:
                                                                                                 RECEIVER ID:
RENDERING PROVIDER: MCD     000000000A     NPI
-----------------------------------------------------------------------------------------------------------------------
ICN          MEMBER ID      MEMBER NAME                BILLED DTE    P AUTH NO       PATIENT NUMBER
COS        FROM DTE - THRU DTE              BILLED        ALLOWED       COPAY/DEDUCT          PT LIAB            COB         TOTAL PAID
-----------------------------------------------------------------------------------------------------------------------
LNN FROM DTE-THRU DTE  POS  SPEC  PROC CD M1 M2 M3 M4  UNITS BILLED/ALLWD        BILLED      ALLOWED        COB        PAID        STATUS
-----------------------------------------------------------------------------------------------------------------------
  1 11012021 11302021  12   030   T2022                     1.00      1.00       175.00      175.00        0.00      175.00         PAID
 2222222222221     111111111111     Medicaid, Man          12032021
590        11012021    11302021           -175.00           -175.00            -0.00          -0.00         -0.00        -175.00
 5922222222221     111111111111     Medicaid, Man          12032021
590        11012021    11302021            175.00              0.00             0.00           0.00          0.00           0.00   PAID
    ADJ RSN: 8515
HEADER EOBS:   8515 OA:23 175.00-
HEADER REMARK CODES: N142
-----------------------------------------------------------------------------------------------------------------------
LNN FROM DTE-THRU DTE  POS  SPEC  PROC CD M1 M2 M3 M4  UNITS BILLED/ALLWD        BILLED      ALLOWED        COB        PAID        STATUS
-----------------------------------------------------------------------------------------------------------------------
  1 11012021 11302021  02   030   T2022                     1.00      1.00       175.00        0.00        0.00        0.00         DENY
    DETAIL EOBS: 2517 CO:16
    REMARK CODES: MA64
                                                         NET AMOUNT OWED TO STATE               175.00
```

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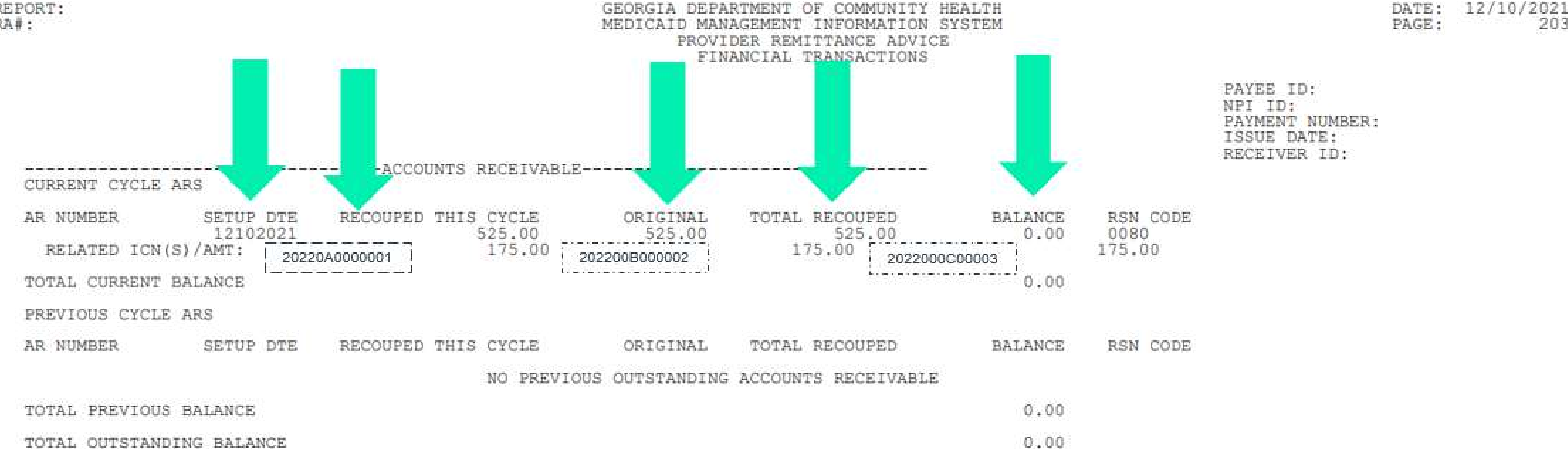
RA Account Receivable Financial Transactions



REPORT:
RA#:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

DATE: 12/10/2021
PAGE: 203

PAYEE ID:
NPI ID:
PAYMENT NUMBER:
ISSUE DATE:
RECEIVER ID:

ACCOUNTS RECEIVABLE

CURRENT CYCLE ARS

AR NUMBER	SETUP DTE	RECOUPED THIS CYCLE	ORIGINAL	TOTAL RECOUPED	BALANCE	RSN CODE
	12102021	525.00	525.00	525.00	0.00	0080
RELATED ICN(S)/AMT:	20220A0000001	175.00	202200B000002	175.00	2022000C00003	175.00
TOTAL CURRENT BALANCE					0.00	

PREVIOUS CYCLE ARS

AR NUMBER	SETUP DTE	RECOUPED THIS CYCLE	ORIGINAL	TOTAL RECOUPED	BALANCE	RSN CODE
NO PREVIOUS OUTSTANDING ACCOUNTS RECEIVABLE						
TOTAL PREVIOUS BALANCE					0.00	
TOTAL OUTSTANDING BALANCE					0.00	

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Financial Summary Page

This page is only accessible when logged into the Payee account

REPORT:
RA#:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
REMITTANCE ADVICE SUMMARY

DATE: 12/10/2021
PAGE: 204

PAYEE ID:
NPI ID:
PAYMENT NUMBER:
ISSUE DATE:
RECEIVER ID:

-------------------------CLAIMS DATA---------------------------

	CURRENT NUMBER	CURRENT AMOUNT
CLAIMS PAID	933	171,426.44
CLAIM ADJUSTMENTS POSITIVE	0	0.00
CLAIM ADJUSTMENTS NEGATIVE	4	(525.00)
TOTAL CLAIMS PAYMENTS	937	170,901.44
CLAIMS DENIED	28	
CLAIMS IN PROCESS	0	

-------------------------EARNINGS DATA-------------------------

PAYMENTS:	
CLAIMS PAYMENTS	171,426.44
SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)	0.00
ACCOUNTS RECEIVABLE (OFFSETS):	(525.00)
NET PAYMENT	170,901.44
REFUNDS:	
CLAIM SPECIFIC ADJUSTMENT REFUNDS	(0.00)
NON-CLAIM SPECIFIC REFUNDS	(0.00)
OTHER FINANCIAL:	
MANUAL PAYOUTS (NON-CLAIM SPECIFIC)	0.00
VOIDS	(0.00)
NET EARNINGS	170,901.44

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Provider Resources

Contacting Gainwell Technologies

We Are Always Here To Assist

- Chatbot
- Interactive Voice Response System (IVRS)
- Provider Services Contact Center (PSCC)
- Provider Relations Representatives

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What's New…. Chatbot

Some of the features will include:

<u>Providers</u>

- How do I change my address?
- How do I reset my GAMMIS password?
- How do I update owners NPI or SSN or Tax ID?

<u>Members</u>

- How do I reset my GAMMIS password?
- How do I apply for Medicaid?
- Where do I go to renew my Medicaid?

We look forward to this new enhancement!

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What's New…. Chatbot *(continued)*

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GAMMIS
GEORGIA MEDICAID MANAGEMENT INFORMATION SYSTEM

gainwell

Search

[Refresh session] You have approximately 18 minutes until your session will expire.

Monday, December 13, 2021

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy | HFRD

Home *Publication Search* *Site Map* *Site Settings* *Language Selection*

GAMMIS:Home <- Bookmarkable Link Click here for help and information about bookmarks

(click to hide) Alert Message posted 11/3/2021

Announcing the Georgia Medicaid Chatbot!

In our effort to implement innovations that will benefit the overall productivity and quality of our provider and member call center experience, **we have implemented a Chatbot feature!**

- Where can I find it?
  - This feature is located at the bottom of the home page.
- What are the benefits of the Chatbot?
  - This will make a positive impact to the provider/member community by reducing call volumes and wait times.

Highlights of the Chatbot include answers to questions like:

- For providers
  - How do I reset my GAMMIS Password?
  - How do I change my address?
  - How do I update my owners NPI or SSN or Tax ID?
- For members

IVRS Overview

The Interactive Voice Response System (IVRS) allows users to call and conduct inquiries or transactions on the Georgia Medicaid Management Information System (GAMMIS) using a touch-tone telephone.

800-766-4456	
Option 1	Member Eligibility
Option 2	Claims Status
Option 3	Payment Information
Option 4	Provider Enrollment
Option 5	Prior Authorization
Option 6	GAMMIS website password reset, Pharmacy Benefits, the Nurse Aide Registry or Nurse Aide Training program, PeachCare for Kids® EDI submission or electronic claim submission, or a system overview

Provider Services Contact Center

PSCC assists providers with inquiries regarding claims status, eligibility coverage, prior authorization, remittance advice, demographic changes, and other Medicaid questions. PSCC is available:

- 1-800-766-4456
- Monday through Friday (excluding state holidays)
- 7 a.m. to 7 p.m. Eastern Standard Time
- Providers can also use the “Contact Us” link on GAMMIS

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Georgia Field Territories

Territory 1 N GA
Bartow, Catoosa, Chatooga, Cherokee, Dade, Dawson, Fannin, Floyd, Forsyth, Gilmer, Gordon, Habersham, Hall, Lumpkin, Murray, Pickens, Rabun, Stephens, Towns, Union, Walker, White, Whitfield

Territory 2 Atlanta
Fulton

Territory 3 NE GA
Banks, Barrow, Clarke, Elbert, Franklin, Gwinnett, Hart, Jackson, Madison, Oconee, Walton

Territory 4: NW GA
Carroll, Cobb, Douglas, Harolson, Paulding, Polk

Territory 5: SE Metro
Clayton, DeKalb, Rockdale

Territory 6: Middle GA
Butts, Chattahoochee, Coweta, Fayette, Harris, Heard, Henry, Jasper, Jones, Lamar, Marion, Meriwether, Monroe, Muscogee, Newton, Pike, Spalding, Talbot, Taylor, Troup, Upson

Territory 7: Augusta
Baldwin, Burke, Columbia, Glascock, Greene, Hancock, Jefferson, Jenkins, Johnson, Lincoln, McDuffie, Morgan, Oglethorpe, Putnam, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes

Territory 8: SW GA
Bibb, Bleckley, Calhoun, Clay, Crawford, Crisp, Dodge, Dooly, Dougherty, Houston, Laurens, Lee, Macon, Peach, Pulaski, Quitman, Randolph, Stewart, Schley, Sumter, Telfair, Terrell, Twiggs, Webster, Wheeler, Wilcox, Wilkinson

Territory 9: SE GA
Appling, Bacon, Bryan, Bulloch, Brantley, Camden, Candler, Charlton, Chatham, Effingham, Emanuel, Evans, Glynn, Jeff Davis, Long, Liberty, McIntosh, Montgomery, Pierce, Tattnall, Toombs, Treutlen, Ware, Wayne

Territory 10: South GA
Atkinson, Baker, Ben Hill, Barrien, Brooks, Clinch, Coffee, Colquitt, Cook, Decatur, Early, Echols, Grady, Irwin, Lanier, Lowndes, Miller, Mitchell, Seminole, Thomas, Tift, Turner, Worth

Territory 11 State Wide
Hospital Field Representative

080_291_07_1206

Provider Relations Field Services Representatives

Territory	Region	Rep
1	North Georgia	Mercedes Liddell
2	Fulton	Deandre Murray
3	NE Georgia	Carolyn Thomas
4	NW Georgia	Vacant
5	SE Metro	Ebony Hill
6	Middle Georgia	Shawnteel Bradshaw
7	Augusta	Jessica Bowen
8	SW Georgia	Jill McCrary
9	SE Georgia	Kendall Telfair
10	South Georgia	Anitrus Johnson
North	Hospital Rep	Sherida Banks
South	Hospital Rep	Janey Griffin

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Provider Relations Representatives

State-Wide Consultants

Sharée C. Daniels
Brenda Hulette
Danny Williams

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Contact My Provider Rep Directly

After logging into the GAMMIS System, select Contact Information then Contact Us

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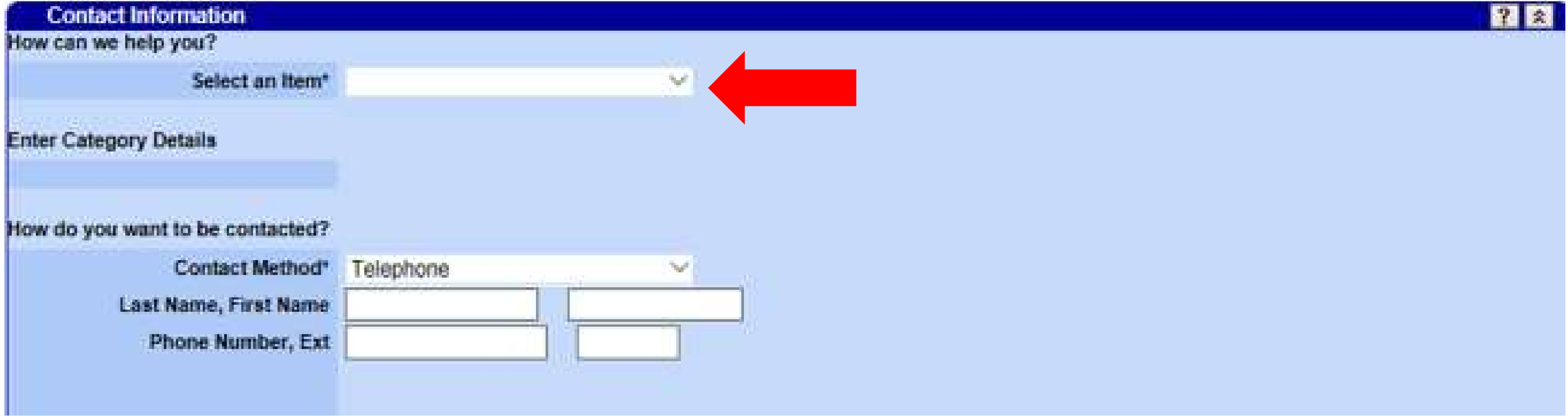
Contact My Provider Rep Directly

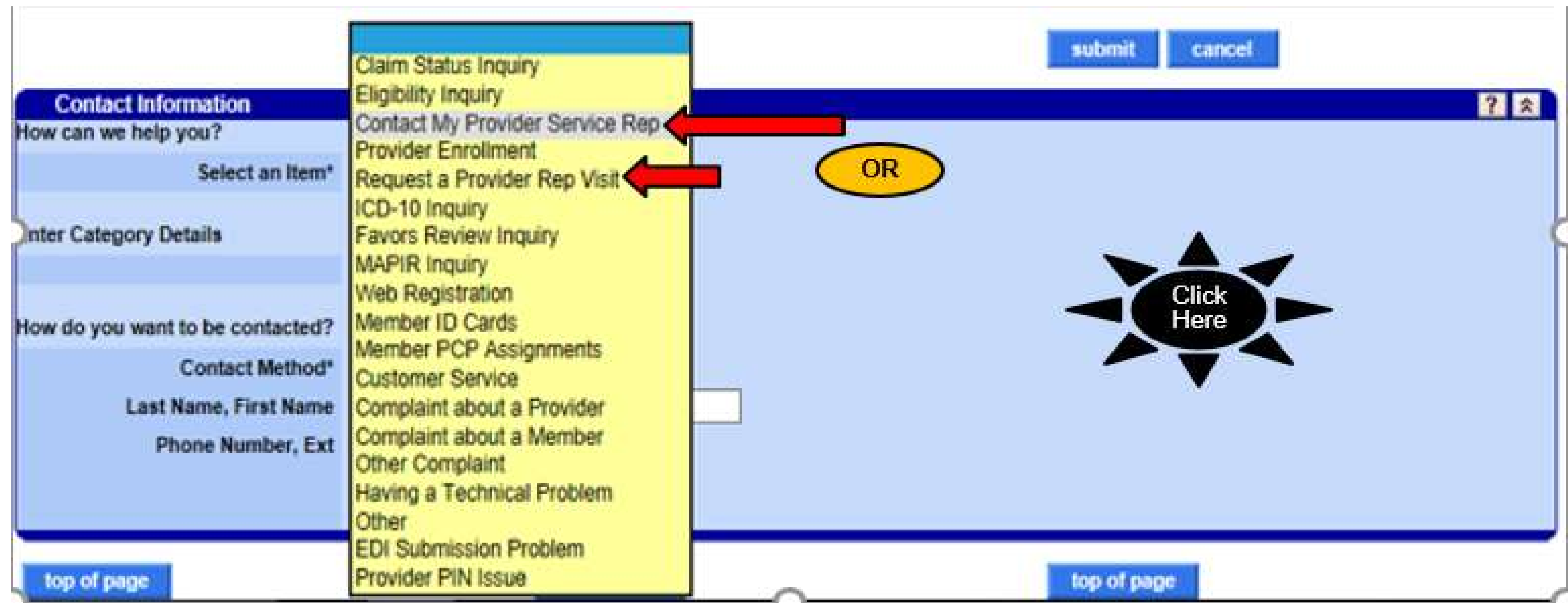
(continued)

Select an Item



Contact My Provider Rep Directly

(continued)



Contact My Provider Rep Directly

(continued)

Requests Requiring PHI

NOTE: If the response to your inquiry contains protected health information (PHI) such as member or claims information, you must log into the secure web portal to submit your question and receive the response. Upon login, additional contact options related to PHI will be available.

submit cancel

Contact Information

How can we help you?

Select an Item*

- Claim Status Inquiry
- Eligibility Inquiry
- Contact My Provider Service Rep
- Provider Enrollment
- Request a Provider Rep Visit
- ICD-10 Inquiry
- Favors Review Inquiry
- MAPIR Inquiry
- Web Registration
- Member ID Cards
- Member PCP Assignments
- Customer Service
- Complaint about a Provider
- Complaint about a Member
- Other Complaint
- Having a Technical Problem
- Other
- EDI Submission Problem
- Provider PIN Issue

OR

Click Here

Enter Category Details

How do you want to be contacted?

Contact Method*

Last Name, First Name

Phone Number, Ext

top of page top of page

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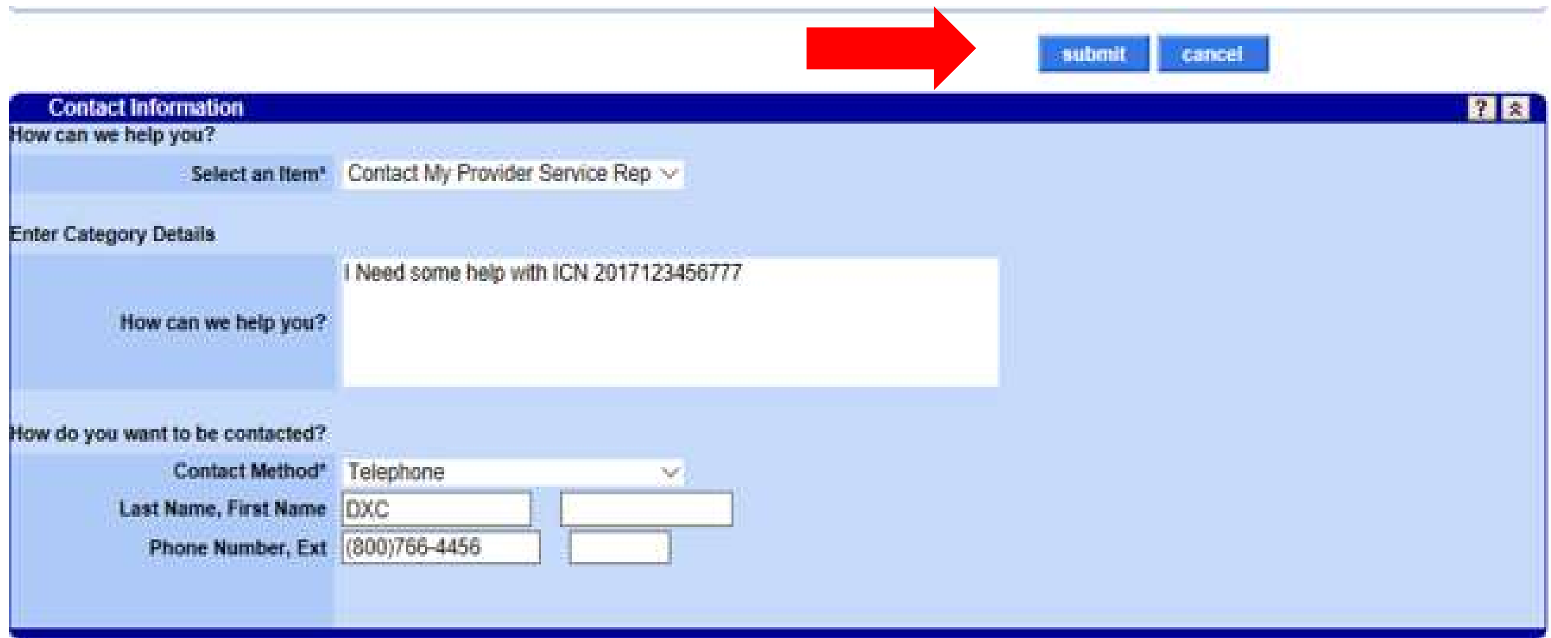
Contact My Provider Rep Directly

(continued)

Please provide all details pertaining to your issue, including ICN, member ID, etc.



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Contact My Provider Rep Directly

(continued)

The following messages were generated:

Your request has been processed. Your tracking number is 20763193.

Providers may call the Provider Contact Center at (770) 325-9600 or toll-free at (800) 766-4456. Members may call the Member Contact Center at (770) 325-2331 or toll-free at (866) 211-0950.

Contact Information

How can we help you?

Select an Item*	Contact My Provider Service Rep

Enter Category Details

How can we help you?	test

How do you want to be contacted?

Contact Method*	Telephone	
Last Name, First Name	HP	test
Phone Number, Ext	(800)766-4456	

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Session Review

You should now be able to:

- Identify general billing information and policy changes
- Resolve common concerns relating to claim denials
- Remittance Advice Navigation
- Perform functions using the IVRS and Web Portal

Questions and Answers

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Thank you!

Meeting Communication Access Needs of Deaf Participants

Robert Bell & Kelly Sterling

Meeting Communication Access Needs of Deaf Participants

Robert Bell

Director of Community Support

Division of Disabilities

Kelly Sterling

Director of the Office of Deaf Services

Georgia
Department of
Behavioral Health
& Developmental
Disabilities

Where to Start

- **Communication Assessment for Deaf Services**
- Communication Assessments (CA) are offered to individuals with hearing loss that access DBHDD services. Communication assessments are performed by a DBHDD Office of Deaf Services Communication Assessor, which identifies:
  - (i) a participant's communication limitations;
    (ii) the participant's preferred communication modality (e.g. American Sign Language (ASL), verbal communication, etc.); and
    (iii) accommodations that are recommended to make services accessible to the individual.
- The Communication Assessment performed by the DBHDD Office of Deaf Services will indicate any need for additional or a specialized staff proficient in communication with deaf individuals

Access to Additional Staffing

“Did you know that waiver participants with a Communication Assessment Report could access Additional Staffing?”

How do I access Additional Staffing?

- Communication Assessment Report Completed by
  DBHDD's Office of Deaf Services
- **Requires a new assessment annually**
- A Communication Assessment performed by the DBHDD Office of Deaf Services indicating the need for additional or a specialized staff proficient in communication with deaf individuals
- See Appendix H in the Part II of the NOW COMP Manual found at GAMMIS https://www.mmis.georgia.gov/portal/default.aspx
- Plus, please review the Provider Toolkit at our Website https://dbhdd.georgia.gov/provider-toolkit-0#toolsddproviders

DBHDD I/DD Providers-Bridging the Gap

- Agency environment culturally/linguistically affirming
- Sign Fluent Staff who are aware of how to work with this population
  - Accessibility issues
  - Communication/interaction issues
  - Aware of non-verbal communication
  - Mental Health needs of the community
  - Health Education Geared towards the Deaf Community
  - Technology that Benefits
- Staff able to identify the unique needs within the ASL using community
  - Obtaining interpreters
  - Hearing Interpreter
  - Deaf interpreter

ASL Training Contract

- Time Limited (**funding <u>will not</u> be indefinite**)
- GCDHH is the approved trainer
- Requires Providers to sign a Memorandum of Understanding (MOU)
- Expects providers to identify the staff who are assigned to work directly with the individual
- SLPI only for those who are assigned to work directly with the individual

How to Begin Receiving Training

- Send an email to kelly.sterling@dbhdd.ga.gov titled “Provider ASL Training”
- A MOU will be sent to you. Complete the attached PDF and return PDF signed.
- Once this is completed, MOU will be sent for Division approval
- Once approved Mrs. Lara Whitfield-Garfinkel will reach out to begin coordination of ASL instruction.
- ASL Training is focused to assist staff in meeting the sign fluency level identified on the Communication Assessment Report (CAR)

What To Expect

- Due to the Pandemic the training is being offered remotely
- Identified staff are expected to participate in the training
- If there are issues where providers are unable to attend the upcoming training notification should be sent to GCDHH at the earliest convenience as there is a late cancellation charge
- Provider staff are expected to leave their camera on during the training otherwise the instructor is unable to gauge progress
- The Sign Language Proficiency Interview (SLPI) will be administered when the trainer feels the staff is ready

Sign Language Proficiency Interview (SLPI)

- Receive interview approval from the ASL Trainer
- Send an email titled SLPI Request to lwhitfield@gcdhh.org
  - Identify the provider agency
  - Include the staff name in the body of the email
  - Identify the ASL Trainer
- Once completed the results should be received in approximately 6-8 weeks

What is the Purpose? Part I

- Having staff who can sign
- Staff trained about the communication needs of Deaf Individuals
- Individual Service Planning instruction provided in manner consistent with communication needs
  - Eye contact
  - Visual gestural prompts
  - Physical Prompts
  - Identifying language of preference on Communication Assessment Report

What is the Purpose? Part II

- Environmental accommodations in provider settings: Visual fire alarms in all common shared settings Flashing door knock signalers (residential front door, and bedroom doors) Closed Captioning on televisions

- Required forms available in ASL…If not available in ASL having an ODS Approved Interpreter to assist communication needs

- Video content that is captioned if used for participant orientation to services

Taking it a step further

ASL Fluent Group Homes
Employing Deaf professionals
Employing Deaf paraprofessionals
Deaf Specific Programming
Deaf individuals in key leadership
Communication access across the organization
Comprehensive training curriculums focused on linguistic access

Contact Information

Robert Bell
Director of Community Support
robert.bell@dbhdd.ga.gov

Kelly Sterling
Director of the Office of Deaf Services
kelly.sterling@dbhdd.ga.gov

Mandated Reporting and Additional Training

Anna Thomas
Certified At-Risk Adult Crime Tactics Specialist
Division of Aging Services
GBI

- **1** in **5** Georgians are classified as an “at-risk” adult.
- **1** in **10** at-risk adults are victims; only **1** in **23** cases are reported.
- Individuals with I/DD are **4** to **10x** more likely to be victimized than the general population.
- Over **70%** of adults with disabilities say they have been victims of abuse, and more than **90%** say that such abuse occurred on multiple occasions.

Physical
Financial
Neglect
Emotional
Sexual

Mandated Reporting – Two Tracks

Title 30: Private home/community

Adult Protective Services

Title 31: Long-term Care Facilities

Healthcare Facility Regulation Division

Law Enforcement

Reasonable Cause to Believe

O.C.G.A. 30-5-4

Mandated reporters having reasonable cause to believe a disabled adult or elder person has been the victim of abuse, other than by accidental means, neglected or exploited…shall report or cause reports to be made…

Reasonable cause defined as

A fact or circumstance that justifies a reasonable suspicion; a reason that would motivate a person of ordinary intelligence under the circumstances to believe abuse had occurred

http://research.lawyers.com/glossary/reasonable-cause.html

Reporting in the Community O.C.G.A. 30-5-4

Any person required to report child abuse as provided in O.C.G.A. 19-7-5 (c);

- Physical Therapists;
- Occupational Therapists;
- Day-care personnel;
- Coroners/Medical Examiners;
- EMS, EMT, Paramedics, 1st Responders;
- Employees of public or private agencies engaged in professional health related services to elder persons or disabled adults;
- Clergy;
- Financial Institutions

Report to Adult Protective Services <u>and</u> Law Enforcement

O.C.G.A. 30-5-4

If the disabled adult or elder person is in need of protective services or has been the victim of abuse, neglect or exploitation,

… a report **shall** be made to [Adult Protective Services] <u>and</u> to local law enforcement or prosecuting attorney.

Central Intake for APS

Business hours:

•Monday – Friday 8 am to 5 pm

•By Phone: 1-866-552-4464 ext. 3

•Report on-line at:
www.aging.dhs.Georgia.gov

O.C.G.A. 31-8-81 LTCF Defined

Long-Term Care Facility is defined as any:

- skilled nursing home,
- intermediate care home,
- assisted living community,
- personal care home, or
- community living arrangement now or hereafter subject to regulation and licensure by the department (HFR).

Mandated Reporting in a Facility

O.C.G.A. 31-8-82

Any person required to report child abuse as provided in O.C.G.A. 19-7-5 (c);

- Administrators, managers, or other employees of hospitals or long-term care facilities;
- Physical Therapists;
- Occupational Therapists;
- Day-care personnel;
- Coroners/Medical Examiners;
- EMS, EMT, Paramedics, 1st Responders;
- Employees of public or private agencies engaged in professional health related services to elder persons or disabled adults;
- Clergy

Report to Healthcare Facility Regulation Division and Law Enforcement

O.C.G.A. 31-8-82

Any person who has knowledge that a resident or former resident has been abused or exploited while residing in a long-term care facility….

…**shall** immediately make a report to [Healthcare Facility Regulation Division] and law enforcement.

Reporting to HFRD

Report complaints against a facility:

- By phone: 1-800-878-6442
- Report Online at:

https://dch.georgia.gov/hfr-file-complaint

Failure to Report
O.C.G.A. 31-5-8

- Any person violating the provision of this subsection shall be guilty of a misdemeanor

- Penalty is up to 12 months in jail and up to $1,000 fine

LOOKING FOR
RESOURCES?

Trainings

ACT (Adult Crime Tactics)

At-Risk Adult Crime Tactics Course (ACT)

- ✓ Free
- ✓ Offered monthly
- ✓ Virtual
- ✓ 2-day bootcamp
- ✓ Certified ACT Specialists

REACT

- ✓ Free/Virtual
- ✓ Offered monthly
- ✓ 1-hour training for mandated reporters
- ✓ Discuss the types of abuse
- ✓ Where and how to report

Anna Thomas
Anna.Thomas1@dhs.ga.gov

Provider Meeting Q&A

BE D·B·H·D·D
Georgia Department of Behavioral Health & Developmental Disabilities
Next All-State Provider Meeting May 12, 2022
D·B·H·D·D
Thank you for you participation!