Provider Frequently Asked Questions
Batch Webinar: March 4, 2015

General Questions

Q. Will the webinar slides be available?

A. Yes, the webinar presentation slides and audio files are posted on the DBHDD website using the following link: https://dbhdd.georgia.gov/administrative-services-organization.

Q. Have the specs been provided to respective EHR vendors so that they can begin development needed to make the necessary changes to support Go-LIVE - batch processing, etc.?

A. Batch system specifications and user companion guides are available on the GA Collaborative website here: http://www.valueoptions.com/providers/Network/Georgia.htm.

Q. Will system testing be compatible and available for Mac users?

A. Yes, system testing is compatible for both PC and Mac users.

Q. Must all providers use electronic health records with this new system?

A. No, providers may interface directly with the web-based application, ProviderConnect, to submit all of registration, authorization, claim and discharge requests online without the use of an electronic health record.

Q. Will there be a webinar to show registration in ProviderConnect page-by-page?

A. Yes, we will have webinars showcasing all of the ProviderConnect functions. We will communicate the dates of these webinars as soon as they are available.

Provider Connect and System Access

Q. Will a new password be required every 90 days; how does this get changed?

A. Yes, you will be prompted to change your password every 90 days through ProviderConnect. If you are an approved user who will be submitting / uploading batch files, an ETS password is also required. Once the ETS password is set up, it will not need to be changed.

Q. How do we get access to the system? Can we have several logins?

A. The provider should designate the administrator for each agency. The individual selected as administrator will manage and register and build new user accounts for the agency. There is no limit on how many user accounts an organization can have.

Q. Will the online portal be available to all clinicians or is this something only UM can do?

A. ProviderConnect will be available to all registered users. There are no user access restrictions utilized by the Georgia Collaborative ASO. Providers will appoint their own administrator to manage access for the provider agency. Note: there will be a limitation where a provider agency can only see the individuals they serve.

Q. Will the data in the data warehouse be available as part of the package or will there be an additional charge to access it?

A. The data warehouse (IntelligenceConnect) can be accessed through ProviderConnect by choosing Reports; there will be no extra charge for this access.

File Transfer

Q. How often can we get an 835 file?

A. The 835 file can be obtained from PaySpan Health weekly. Registration with PaySpan is required and it is free of charge.

Q. Will an electronic response file be available for download with the authorizations?

A. Yes an electronic response file will be available. File layout and companion guides are available here: http://www.valueoptions.com/providers/Network/Georgia.htm.

Q. Will ProviderConnect allow for an API (Application Program Interface) to support other EHR's used by providers?

A. No, the Collaborative will not utilize API protocols as a means of data exchange with Provider EHR vendors. EDI protocols will be the protocol employed for batch providers to exchange data with the Georgia Collaborative.

Q. Will the file formats be industry standards such as 834, 837, 835, 270/271 etc.?

A. Beacon Health Options accepts the following standard transaction files:
   a. Claims: 837i and 837p claim submission and 999 and 277CA response files.
   b. We do offer 835 files through PaySpan Health.
   c. Registration, authorization and discharge use a proprietary file format.
   d. **Note**: The GA Collaborative does not use 270 eligibility files or the 271 response file. In addition, the Collaborative does not accept 834 files.

Q. How many times a day can files be submitted?

A. There is no limit to the number of file submissions per day; however, processing is twice per day**.**

Q. Will the entire file be rejected if there are errors?

A. An entire file can be rejected if it does not match our format. It is possible that a specific portion of a file will error but other portions of the file will be accepted.
   a. An example of where a single claim will reject in a file would be the 2400 Loop SV1 Segment, 01 Element- Procedure code 90806 received. This procedure code was valid prior to 01/01/2013. If received after 01/01/2013, the claim is rejected.

Q. What is the difference between accessing the EDI link and the ETS (Electronic Transport System) process with SFTP (Secure File Transfer Protocol)?

A. The EDI Links (ETS) is a website that you would login and upload files; this will also require entry of a claim count and dollar amount for claim submission. The SFTP is a direct connection to send files to us. Password updates are required every 90 days for the ETS system; updates are not required for the SFTP site.

Registration

Q. For batch submitters, will the same registration process be used for crisis, BH, and DD?

A. Providers do not register individuals for IDD services, DBHDD regional staff complete this function. Staff will utilize the CONNECTS system as of July 1, 2015 to get the CID though the existing Case Management Information System will be maintained until further notice.

For crisis (short term, immediate services fund), if the individual is referred to the crisis provider from GCAL, GCAL will register the individual and should give the provider the CID. If an individual shows up at the provider agency in crisis then the provider agency can register the individual using the short registration process.

Q. Is registration required only for Medicaid, SCS and Fee for Service?

A. Registration is required for all funds managed by DBHDD and the Georgia Collaborative which includes non-CMO Medicaid, State Contracted Services and State Funded Fee-For-Service. CSU's must register and authorize all individuals receiving services without regard to the individual's payor source. There are a few other services that a CMO member might be able to receive. In this case, the CMO member would need to be registered.

Q. Would we be required to register an individual in ProviderConnect for any reason other than trying to obtain an authorization?

A. No. Registration and authorization are two separate processes. The registration will designate which services an individual can qualify for; the authorization is basically permission to render services.

Q. Will the individuals we are currently serving be automatically registered or will each provider have to register current individuals?

A. Individuals that have active authorization at the time of transition will be automatically registered in the new system.

Q. Can you speak to the ability to verify eligibility and benefits?

A. ProviderConnect is available 24/7 for providers to verify eligibility and benefits for an individual specific for DBHDD services. For Medicaid eligibility, GAMMIS should remain the

source of information for Medicaid eligibility. While eligibility information is being imported from GAMMIS to ProviderConnect, this is applicable for use as it applies to DBHDD services.

Q. Regarding registrations; what if an individual is seen by multiple agencies; will their CID be unique at the state level, or the provider level?

A. Individuals will only have one CID - at the state level.

Q. If a client already has a CID number under the old system, will a new CID number be assigned to them when submitting a batch?

A. No, the Collaborative will be loading prior CIDs to our system.
   a. If you are using batch registration than you need to enter the CID in the appropriate field for Individual's CID Number.
   b. If using ProviderConnect, enter the CID and the individual's Date of Birth in the search function to find the individual. Then select "Add Registration" and all demographics on file will pre-populate in the initial registration page.

Q. Will referrals from GCAL include all necessary information required to obtain a registration?

A. GCAL will do a clinical review, register (as needed), and issue an initial authorization for individuals requiring CSU and inpatient services. Registration and authorization information for CSU and inpatient services will be shared with the provider. GCAL will not complete the registration or authorization for other services.

CANS/ANSA

Q. For CANS and ANSA, can you provide reference to the version? Is there a standard version or will it be Georgia specific?

A. CANS and ANSA will be Georgia specific. The link will be provided once available.

Q. Are there copyright requirements around CANS and ANSA?

A. No, CANS and ANSA are open source domain tools that are free for anyone to use. There is a community of people who use the ANSA and share experiences, additional items and supplementary tools.

Q. Do the providers have to pay to utilize CANS and ANSA tools or did the state pay for the use?

A. Both tools are free to use.

Authorization

Q. For an authorization request via batch, can the registration and the authorization request be submitted in the same processing run?

A. The authorization and registration for the same individual cannot be sent at the same time. The authorization request will require a CID which is provided as a response to the registration. You will need to wait for the registration to update the fund time span so the authorization can be processed.

Q. Will we have to make new authorization requests for all services / individuals?

A. Services that have been authorized previously by APS will be honored. When that authorization expires or as new services are required or additional units are needed for ongoing services, these will require a registration and authorization to be obtained.

Q. Will all services require authorization or only high level services?

A. All services will require an authorization.

Q. Will agencies be able to track units electronically, via ProviderConnect?

A. Yes, ProviderConnect can be accessed to view authorization requests and the status of those requests. In addition, the system will reflect authorization units used, so agencies can be able to determine how many are remaining.

Q. Will the authorization units and available units dataset be available for download to providers?

A. ProviderConnect has functionality that will allow providers to download their authorizations in XML and PDF format.

Q. Will there be updates to extend or add units for the authorizations?

A. If a provider finds that the current authorization does not have sufficient units to provide services until the end of the effective period, the provider can submit a new authorization request. This request will term the previous authorization request as of the effective date of the new request and build a new authorization for the next timeframe for services delivery.

Note: Providers should request all services they will need for the new authorization period if multiple services are indicated, as all services on the previous authorization request will term with the new request.

Q. Registration will follow individual but will the authorization for services follow them across providers as well?

A. No, authorizations are for an individual and are specific to each provider or group/agency.

Q. Authorization requests through the web portal ProviderConnect allow for only 10 services to be requested for certain outpatient services. What do I do if I need more than 10 services?

A. If you require more than 10 services for an authorization request please contact the Georgia Collaborative clinical department for assistance in adding the additional services. The system will be modified in the near future to allow for more than 10 services to be added to a request when appropriate. We hope this will not cause too much inconvenience until this fix is put in place*. Please note: the above answer is specific to ProviderConnect. Batch files will not be effected by this rule.*

Claims

Q. I did not see number of claims prompt on SFTP submission process, is this something that is not needed to be done if submitting files this way?

A. This is correct; the claim count and dollar amount requirements are only needed when sending through ETS or ProviderConnect.

Q. Will the current weekly Medicaid, monthly STATE payout schedule remain the same?

A. There are no expected changes to the timing of the existing provider Medicaid payment schedule. When DBHDD transitions from an encounter based payment system to a Fee for Service system, State claims will be paid on a weekly cycle.

Q. With ProviderConnect, if an individual's units are exhausted, will the biller be notified or stopped during the billing process, or will they have to wait until the claim is processed to receive a denial?

A. The ProviderConnect system does not alert the user during the claim submission process that the claim will be declined. The user does have the ability to review the authorization status prior to claim submission, if authorization is pending or missing the user can make their request then follow up with a claim submission.

Medicaid

Q. Does this replace GHP (Georgia Health Partnership)?

A. No, this does not replace GHP for Medicaid claims.

Q. Will this replace GAMMIS for Medicaid billing? If not, how often will GAMMIS be updated with the authorization information for Medicaid billing?

A. No, GAMMIS (HP) will remain the same and all authorized services will be passed on to Medicaid to pay against. GAMMIS will be updated daily, seven days per week with the authorization information for Medicaid billing.

Transition from APS to Beacon Health Options

Q. When we will begin to phase out of the MICP system?

A. The MICP system will be sunset June 30, 2015. The ProviderConnect system will go live July 1, 2015. Additional information related to the phasing of this process (e.g. any down times associated with the transition) will be provided at a later date.

Q. Will the current MICPs end on June 30th?

A. On July 1, 2015, the MICP's will no longer be the source of authorization. However, DBHDD, APS, and Beacon Health Options are working to ensure a smooth transition of authorizations from APS to Beacon Health Options so re-entry of existing authorizations will not be required.

Q. What happens to outstanding MICPs that we are working on with APS on July 1st?

A. A transition plan is being developed with APS on how to hand off cases in transition. As that plan is finalized further details will be available; however you will not be required to re-register or authorize everyone. It is anticipated that only MICPs that are currently authorized will be transitioned to Beacon Health Options.

Intellectual and Developmental Disabilities (IDD) Case Management Information System

Q. On the DD side, will the claim payment process be done within the new data system? If so will there be a fee for the agencies to use this for billing?

A. All Medicaid fee for service claims will continue to be processed and paid through the Medicaid Management Information System vendor, HP. At a future go-live date for DD, all state funded fee for service and encounter claims will be processed and paid by the Georgia Collaborative ASO. See additional information from DBHDD here. There will be no fee associated with the use of ProviderConnect.

Q. Who will be responsible for uploading the crisis plans for the DD population?

A. Development of the future IDD case management is currently being considered – additional information will be forthcoming.

Q. Will PA's be generated for IDD?

A. The development for the IDD Case Management System is underway and on a different timeline than the behavioral health information system. It is anticipated that Beacon Health Options will support the authorization system for IDD services as well.

Q. What is the approximate target date for the DD case management system?

A. Development of the future IDD case management is currently being considered. The exact go live data has not yet been determined. Communication will be forthcoming when a date is determined.