PART II

POLICIES AND PROCEDURES
for
CHILDREN'S INTERVENTION SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: April 1, 2020

Policy Revisions Record
Part II Policies and Procedures Manual for Children's Intervention Services 2020

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
1/1/20	Chapter 1000	HCPCS 2020 Updates	M	Regulation
1/1/20	Appendix A	Office of Child Health Contact Information	M	
4/1/20	Chapter 800	Progress Notes	M	
4/1/20	Chapter 800	Shared Prior Authorization Requests	M	
4/1/20	Chapter 800	Family of Codes	M	
4/1/20	Chapter 1000	HCPCS 2020 Updates	M	Regulation
4/1/20	Chapter 1000	Telehealth Services	M	
4/1/20	Appendix A	Office of Child Health Contact Information	M	

PART II - POLICIES AND PROCEDURES
FOR
CHILDREN'S INTERVENTION SERVICES

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PART II - CHAPTER 600
SPECIAL CONDITIONS OF PARTICIPATION

601. General

The Children's Intervention Service (CIS - Category of Service 840), program offers coverage for restorative and/or rehabilitative services to eligible members in non-institutional settings. Note: Hospital employed therapists who are enrolled in the CIS Program may provide services and bill for services rendered in the hospital outpatient facility or outpatient clinic. Services must be determined medically necessary and be recommended and documented as appropriate interventions by a physician for the maximum reduction of physical disability or developmental delay and restoration of the member to the best possible functional level. Medical necessity means medical services or equipment based upon generally accepted medical practices in light of conditions at the time of treatment which are: appropriate and consistent with the diagnosis of the treating physician and the omission of which could adversely affect the eligible member's medical condition; compatible with the standards of acceptable medical practice in the United States; provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; not provided solely for the convenience of the member or the convenience of the health care provider or hospital; not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage; and there must be no other effective and more conservative or substantially less costly treatment, service and setting available.

The CIS program is comprised of seven intervention services that must be provided by qualified providers. The seven services are: audiology, nursing, nutrition provided by licensed dietitians, occupational therapy, physical therapy, counseling provided by licensed clinical social workers and speech-language pathology. Qualified providers must be currently licensed in the State of Georgia as audiologists (018), licensed clinical social workers (107), occupational therapists (151), physical therapists (201), registered nurses (234), speech-language pathologists (251), or licensed dietitians (108).

602. Enrollment

All providers who meet the Conditions of Participation in Medicaid's Part I Policies and Procedures for Medicaid and PeachCare for Kids Manual (Part I Manual) and the special conditions listed in Section 603 below are eligible to enroll. Professional practitioners must enroll as individual providers and attach a copy of their professional license. They must also maintain documentation that the continuing education requirements have been met.

In a group practice, hospital or agency, each provider must enroll separately and bill for services directly provided under their own provider number. For purposes of this policy, a group practice is defined as a partnership, a corporation, or an

assemblage of therapists in a space-sharing arrangement in which the therapists each maintain offices and the majority of their treatment facilities in a contiguous space. Services performed by non-enrolled providers in a group practice are not covered.

Indiscriminate billing under one provider's name or provider number without regard to the specific circumstances of rendition of the services is specifically prohibited and will be grounds for adverse action. (See Chapter 400 of Part I)

Clinical Fellows

Clinical Fellows attempting to fulfill the necessary hours for licensure according to the guidelines in the State Practice Act will be allowed to render services in the CIS program under the direct supervision of a Georgia licensed, enrolled speech language pathologist. This requirement is also known as the Paid Clinical Experience (PCE). The Department will not allow clinical fellows to enroll into Georgia Medicaid and bill under their own Medicaid provider number. The services will be billed by the licensed, enrolled speech language pathologist.

The Clinical Fellow will need to continue working under the supervision of the licensed SLP until they have been licensed successfully and enrolled as a Medicaid provider. Medicaid will not reimburse the CF until they have a Medicaid number and the number will not be issued until they are licensed, credentialed and enrolled.

The Paid Clinical Experience Fellow and qualifications and responsibilities of the PCE Supervisor must follow State of Georgia rules and regulations (Rule 609-3-.04). The Clinical Fellow's work will be documented in member charts and in the supervisor's monitoring and evaluation records.

603. Special Conditions of Participation

In addition to the general conditions of participation in the Georgia Medicaid program contained in the Part I Manual, Section 106, providers in the CIS program must meet the following conditions:

603.1 Maintain a copy of professional license;

603.2 Adhere to the service limitations stipulated in the written service plan or program;

603.3 Maintain a copy of the written service plan, prescription, progress notes, etc. in the child's confidential medical file or record;

603.4 Assure there is no duplication of the service(s) provided to a member by two or more CIS provider types or by a CIS provider and a school-based (CISS program) provider.

603.5 Notify the Provider Enrollment Unit via mail, phone, or web site of any changes in enrollment status, such as: new address and or telephone number; additional practice locations; change in payee; or voluntary termination from the program. See Appendix D for contact information. Each notice of change must include the date on which the change is to become effective.

603.6 Bill the Division your "Usual and Customary" fee for each procedure performed. "Usual and Customary" is defined as the fee charged to private paying patients for the same procedure during an equivalent period of time.

603.7 Bill the Division the procedure code(s) which best describes the level and complexity of the service rendered (See Section 900);

603.8 Maintain member confidentiality at all times;

603.9 Maintain written documentation of all services provided to members for a minimum of five (5) years after the date of service; (See Section 903 for record requirements).

603.10 All providers are required to maintain on file, on site verification indicating they have obtained a minimum of 1/3 of their required professional state licensing board Continuing Education Units (CEU) in pediatrics. In addition, registered nurses must obtain and keep on file, on site verification of 10 clock hours or one CEU in pediatrics every two years.

All providers must maintain required continuing education documentation on file for audit purposes. Continuing education documents must be readily available and accessible at the time of the audit.

PART II - CHAPTER 700
SPECIAL ELIGIBILITY CONDITIONS

Children's Intervention Services are provided to Medicaid eligible members from birth to twenty-one (21) years of age with physical disabilities or a developmental delay, who have been prescribed rehabilitative or restorative intervention services by the child's primary care practitioner (PCP) or other prescribing practitioner at the request of the PCP. These children are included in one of the following categories:

1. Children with a Letter of Medical Necessity (LMN), or Plan of Care (POC) established or approved by their PCP;

2. Infants and toddlers who are eligible under the Individuals with Disabilities Education Act (IDEA, Part C) and meet eligibility for the Early Intervention program (Babies Can't Wait), and have an authorized Individualized Family Service Plan (IFSP) developed by the multi-disciplinary team. A plan of care or letter of medical necessity (POC/LMN) as well as the IFSP are required for services billed under the CIS program.

PART II - CHAPTER 800
MEDICAL NECESSITY AND PRIOR APPROVAL

801. Documentation of Medical Necessity

Providers must document medical necessity for service delivery under the CIS program.

Rev. 04/15

Medically necessary, medical necessity or medically necessary and appropriate means medical services or equipment based upon generally accepted medical practices in light of conditions at the time of treatment which are: appropriate and consistent with the diagnosis of the treating physician and the omission of which could adversely affect the eligible member's medical condition; compatible with the standards of acceptable medical practice in the United States; provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; not provided solely for the convenience of the member or the convenience of the health care provider or hospital; not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage; and there must be no other effective and more conservative or substantially less costly treatment, service and setting available.

This documentation includes: documentation of the medical diagnosis, the Letter of Medical Necessity, the Plan of Care, and the provider's progress notes. The Plan of Care (POC) and the Letter of Medical Necessity (LMN) may be combined into one document as long as all elements stated below are included and the PCP has reviewed and approved the document by affixing their signature to the document or by including an electronic signature in the document. The POC, signed by the member's PCP, is equivalent to the PCP's Letter of Medical Necessity.

Electronic signatures are acceptable on CIS documentation. Refer to Medicaid Part I Policies and Procedures for information on electronic signature criteria.

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The PCP's Letter of Medical Necessity or the POC approved by the PCP must contain the components listed below. The LMN or the PCP approved POC, at a minimum, must be submitted for the Medicaid member as documentation of medical necessity.

- Member's name and member ID number
- Date of Birth
- Diagnosis and/or condition requiring treatment
- Modalities
- Procedures (i.e., description of the services requested)
- Evaluation and date the evaluation was conducted (if one was completed)
- POC completion date (this must be on or after the evaluation date)

- Effective POC start and end dates along with the frequency and duration of services.
    - The effective POC start date must be on or after the therapist completion date, PCP signature and date, and must be within thirty (30) calendar days of the therapist completion date. If the PCP's signature date is after the effective date, then the POC will be valid from the PCP's signature date to the end date. However, the effective date still must be within 30 days of the therapist completion date.
- Location of services
- Team members that are treating the patient (i.e., OT, SLP, PT, etc.)
- Current level of function
- Patient's progress to date
- Functional outcomes (potential for rehabilitation, long term goals of therapy
- Goals to be achieved as well as time lines to reach projected goals
- Any other relevant medical information.
- The therapist that develops the POC must sign and date the document on the date it is completed. The therapist must sign and date the POC prior to the PCP's signature and date. The PCP may sign and date the POC on the same date the therapist signs and dates the POC.

801.1 Plan of Care (POC)

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All services rendered under the CIS Program, including services for the BCW program, must be furnished under a plan of care or letter of medical necessity (POC/LMN) signed and dated by the PCP prescribing the services. If the therapist prepares the POC or LMN, it must be signed by the therapist as well as the PCP prescribing the services. A signed and dated copy of the POC/LMN must be on file in the child's records and available for audit purposes. Under most circumstances, the prescribing practitioner should be the child's PCP. If the prescribing practitioner is not the child's PCP, the prescribing practitioner must send the PCP a copy of the POC/LMN within five (5) business days of completion or receipt of the document.

If a member is receiving services under the Babies Can't Wait Program (BCW), and if the need for services is in excess of those determined necessary by the BCW multidisciplinary team (MDT), this must be documented in the POC/LMN.

Rev. 01/15

The signed and dated POC/LMN must identify the rehabilitation potential, set realistic goals and measure progress. The goals and service needs must not be duplicative of those established for children receiving PCP defined/approved medically necessary services in the school setting. Goals defined in the IEP, established under IDEA criteria for educational purposes only, that have not been deemed medically necessary by the child's PCP are not considered to be duplicative of the goals defined as part of the medical necessity documentation in the CIS POC/LMN. The CIS POC/LMN document must also contain the type of modalities and procedures, frequency of visits, estimated duration, diagnosis, functional goals and recovery potential, as well as the additional information as specified under the prior approval process (See Section 802.2).

Duplicated services are defined as medically necessary therapy services that provide the same general areas of treatment, treatment goals, or ranges of specific treatment or processing codes, notwithstanding a difference in the setting, intensity, or modalities of skilled services, and address the same types and degrees of disability as other concurrently provided services (via other community, school or hospital-based providers).

The signed and dated POC/LMN with the prescribing practitioner's signature (and therapist's signature) is required for services rendered under the CIS program. The POC/LMN must be on the letterhead of the practitioner or CIS provider. This document with the original signatures (electronic or fax signatures are acceptable only if these documents are legible) must be on file in the CIS providers' (therapists, nurses, dietitians, licensed clinical social workers) records. When a fax document or signature is included in the medical record, the document with the original signature must be retrievable from the original source. (Note: If the CIS provider has been provided the authorization to use a PA from another CIS provider within the same specialty, a fax copy of the POC/LMN in the rendering CIS provider's records will suffice, but only for the duration of that PA request).

If the POC/LMN was prepared on the CIS provider's letterhead, the CIS provider must submit the original POC/LMN to the PCP and receive from the PCP the POC with the PCP's original dated signature (electronic or fax document is acceptable if the document is legible). When a fax document or signature is included in the medical record, the document with the original signature must be retrievable from the original source.

The POC/LMN with the PCP's signature (electronic and fax signatures are acceptable if legible) must be in the official clinical record prior to the effective date of the POC.

If the POC/LMN is on the PCP's letterhead, this document must have the original handwritten signature (electronic or fax signature is acceptable) from the PCP. All POC/LMN must be re-signed, reviewed and dated no less

than every six (6) months by the prescribing practitioner. If the prescribing practitioner is not the member's PCP, a copy of the revised plan of care should be sent to the PCP within 5 business days.

The amount, frequency and duration of the services must be reasonable under accepted medical standards of practice.

The services must relate directly and specifically to a POC agreed upon by the member's PCP.

801.2 Individualized Family Service Plans (BCW)

An Individualized Family Service Plan (IFSP) is required for members who are eligible under the Early Intervention program (Babies Can't Wait). The IFSP is a written plan for providing early intervention services approved by the parent(s) and authorized by the PCP. It is developed jointly by the Multidisciplinary Team (MDT), which includes the family, the Service Coordinator, and appropriate licensed practitioner(s). It is based on a multi-disciplinary and family-directed assessment of the unique strengths and needs of the infant or toddler and the identification of early intervention services appropriate to meet such needs.

The IFSP includes the recommended services necessary to enhance the development of the child and the capacity of the family to meet the special needs of the child, along with the amount, frequency, duration and method of delivering the services.

The child's primary care practitioner or other prescribing practitioner, at the request of the PCP, must prescribe and/or refer a child for IFSP therapy services and other medical services. The PCP's written referral to the audiologist will serve as the medical necessity document for a child suspected of a hearing loss. Additionally, audiologists may provide services to children who have an Individualized Family Service Plan (IFSP), which includes testing as a necessary service. In order to receive Medicaid reimbursement, a dated and signed POC/LMN (as described above) for therapy services must be on file. The POC/LMN must have the date and PCP's original signature (electronic or fax signature is acceptable if legible). A separate prescription for service delivery is not required because the PCP's signature on the dated POC/LMN serves as the prescription for services. A referral from a PCP for speech-language pathology, counseling, and nutrition services must also be on file.

Rev. 10/19

Babies Can't Wait is not a mandatory program, and parents may choose not to participate. The POC/LMN is required to indicate whether the parent chooses to receive the recommended services as documented in the IFSP or chooses a modified version of the recommended services. A review of the IFSP is necessary for all children receiving services through the Babies

Can't Wait Program for coordination of care and services. A copy of the IFSP will be obtained from the parent and submitted as part of the PA request. BCW is not required to list the actual service(s) in the "Other Services" section of the IFSP; as such, the provider will still be considered for PA approval.

A therapist cannot change the amount, duration and frequency of the service documented on an IFSP without the consensus of the MDT and the child's PCP. In the event the level of service needs to be changed, the therapist must notify the service coordinator and the child's PCP. If necessary, the service coordinator will convene a meeting including the parent and therapist. It is the expectation that the BCW MDT, the PCP, and other CIS providers collaborate and coordinate care to document justification of services to be provided prior to the initiation of services.

In order for services to be reimbursable, the IFSP must be current and the POC/LMN must be current and signed and dated by the PCP. A separate prescription for service delivery is not required because the PCP's signature and date on the POC/LMN will serve as the prescription of services. A PCP's referral is needed for speech therapy, counseling, and nutrition services. IFSPs, at a minimum, are reviewed every six months.

Note: The IFSP must be signed by the parent and at a minimum, the service coordinator. The six month review of the IFSP must be signed by the parent and the service coordinator. This does not negate the need for the POC/LMN which must be signed by the prescribing PCP.

Rev. 04/15

802. Prior Approval

Effective August 1, 2015, CIS providers must submit PA requests via the Centralized PA Portal.

802.1 Services Which Require Prior Approval

As a condition of reimbursement, the Division requires that services which exceed the service limit established in policy be approved prior to the time they are rendered. Prior approval from the Division pertains to medical necessity only; the member must be Medicaid-eligible at the time the service is rendered.

The Division may require prior approval of all or certain procedures performed by a specified provider based on the findings or recommendations of the Division, its authorized representatives or agents, the Secretary of the U.S. Department of Health and Human Services or the applicable State Examining Board. The Commissioner may invoke this action as an administrative recourse in lieu of or in conjunction with an adverse action described in Part I, Chapter 400. In such instances, the Division will serve written notice to the provider of this requirement and the

grounds for such action. Children's Intervention services which exceed the limitations established in policy must receive prior approval.

Prior authorization is not required for evaluation services.

802.2 Procedures for Obtaining Prior Authorization

A PA is only granted for services that are documented to be medically necessary and appropriate. A PA is good for up to 180 calendar days. PA is based solely on the medical needs of the child.

The Plan of Care (POC) and the Letter of Medical Necessity (LMN) can be combined into a single document, as described in Section 801. If there is a discrepancy between the effective dates of the POC/LMN and the PA request period, the POC/LMN effective dates will take precedence.

Rev. 01/15

Effective 4/1/11, CIS providers must submit the cover page from the IFSP and/or the IEP which identifies the member and the pages of the IFSP and/or IEP which pertain to therapy services. The CIS provider must collaborate with the CISS provider to ensure services are not duplicated in these two settings.

If there is no IFSP or IEP, please provide a detailed explanation in the "Text Message Section" for the on-line PA request. Also attach the Attestation Form found in Appendix P.

All supporting documentation, i.e., the POC/LMN and the progress notes, must be updated and signed as specified in policy for additional services above those specified in Policy.

Rev. 10/16
Rev. 01/17

Providers are required to provide standardized test results for ongoing therapy requests. Standardized testing is an important component to determine the nature and extent of any deficits relative to age appropriate norms. Standardized testing can help determine whether a child has a significant delay that requires correction or amelioration and shall be required once per year. Standardized testing may be conducted prior to one year as deemed appropriate. Standardized test results will not be used as the sole determinant as to the medical necessity of requested services.

If the provider submits the standardized testing embedded in the body of the LMN/POC, please make it clear where this information is located by circling or blocking this information so that it is easily accessible by the preliminary review team. Do not highlight as this may cause difficulty in reading the scores and results. The standardized testing dates should align with the effective dates of the POC to ensure the standardized testing is valid for the duration of the PA.

If the CIS provider feels that the member is not amenable to standardized testing, that provider may provide rationale which will be reviewed on a case by case basis by the medical review team. Please indicate the reason why standardized testing is not appropriate on a separate document.

Although not required, putting the standardized test results or the rationale for why this member is not appropriate for standardized testing on a separate sheet of paper will facilitate the review.

A. Requests for prior authorization for services that exceed the maximum units established in policy may be made only if the additional services are medically justified. Note: Social Security numbers are not required. Prior authorizations (PA) must be approved prior to rendering the service.

B. PAs should be submitted thirty (30) calendar days prior to the date services are to begin. This will allow time for the PA to be peer reviewed and approved. The requested PA start date must be specified on the PA request.

C. Providers must submit Prior Authorization requests and all supporting documentation via the web portal for members who receive services through the CIS program. Instructions for electronically attaching supporting documentation can be accessed via the Georgia Web portal at www.mmis.georgia.gov under the Provider Information tab. See Appendix L. The signed and dated POC/LMN and all supporting documentation must have the member's ID number. The POC/LMN along with other required information should be electronically attached to the PA request (See Appendix L). Providers should strive to send the POC/LMN and all supporting documentation the same day the PA is entered via the web. Web requests that do not have the supporting documentation attached within five (5) calendar days of submission of the PA request will be issued an initial "technical denial" and the provider will receive notification of what supporting documentation is missing and have the opportunity to submit this documentation. Missing documentation must be submitted within ten (10) calendar days of the initial "technical denial."

Rev. 01/15

The documentation should be electronically attached to the PA request. (See Appendix L.) Place the PA denial number on the missing documentation that is submitted. If missing information is not received within ten (10) calendar days from the date of the initial "technical denial", the provider will receive a final technical denial and will have to re-submit the entire PA request.

Effective July 1, 2011, all supporting documentation for a technical denial must be submitted via the CIS reconsideration link at the web portal. (See Appendix L)

Effective November 1, 2010, modifier 59 is not required when requesting a PA. However, when applicable, modifier 59 must be placed on the claim along with all other required modifiers.

D. The IFSP must be reviewed and re-signed every 6 months. Additionally, the attestation statement must be updated every 6 months. The IEP must be reviewed yearly. If the child has an IEP/IFSP, it along with the POC/LMN must be submitted with the request. If the child does not have an IFSP or IEP, please make a detailed notation in the text message box on the web portal submission page as well as submission of Appendix P (Attestation Form (IFSP/IEP).

Rev. 07/19
Rev.04/20

E. The provider's progress notes showing details of previous therapy interventions and the member's response to said therapy sessions must be submitted with each PA request. Please submit current / last 3 months progress notes for review. If 3 months of progress notes are not available for submission, please indicate the reason on the PA request form. Progress notes must reflect the member's name and identification number; date(s) of service; time of visit; duration of visit; description of services rendered and response of member. A significant change in condition may warrant the need for a PA request with intensive services. When applicable, please ensure the notes from intensive services are included with subsequent PA requests.

F. A separate prescription for services is not required. The PCP's original signature on the dated POC/LMN serves as the prescription for services (electronic and fax signatures are acceptable if legible).

G. The initial request for additional units must include a valid signed and dated POC/LMN, the IFSP or IEP if one is available and the progress notes if the child has been receiving services.

H. Effective 4/1/11, you must submit the cover page from the IFSP and/or the IEP which identifies the member and the pages of the IFSP and/or IEP which pertain to therapy services. After the initial request for additional units, you may send only the PA request and the progress notes if the other supporting documentation is current (POC/LMN, IEP, IFSP) and you feel the progress notes alone provide the medical necessity justification for the units requested. If you are only sending in the PA request form and the progress notes, you must note the previous PA number on the PA request form (under text comments section) so that the medical review team can access the POC/LMN, IEP and/or IFSP.

NOTE: If any of the supporting documents have been updated, or the request for additional services warrants an update, please forward all supporting documentation with any subsequent PA requests.

I. PA requests will undergo Peer Review which includes review of the member's clinical records.

J. Listed below are some of the Deny Reason Codes you may get for PAs submitted via the web:

PA Deny Reason Code

Value	Short	Long
ACL	ACTV DLY	INADEQUATE DOC ACTV DLY LV
CMP	CPT NO MTC	CPT DOESN'T MATCH DOC OF PROC
DMM	MED MGMT	INADEQUATE DOC MED MGMT
DOM	OP MGMT	INADEQUATE DOC OP MGMT
DUA	URGENCY	INADEQUATE DOC URGENCY OF ADM
DUP	DUP PA RQS	DUPLICATE PA REQUEST
INC	INC INFO	INCOMP INFO TO MAKE DECISION
IPC	PA INVALID	INVALID PROCEDURE CODE
LJS	JUSTIFY	LACK OF JUSTIFICATION
LMN	MED NECESS	LACK OF PROOF OF MED NECESSITY
MIE	MBR ELIG	MEMBER IS NOT MEDICAID ELIG
MIS	MISS INFO	MISSING INFORMATION
MPC	SUBM PLN	PLAN OF CARE NOT SUBMITTED
NFD	NORM FIND	DOC NORM FIND- TREAT NOT SUP
OEC	ELIG CRIT	DOES NOT MEET ELIG CRITERIA
OLC	LVL CARE	DOES NOT MEET LVL CARE REQMT
OPG	PLCY GUIDE	DOES NOT MEET PLCY GUIDELINES
OTH	OTHER	OTHER
WRD		WAITING REVIEW DECISION

K. PA requests must have all the required supporting documentation before approval will be granted.

L. While PAs may be granted for up to 180 calendar days (6 months), PAs must be requested in monthly increments; i.e., 1/1/14 – 1/31/14; 2/1/14 – 2/28/14, etc. PA requests for greater than 180 calendar days or that span in months will be denied.

When you submit a PA request, the effective start date of service cannot be prior to the date you submit the PA request; i.e., if you submit a PA on 1/10/14 and you would like to provide services during the month of January, the first month request period would be from 1/10/14 – 1/31/14.

When submitting a PA request for six months, please be aware that the peer reviewers will only review those months for which all required

documentation is provided and the IEP is active. For example, if the provider requests six months of therapy, yet the IEP is expired for three of those months, only the covered three months will be reviewed. The only exception would be if the IEP expires during non-school time.

Rev. 04/20

M. PA requests per child may be split between two providers (of the same specialty or providers that share billable procedure codes) or one provider may receive all approved PA units. If a PA will be shared between two providers, please indicate on the PA request form. It is the responsibility of the provider who requests and receives the PA units to coordinate sharing of the PA.

Rev. 07/15
Rev. 10/18

N. If there are questions regarding PA submissions, providers should review the PA status on the web portal **first**. (See Appendix Q) Any additional questions can be directed to Alliant Health Solutions via the Contact Us link on the web portal. (See Appendix E). For claims issues and billing questions, please contact the DXC Contact Center at (800) 766-4456. For CIS Policy questions, please call DCH's CIS Program Specialist at (404) 656-5934.

O. All Web submissions will initially 'suspend' until a reviewer views the PA request.

P. Providers must have all supporting documentation with original signatures (electronic and fax signatures are acceptable if they are legible) readily available on site in the patient's medical record for audit purposes.

Q. There are no "retro-authorizations." PA must be obtained prior to rendering the service. All 'retro' requests for routine therapy services will be denied – see Section 802.2, Paragraph CC for requesting a PA for an emergent need.

R. Requests for PA should include the total number of units requested per each specific procedure code requested (i.e., 12 units 97533; 6 units 92609, not 18 units of 97533 and 92609).

S. Dates of Services cannot overlap between PAs. Providers who submit a new PA request for services that will overlap a current approved or denied PA must submit a request to withdraw the overlapping approved hours from the original PA. If this request to withdraw the overlapping hours from the original PA is not submitted, the new PA request will deny for duplication of services. Requests for prior authorization of units above policy limits can be submitted thirty (30) calendar days prior to beginning services.

T. Requested Units: Enter the total number of units requested.

U. Units/Day: Document the maximum units per day as stated in policy.

V. Frequency/Month: Enter the number of units requested per month.

W. Requested Months: This number will always be one per month since policy states that PAs are viewed on a month by month basis. Each PA request can be for a maximum of up to 6 months.

X. Providers must electronically attach required PA supporting documentation (Appendix L). If providers need to contact Alliant Health Solutions, please utilize the "Contact Us" on the web portal. (Appendix E)

Y. Prior Authorizations will be approved as of the date requested by the provider. Again, there are no retro PA approvals except as referenced in Section 802.2, Paragraph CC regarding PA requests for an emergent need.

Z. The signed and dated LMN/POC must include the rendering therapist's signature as well as the signature of the PCP.

AA. Request for units above those allowed by policy must contain all information as specified in policy. If there is an IEP or IFSP, it must be submitted for review. If there is no IEP/IFSP, providers must indicate in detail the reason for the missing IEP/IFSP (in the appropriate section) i.e., child is in private school, child is home schooled, not currently enrolled in school system, not in BCW, etc. If the child is home schooled, the provider must provide documentation to this effect; i.e., a copy of the "Declaration of Intent to Utilize a Home Study Program." Documentation of private school attendance is required as well – this could be in the form of an attestation from the parent as to the private school that the member attends and that the child does not have an IEP. If a member does not have an IFSP or IEP, please submit the Attestation form (IFSP/IEP) found in Appendix P of this Manual.

BB. A signed and dated POC/LMN is required for services rendered under the CIS program. This includes members who are covered under the Babies Can't Wait Program.

CC. If during the course of your treatment of a client (with an existing PA) an emergent need arises, you may provide service and request a PA after providing the service; i.e., a retro PA request. The following criteria must be met:

- The request for prior approval of an emergent need must be filed within fifteen (15) calendar days of the date of service.

- An updated LMN/POC signed and dated by the PCP and therapist must accompany the request.
- Only the following therapy codes can be utilized when requesting a retro PA for services provided as an emergent need:

  i. Speech Therapy:
  Code 92526-treatment of swallowing dysfunction

  ii. Occupational Therapy:
  Code 97760-Orthotics management & training
  Code 97530-therapeutic activities
  Code 97761-prosthetic training
  Code 97140-manual therapy
  Code 97542-wheelchair management
  Code 97762-checkout for ortho/prosthetic use

  iii. Physical Therapy
  Code 97110-therapeutic procedure
  Code 97716-gait training
  Code 97140-manual therapy
  Code 97530-therapeutic activities
  Code 97542- wheelchair management
  Code 97762-checkout for ortho/prosthetic use

- Please be aware, these requests will only be honored with supporting documentation of the emergent need. There are no retro PA approvals for routine therapy services.

Family of Codes:

Effective August 15, 2008, Children's Intervention Services providers will be given the additional option of requesting units for a "family of codes" as follows:

Note: When obtaining a PA using the family of codes, providers of different specialties cannot share the PA even if they share a common procedure code. For example, a PA granted to a physical therapist under the family codes cannot be used by an occupational therapist who shares a common procedure code with the physical therapist. The modifiers on the PA for PT will not match the modifiers on the claim for OT, so the claim will deny. Each specialty must request a separate prior authorization or the claim will deny for PA/ provider specialty mismatch.

<u>Physical Therapy/Occupational Therapy (Note therapists may only use codes approved for their discipline as stated in the CIS Policy Manual)</u>

- 97110 – Therapeutic procedure
- 97112 – Neuromuscular re-education
- 97116 – Gait training
- 97530 – Therapeutic activities
- 97535 – Self care/home management training

Speech Therapy Family

- 92507 – Speech language therapy
- 92526 – Treatment of swallowing dysfunction

Special instructions for requesting any of the above family of codes are as follows:

General Rule:

If the provider would like to request a PA for their specific specialty for a family of codes, the provider should only request one (1) procedure code from the family of codes for the month with the total number of units for the month. When the PA is accessed from the claims system, it will list all procedure codes in the family of codes. This means that the provider can bill any procedure codes from the family of codes for the approved number of units for the month.

Rev. 04/20

Effective 4/1/20, when requesting a PA using family of codes, multiple lines will no longer be accepted in the centralized PA portal.

Examples:

- PT provider requests a PA for procedure code 97530 for 12 units for dates of services (DOS) 7/1/08 to 7/31/08. The PA request is approved by the peer reviewer. The claims system will reflect the family of codes (97110, 97112, 97116, 97530 and 97535). When the provider bills, they may bill any code from the family of codes for the month.
    - A physical therapist may bill:
        - DOS 7/3/08, procedure code 97110, 2 units billed & procedure code 97530, 2 units billed
        - DOS 7/6/08, procedure code 97110, 2 units billed & procedure code 97530, 2 units billed

Note: The above 8 units are the 8 units provided for by CIS Policy

- DOS 7/10/08, procedure code 97112, 4 units (billed with PA#)
- DOS 7/17/08, procedure code 97116, 4 units (billed with PA#)
- DOS 7/24/08, procedure code 97530, 4 units (billed with PA#)

When the family of codes is sent to the claims system, the system will re-order the procedure codes and will display the lowest numbered code in the family on the procedure detail line. For example, if a PA was requested for speech therapy code 92526, then procedure code 92507 will always display on the first detail line. Providers may bill any code in the family **appropriate to your specialty** and up to the approved units. If the family of codes request is not submitted correctly, then the provider will need to withdraw the PA request and submit a new PA with the required documentation. Please note that this is not grounds for reconsideration or a change request.

In addition to the above, providers can continue to request other Medicaid CIS approved procedure codes as deemed medically necessary and supported by appropriate documentation.

Note: CIS providers may not withdraw and then resubmit a PA request for the same services just withdrawn if all of the following statements are applicable:

- The PA was denied after peer review for insufficient documentation to substantiate medical necessity, and
- The PA request is for the same service(s) that was previously denied for insufficient documentation to substantiate medical necessity following peer review, and
- The provider did not provide any additional documentation needed to substantiate medical necessity.

Rev. 01/15

Note: If you have received a partial denial on a PA request, you may not withdraw denied procedure codes of a partially approved PA and resubmit those codes on a new PA.

DD. **Additional tips for submitting requests for prior authorization of units above policy limit:**

1. If a provider makes an error on a PA submission, the provider should request that the PA be withdrawn so that a correct PA may be submitted. This can be accomplished by using the Change Request link on the web portal (See Appendix E).

2. All supporting documentation must be legible and current according to policy. PA documentation that is not legible or is out of date may cause the PA to receive a technical denial.

3. If a technical denial is received, the provider has ten (10) calendar days from the date of the technical denial to electronically attach the missing information. Effective July 1, 2011, all missing information must be attached via the CIS reconsideration link at the web portal. (See Appendix L). If the information is not received within the ten (10) calendar days, the provider will have to re-submit the entire PA request packet. Instructions for electronically attaching supporting documentation can be accessed via the Georgia Web portal at **www.mmis.georgia.gov** under the Provider Information tab. See Appendix L.

4. PAs can be shared only with other providers who are eligible to use and bill those codes; i.e., a PT cannot share their PA units with an OT or SLP – unless this is a "shared" code between the two specialties as referenced in policy. It is the responsibility of the provider who receives the PA units to coordinate care with the provider that units are shared with.

5. Please refer to the Web portal or hard copy, which is sent via U.S. Mail for PA denial reasons.

6. If a request for additional units is denied, the provider has the right to submit a request for "A Reconsideration of the PA Request" within thirty (30) calendar days of the peer denial. Only submit the necessary additional documentation supporting the request for reconsideration. There is no need to resubmit all information sent with the original request. Please electronically request a reconsideration review via the web portal and attach your supporting documentation at that time. See Appendix N for instructions.

7. If you have submitted a timely request for a reconsideration of a PA request and have received a final denial, please refer to Part I Policies and Procedures for Medicaid/PeachCare for Kids for the instructions to appeal the decision.

8. Reconsideration of PA requests are not appropriate for PAs that have received technical denials. A technical denial means that there are missing documents and the case cannot be referred to a peer consultant for final determination. If you receive an "initial technical denial", you have ten (10) calendar days to submit the required supporting documentation. If you receive a "final technical denial", the PA should be resubmitted with all the required documentation.

9. Providers have the option to submit a "change request" via the web portal requesting a modification to a prior approval request; however the following criteria must be met:
   1) A significant change in condition must be documented by submission of an updated LMN/POC signed by the PCP and therapist and be forwarded to the medical review team.
   2) For a member whose name and Medicaid ID number has changed due to an adoption, the change request must also include the new Medicaid ID number. If there have been any paid claims against the PA, the GAMMIS will not accept changes made to the PA.
   3) If a change in modality is requested, the units to be withdrawn (for substitution) must be specified.
   4) This is applicable to PAs for which reconsideration has not been requested.
   5) Instructions for this process are found in Appendix O.

Rev. 04/15
Rev. 07/15

10. If you have received a partial denial on a PA request for documentation that has expired, you should attach the updated documents via the Change Request link to the PA that was partially tech denied for expired paperwork.

11. NOTE: Effective immediately, CIS providers must now submit claims with procedure codes linked to a prior authorization (PA) SEPARATELY from claims with codes not linked to a PA. When submitting claims associated with a PA, if ALL CODES on the claim are authorized by the same PA, the PA should be documented at the HEADER. PAs recorded at the header level apply to all codes listed on the claim. If the codes on the claim are authorized by different PAs, the provider must include the appropriate PA on the detail line linked with the authorized code. If the provider documents an incorrect PA number on a claim detail line, the code linked to the PA number will be denied payment.

CHAPTER 900
SCOPE OF SERVICES

901. General

The services covered under this program are audiology, nursing, nutrition services provided by licensed dietitians, occupational therapy, physical therapy, counseling provided by clinical social workers and speech-language pathology. Services may be provided in the practitioner's office, the member's home, or child care setting or other community setting. Note: Hospital employed therapists who are enrolled in the CIS Program may provide services and bill for services rendered in the hospital outpatient facility or outpatient clinic. In the provision of services, the child should be seen in the context of the family and the family should be assisted in understanding the special needs of the child in order to enhance the child's development. Procedure codes which may be billed in the CIS program are listed under Chapter 1000 – Basis for Reimbursement. All services reimbursable under this program are listed. If a service is not listed, it is not covered.

902. Covered Services

902.1 Audiology Services include but are not limited to:

- Auditory acuity (including pure tone air and bone conduction), speech detection, and speech reception threshold;
- Auditory discrimination in quiet and noise;
- Impedance audiometry, including tympanometry and acoustic reflex;
- Central auditory function;
- Testing to determine the child's need for individual amplification
- Auditory training;
- Speech reading;
- Aural rehabilitation; Individual treatment to children with auditory problems. This includes speech, language and voice problems as a result of hearing loss; and
- Augmentative communication.

Rev. 07/15

902.2 Nursing services include but are not limited to:

- Skilled, intermittent nursing care (e.g., suctioning, dressing changes, and catheterization);

- Administration of medication as prescribed by the child's PCP;
- Administration of treatment regimens as prescribed by the child's PCP;
- Assessment of the capabilities of the child, his family, and other caretakers to carry out nursing care, medication administration or monitoring, and specific ordered treatments;
- Teaching nursing self-care to the child and family or caretaker.

902.3 Occupational Therapy services include but are not limited to:

- Activities of daily living;
- Sensory or perceptual motor development and integration;
- Neuromuscular and musculoskeletal status (muscle strength and tone, reflex, joint range of motion, postural control, endurance);
- Gross and fine motor development;
- Feeding or oral motor function;
- Adaptive equipment assessment;
- Adaptive behavior and play development
- Prosthetic or orthotic training; and
- Fabrication or observation of orthotic devices.

902.4 Physical Therapy services include but are not limited to:

- Neuromotor or neurodevelopmental assessment;
- Musculo-skeletal status (including muscle strength and tone, posture, joint range of motion);
- Gait, balance, and coordination skills;
- Postural control;
- Cardio-pulmonary function;
- Activities of daily living;
- Sensory motor and related central nervous system function;

- Oral motor assessment;
- Adaptive equipment assessment;
- Gross and fine motor development;
- Fabrication and observation of orthotic devices; and
- Prosthetic or orthotic training.

902.5 Counseling services provided by licensed clinical social workers include but are not limited to:

- Assessment of the family resources including the social and emotional impact of the child's physical disability or developmental delay on the child and family, and its effect on the child's response to treatment and adjustment to medical care.
- Provision of counseling services to resolve social and emotional barriers to effective treatment of the child's physical disability or developmental delay.

902.6 Speech-Language Pathology services include but are not limited to:

- Expressive language;
- Receptive language;
- Auditory processing, discrimination, perception, and memory;
- Vocal quality;
- Resonance patterns;
- Phonological;
- Pragmatic language;
- Rhythm or fluency;
- Feeding and swallowing assessment;
- Articulation therapy;
- Language therapy;
- Augmentative communication treatment or instruction;

- Voice therapy; and
- Oral motor dysfunction, swallowing therapy.

902.7 Nutrition services include but are not limited to:

- Nutritional history;
- Dietary intake;
- Anthropometric measurements;
- Evaluation of laboratory work;
- Evaluation of feeding behavior and environment;
- Biochemical and clinical variables; and
- Food habits and preferences.

903. Record Requirements and Service Limitations

Each practitioner must maintain legible, accurate, and complete charts and records in order to support and justify the services provided. *Chart* means a summary of each encounter of essential medical information on an individual member. *Record* means dated reports supporting claims submitted to the Division for services provided in an office, home, or other acceptable place of service. Records of service shall be entered in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible and shall include at a minimum:

A) date (s) of service; time of visit; duration of visit; description of services rendered and response of member.

B) member's name and date of birth;

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C) signature and title of person performing the service after each encounter, progress notes are typically written/signed on the date of service; however, DCH will allow up to 3 business days for the notes to be finalized; **NOTE**: Alliant Health Solutions review progress notes with prior authorization (PA) requests; however PA requests should not be denied due to progress notes not being signed timely.

D) chief complaint or reason for each visit;

E) pertinent medical history;

F) pertinent findings on examination;

G) medications, equipment or supplies prescribed or provided;

H) description of treatment (each encounter);

I) recommendations for additional treatments, procedures, or consultations;

J) x-rays, tests, and results;

K) all required documentation; i.e., signed and dated WSP/POC/LMN IFSP if eligible under Early Intervention, services provided, outcomes, etc. records must be available to DCH and its agents and to the U.S. Department of Health and Human Services upon request. Documentation must be timely, complete, and consistent with the by-laws and medical policies of the office or facility where the service is provided.

The services or groups of services in this section are covered with limitations. If a practitioner has special medical justification for exceeding a service limitation, the medical justification must be well-documented and made available to the Division upon request.

Lack of appropriate medical justification may be grounds for denial, reduction or recoupment of reimbursement.

904. Non-Covered Services

A) Services provided to Early Intervention (Babies Can't Wait) eligible children who do not have an authorized current IFSP.

B) Services provided in a school setting.

C) Services provided to children who do not have a written service plan.

D) Services provided in excess of or other than those indicated on the IFSP or written service plan without prior approval.

E) Services provided to a child who has been admitted to a hospital or other institutional setting as an inpatient.

F) Service of an experimental or research nature.

G) Services in excess of those deemed medically necessary by DCH, its agents or the federal government, or for services not directly related to the child's diagnosis, symptoms or medical history.

H) Failed appointments or attempts to provide a home visit when the child is not at home.

I) Services which are not described in Chapter 900 of this manual.

J) Services which are provided in a manner which is non-compliant or inconsistent with the provisions of this manual.

K) Services normally provided free of charge to indigent patients.

L) Services provided for temporary disabilities which would reasonably be expected to improve spontaneously as the member gradually resumes normal activities.

M) Services provided by individuals other than the enrolled licensed practitioner of the healing arts. **Note: OTA, PTA, Students, SLPA (aides or assistants) etc. are not allowed to provide services under the CIS Program.**

N) Audiology services that are a part of the Health Check screen will not be reimbursable by the Children's Intervention Services Program.

O) Universal hearing screenings for newborns which do not meet the recommendations established by the American Academy of Pediatrics.

P) Group Therapy

Q) Billing for documentation time

R) Co-treatment.

S) Habilitative services that assist in acquiring, retaining and improving the self-help, socialization, and adaptive skills of the child.

T) Co-teaching.

905. Other Related Medicaid Programs Which Provide Services to Children

Medicaid eligible children who are eligible for participation in CIS are also eligible for other related Medicaid services for children (See Appendix B).

Refer to the Hospital Services Manual section for rehabilitation services provided under that COS; i.e., "903.5 Rehabilitation Services."

PART II - CHAPTER 1000
BASIS FOR REIMBURSEMENT

Rev. 10/16

1001. Reimbursement Methodology

Note: Effective October 1, 2011, All Reimbursement Rates Were Adjusted For Each Category of Service.

The Division will pay the lower of the lowest price regularly and routinely offered to any segment of the general public for the same service or items on the same date(s) of service, the lowest price charged to other third party payers, or effective with dates of service July 1, 2003, the statewide maximum allowable reimbursement which is 84.645% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2000 for Region IV (Atlanta). All procedure codes recognized and adopted after the 2000 RBRVS are subject to the statewide maximum allowable reimbursement - 84.645% of the Region IV Medicare RBRVS in effect at the time the procedure code was adopted.

Rev. 10/16

Effective for dates of service on or after July 1, 2016, the state's maximum allowable rate for codes 97001 – 97004, 97110, 97112, 97116, 97140, 97530 and 97535 is 80% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2014 for Region I (Atlanta).

Rev. 04/15

All Reimbursement Rates for CIS program services were updated effective October 1, 2011 after the provider rate decrease, documented in the July 1, 2011 manual, was abandoned. As of April 1, 2015, the descriptions for the HIPAA Compliant CPT Codes have been removed from this manual. Please consult the latest version of the Current Procedural Terminology for the procedure code descriptions.

Note: When billing procedure codes, 1 unit equals a minimum of 15 minutes unless otherwise specified.

Please refer to the Part I Policies for Medicaid and PeachCare for Kids Manual for information concerning submission and resubmission of claims; coordination of benefits; third party liability and utilization review; adverse actions; and appeals.

NOTE: Effective September 1, 2006, the limit for services is:

8 units per month for any one therapy specialty

1) **Nursing Services: Procedure codes to bill when providing Nursing Services**

	HIPAA Compliant CPT Code:	Modifier	Modifier	Current Rate
	T1502	HA	TD	$5.78

	T1002	HA		$5.78

2) **Nutrition Services: Procedure codes to bill when providing Nutrition Services**

	HIPAA Compliant CPT Code:	**Modifier**	**Modifier**	**Current Rate**
Rev. 01/14	**97802**	HA		$14.89
	97803	HA	TS	$14.89

3) **Counseling Services: Procedure codes to bill when providing Counseling Services**

	HIPAA Compliant CPT Code:	**Modifier**	**Modifier**	**Current Rate**
Rev. 01/20	**96156**	HA		$84.57
Rev. 01/20	**96158**	HA		$57.70
Rev. 01/20	**96159**	HA		$20.15
Rev. 01/20	**96167**	HA		$61.98
Rev. 01/20	**96168**	HA		$21.98

4) **Audiology Services: Procedure codes to bill when providing Audiology Services**

	HIPAA Compliant CPT Code:	Modifiers	Maximum Allowable	Service Limits:
	92507	UC HA	$62.53	8 units per month; 1 unit per visit
Rev. 01/19	**92550**	HA	$13.81	2 units per year
	92552	HA	$15.63	2 units per year
	92555	HA	$13.38	2 units per year
	92557	HA	$42.04	2 units per year
	92567	UC HA	$18.46	4 units per year
	92568	HA	$13.38	2 units per year
	92579	HA	$25.19/unit	4 units per year
	92582	HA	$25.19	4 units per year
	92585	HA	$109.76	2 units per year; 1 unit per visit

	92586	HA	$65.99	2 units per year

	HIPAA Compliant CPT Code:	**Modifiers**	**Maximum Allowable**	**Service Limits:**
	92587	HA	$52.51/unit	3 units per year
	92588	HA	$70.52/unit	3 units per year
	92601	UC HA	$116.23	Limited to 1 unit per calendar year.
	92602	UC HA	$81.09	Limited to 7 units per calendar year. 1 unit = 1 visit.
	92603	UC HA	$76.74	Limited to 1 unit per calendar year.

	92604	UC HA	$51.30	Limited to 7 units per calendar year. 1 unit = 1 visit

5) Occupational Therapy: Procedure codes to bill when providing Occupational Therapy

	HIPAA Compliant CPT Code:	**Modifiers**	**Maximum Allowable:**	**Service Limits:**
Rev. 01/17	**97165**	GO HA	$67.21	1 per year
Rev. 01/17	**97166**	GO HA	$67.21	1 per year
Rev. 01/17	**97167**	GO HA	$67.21	1 per year
Rev. 01/17	**97168**	GO HA	$44.40	1 every 180 days
	97113	GO HA	$22.32	Limited to 8 units per calendar month or combination of 8 units per calendar month
	97140	GO HA	$24.18	Limited to 8 units per calendar month or combination of 8 units per calendar month
	97530	GO HA	$28.23	8 units per calendar month or combination of 8 units per calendar month

	97533	GO HA	$24.46	8 units per calendar month or combination of 8 units per calendar month
	97535	HA	$28.23	8 units per calendar month or combination of 8 units per calendar month
	97537	HA	$21.37	8 units per calendar month or combination of 8 units per calendar month.
	97542	GO HA	$14.82	8 units per calendar month or combination of 8 units per calendar month.
	97750	GO HA	$22.31	8 units per calendar month or combination of 8 units per calendar month
	97760	HA	$27.38	Limited to 8 units per calendar month or combination of 8 units per calendar month.
	97761	GO HA	$24.98	Limited to 8 units per calendar month or combination of 8 units per calendar month.
Rev. 01/18	**97763**	GO HA	$41.69	8 units per calendar month or combination of 8 units per calendar month
Rev. 01/20	**97129**	GO HA	$20.76	8 units per calendar month or combination of 8 units per calendar month

Rev. 01/20	**97130**	GO HA	$19.84	8 units per calendar month or combination of 8 units per calendar month

6) Physical Therapy: Procedure codes to bill when providing Physical Therapy

	HIPAA Compliant CPT Code:	**Modifiers**	**Maximum Allowable:**	**Service Limits:**
Rev. 01/17	**97161**	GP HA	$69.34	1 per year
Rev. 01/17	**97162**	GP HA	$69.34	1 per year
Rev. 01/17	**97163**	GP HA	$69.34	1 per year
Rev. 01/17	**97164**	GP HA	$47.14	1 every 180 days
	97110	HA	$25.91	8 units per calendar month or combination of 8units per calendar

				month
	97112	HA	$27.07	8 units per calendar month or combination of 8units per calendar month
	97113	GP HA	$22.32	8 units per calendar month or combination of 8units per calendar month
	97116	HA	$23.03	8 units per calendar month or combination of 8 units per calendar month
	97022	HA	$12.97	8 units per calendar month or combination of 8 units per calendar month
	97024	HA	$9.22	8 units per calendar month or combination of 8 units per calendar month
Rev. 01/15	**97032**	HA	$14.50	8 units per calendar month or combination of 8 units per calendar month
	97035	HA	$10.69	8 units per calendar month or combination of 8 units per calendar month
	97124	HA	$17.29	8 units per calendar month or combination of 8 units per calendar month

	97140	GP HA	$24.18	8 units per calendar month or combination of 8 units per calendar month
	97530	GP HA	$28.23	8 units per calendar month or combination of 8 units per calendar month
	97542	GP HA	$14.82	8 units per calendar month or combination of 8 units per calendar month
	97750	GP HA	$22.31	8 units per calendar month or combination of 8 units per calendar month
	97761	GP HA	$24.98	8 units per calendar month or combination of 8units per calendar
Rev. 01/18	**97763**	GP HA	$41.69	8 units per calendar month or combination of 8units per calendar month

7) **Speech-Language Pathology Services: Procedure codes to bill when providing Speech-Language Pathology Therapy Services**

	HIPAA Compliant CPT Code:	Modifiers	Maximum Allowable	Service Limits:
	92507	GN HA	$62.53	8 visits per calendar month; 1 unit per visit
	92521	HA	$97.14	2 units per year; 1 unit per visit; 1 unit per 180 days
	92522	HA	$78.86	2 units per year; 1 unit per visit; 1 unit per 180 days
	92523	HA	$163.81	2 units per year; 1 unit per visit; 1 unit per 180 days
	92524	HA	$82.12	2 units per year; 1 unit per visit; 1 unit per 180 days
	92526	HA	$44.66	8 visits per calendar month; 1 unit per visit
	92567	GN HA	$18.46	4 units per calendar year
	92597	HA	$85.57	1 per calendar year; 1 unit per visit

	HIPAA Compliant CPT Code:	Modifiers	Maximum Allowable	Service Limits:
	92601	GN HA	$116.23	1 unit per calendar year.
	92602	GN HA	$81.09	7 units per calendar year. 1 unit = 1 visit.
	92603	GN HA	$76.74	1 unit per calendar year.
	92604	GN HA	$51.30	7 units per calendar year. 1 unit = 1 visit.
	92607	HA U1	$109.28	2 units per year; 1 unit per visit; 1 unit per 180 days
	92609	HA U1	$54.75	8 visits per month; 1 unit per visit
	92610	HA	$117.54	2 per year 1 unit per visit; 1 unit/180 days
	96105	HA	$62.10	2 units per calendar year;1 unit per visit; 1 unit/180 days
	96110	HA	$11.77	2 units per calendar year; 1 unit per visit
Rev. 01/19	**96112**	HA	$110.42	2 units per calendar year; 1 unit per visit
Rev. 01/19	**96113**	HA	$50.48	2 units per calendar year; 1 unit per visit
Rev. 01/20	**97129**	GN HA	$20.76	8 units per calendar month or combi-nation of 8 units per calendar month

	HIPAA Compliant CPT Code:	**Modifiers**	**Maximum Allowable**	**Service Limits:**
Rev. 01/20	**97130**	GN HA	$19.84	8 units per calendar month or combination of 8 units per calendar month
	97533	GN HA	$24.46	8 units per calendar month or combination of 8 units per calendar month

Note: Procedure code 92506 has been discontinued effective 12/31/13.

Note: Providers cannot use code 92609 unless the child has had an evaluation for a speech-generating device (SGD).

Note: The U1 modifier must be added to procedure codes 92607 and 92609 to indicate the services are related to a mobile SGD (92607) and the use of the mobile SGD with an Alternative Augmentative Communication (AAC) software application (92609).

Please refer to CMS for the codes that may not be billed in combination per NCCI edits and the medically unlikely edits (MUEs). These codes and MUEs may change each quarter. A provider who wishes to appeal a claim that denied for an NCCI edit or the MUE units must follow the appeals process and submit form 520A, along with clinical documentation, to Alliant Health Solutions for review.

Remember effective November 1, 2010, modifier 59 is not required when requesting a PA. However, if applicable, modifier 59 should be placed on the claim along with all other required modifiers.

All PAs must be submitted with the same modifiers (except as noted above for the NCCI edit, modifier 59) that will be used for billing purposes. The modifiers on the PA and the claim must match.

The PCP's National Provider Identifier (NPI) number is required on all CIS claims submitted to DCH.

Rev. 01/15

Effective 1/1/15, claims will suspend to Alliant Health Solutions to be manually priced at half the rate for reduced services when the 52 modifier (along with the HA modifier) is placed on the claim for procedure code 92523.

Rev. 01/17

Note: Procedure codes 97001-97004 have been discontinued effective 12/31/16.

Note: As of 1/1/17, final rates for codes 97161 – 97168 have not been received from CMS. Rates will be updated upon receipt from CMS.

Rev. 04/17

Effective 4/1/17, the Department of Community Health (DCH) will allow some speech therapy services to be rendered via telehealth. The allowed procedure codes are 92507, 92521, 92522, 92523, and 92524. Each billed procedure code must be submitted with the usual program modifier(s). Additionally, the GT modifier and place of service code 02 must be added to the allowed procedure codes to indicate the services are related to telehealth services.

Originating sites are paid an originating site facility fee for telehealth services by billing procedure code Q3014. Please reference the Telemedicine Guidance Manual for additional billing information.

Rev. 07/17

Effective 7/1/2017, the new physical and occupational therapy evaluation codes require a specific modifier to identify the type of therapy. Procedure codes 97161-97164 must be accompanied by the GP modifier and procedure codes 97165-97168 must be accompanied by the GO modifier in addition to the usual program modifier.

Rev. 01/18

Note: Procedure codes 97532 and 97762 have been discontinued effective 12/31/17. Procedure code 97532 has been replaced with 97127. Procedure code 97762 has been replaced with 97763.

Rev. 10/18

Effective 10/1/18, the Department of Community Health (DCH) will allow some audiology services to be rendered via telehealth. The allowed procedure codes are 92567, 92568, 92585, 92586, 92587 and 92588. Each billed procedure code must be submitted with the usual program modifier(s). Additionally, the GT modifier and place of service code 02 must be added to the allowed procedure codes to indicate the services are related to telehealth services.

Rev. 01/19

Effective 1/1/19, procedure code 92550 will be open for reimbursement. The procedure codes must be submitted with the usual program modifier(s). Standards of practice dictates that audiologists should bill procedure code 92550 if performing both 92567 & 92568 on the same day. If not, providers should bill the respective code for the service performed.

Rev. 01/20

Note: Procedure codes 96150 and 96151 have been discontinued effective 12/31/19.

Rev. 01/20

Note: Procedure code 97127 has been discontinued effective 12/31/19. Procedure code 97127 has been replaced with 97129 and 97130.

Rev. 04/20

Effective 4/1/20, the Department of Community Health (DCH) will allow therapy services to be rendered via telehealth. Each billed procedure code must be submitted with the usual program modifier(s). Additionally, the GT modifier and place of service code 02 must be added to the allowed procedure codes to indicate the services are related to telehealth services.

APPENDIX A

OFFICE OF CHILD HEALTH DISTRICT COORDINATORS
UPDATED APRIL 2020

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
1-1 ROME Northwest Health District	Bartow Gordon Catoosa Haralson Chattooga Paulding Dade Polk Floyd Walker	**Scottie Worthington** 1309 Redmond Road, NW Rome, GA 30165 (706) 802-5076 Toll free referrals (888)736-5329 FAX: (706) 802-5071 Referrals 706-802-5072 Scottie.Worthington@dph.ga.gov	**Stacy Henderson** 1309 Redmond Road, NW Rome, GA 30165 (706)802-5626 FAX: (706) 802-5309 Stacy.Henderson@dph.ga.gov	**Kassandra Pichardo** 1309 Redmond Road, NW Rome, GA 30165 (706) 802-5387 FAX: (706) 802-5309 Kassandra.Pichardo@dph.ga.gov
1-2 Dalton North Georgia Health District	Cherokee Murray Fannin Pickens Gilmer Whitfield	**Lois Blockley** 1710 Whitehouse Ct. Dalton, Georgia 30720 706-529-5763 Toll Free: (888) 276-1558 FAX: (706) 529-5794 Lois.Blockley@dph.ga.gov	**Holli Collier** 1710 Whitehouse Ct. Dalton, GA 30720-8402 Phone: (706) 529-5763 FAX: (706) 529-5767 Holli.Collier@dph.ga.gov	**Susan Sims** 1710 Whitehouse Ct. Dalton, GA 30720 706-529-5763 FAX: (706) 529-5798susan.sims@dph.ga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
2 Gainesville North Health District	Banks Lumpkin Dawson Rabun Forsyth Stephens Franklin Towns Habersham Union Hall White Hart	**Tena K. Sewell** 440 Prior Street SE Gainesville, GA 30501 (770) 535-5963 FAX: (770) 718-5096 Tena.Sewell@dph.ga.gov	**Angela Gilstrap** 440 Prior Street, SE Gainesville, GA 30501 Phone: (770) 538-2788 FAX: (770) 531-6494 Angie.Gilstrap@dph.ga.gov	**Tonya Newsom** 440 Prior Street SE Gainesville, GA 30501 (770) 538-2778 FAX: (770) 538-2784 Tonya.Newsom@dph.ga.gov
3-1 Cobb Health District	Cobb Douglas	**Yvette James** Cobb County Board of Health 1738 County Services Pkwy Marietta, GA 30080 (770) 319-4717 FAX: (770) 514-2803 Yvette.James@dph.ga.gov	**Amanda Holley** Cobb County Board of Health 1738 County Services Parkway Marietta, GA 30008 (770) 319-4719 Fax 770.432.1774 Julie.Burns@dph.ga.gov	**Beverly Shatteen** 1650 County Services Parkway, Bldg B Marietta, GA 30008 (770) 514-2404 FAX: (770) 730-8781 beverly.shatteen@dph.ga.gov
3-2 Fulton Health District	Fulton	**Fanthnecia "Nisey" Dunbar** 2805 Metropolitan Parkway Atlanta, Georgia 30315 (404) 612-4017 Referral Line : 404.612.8774 FAX: 404.612.4038 Fanthnecia.Dunbar@fultoncountyga.gov	**Wendolyn Miller** 2805 Metropolitan Pkwy Atlanta, GA 30315 (404) 612-1496 FAX: (404) 612-4038 Wendolyn.Miller@fultoncountyga.gov	**Cynthia Corsino** 2805 Metropolitan Pkwy, SW Atlanta, GA 30315 (404) 612-8770 FAX: (404)612-4038 cynthia.corsino@fultoncountyga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
3-3 Clayton County Health District	Clayton	**Beleta Lockwood** 1895 Phoenix Blvd College Park, Georgia 30349 (678) 610-7252, FAX: (770) 603-4874 Beleta.Lockwood@dph.ga.gov	**Susan Strom** 1895 Phoenix Blvd College Park, Georgia 30349 (678) 479-2229 FAX : 770-603-4874 Susan.Strom@dph.ga.gov	**Sandra Pye** 1895 Phoenix Blvd College Park, GA 30349 (678) 610-7259 FAX: 770-603-4874 Sandra.Pye@dph.ga.gov
3-4 Gwinnett East Metro Health District	Gwinnett Rockdale Newton	**Laura Moncada** **Easter Seals N. Georgia** 4335 Steve Reynolds Blvd Norcross, GA 30093 (770) 822-9115 FAX: (770)822-9457 lmoncada@esng.org	**Shelley Fadeley** East Metro Public Health District 455 Grayson Hwy, Ste 500 Lawrenceville, GA 30046 (770) 339-4270 ext. 422 FAX: (770) 237-5309 Shelley.Fadeley@gnrhealth.com	**Eloise Hodges** East Metro Health District P.O. Box 897 Lawrenceville, GA 30046 (770) 339-5048 FAX: (770) 963-1418 eloise.Hodges@gnrhealth.com
3-5 DeKalb Health District	DeKalb	**(Elle) Beronica Gonsalves** 440 Winn Way / P.O. Box 987 Decatur, Georgia 30031-0987 (404) 294-3722 FAX: (404) 294-6316 Beronica.Gonsalves@dph.ga.gov	**Patrice Cannon** 440 Winn Way/P.O. Box 987 Decatur, GA 30031-0987 (404) 508-7762 FAX: (404) 294-6316 Patrice.Cannon@dph.ga.gov	**Aletha Dixon** 440 Winn Way/P.O. Box 987 Atlanta, GA 30030 (404) 294-3814 FAX: (404) 294-6316 Aletha.Dixon@dph.ga.gov
4 LaGrange Health District	Butts Lamar Carroll Meriwether Coweta Pike Fayette Spalding Heard Troup Henry Upson	**Tracy Bain** 301 Main Street LaGrange, GA 30240 (706) 298-7750 FAX: (706) 845-4351 Tracy.Bain@dph.ga.gov	**Wendy Wilson** 301 Main Street LaGrange, GA 30240 Wendy.Wilson@dph.ga.gov (706) 298-7753 **Cindy Cross** (706) 298-7723) FAX: (706) 845-4351 Cindy.Cross@dph.ga.gov	**Tracy Bain** 301 Main Street LaGrange, GA 30240 (706) 298-7750 FAX: (706) 845-4351 tracy.bain@dph.ga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
5-1 Dublin South Central Health District	Bleckley Pulaski Dodge Telfair Johnson Treutlen Laurens Wheeler Montgomery Wilcox	**Sherrian Dorsey** 2121- B Bellevue Rd. Dublin, GA 31021 (888) 262-8305 (478) 275-6568 FAX: (478) 275-6764 Sherrian.Dorsey@dph.ga.gov	**Tamiko Coley** 2505 Bellevue Rd. Dublin, GA 31021 (478)274-7717 FAX: (478) 274-7893 Tamiko.Coley@dph.ga.gov	**Kerrie Fountain** 2121-B Bellevue Rd. Dublin, GA 31021 (478) 275-5116 FAX: (478) 275-5117 Kerrie.Fountain@dph.ga.gov
5-2 Macon North Central Health District	Baldwin Monroe Bibb Peach Crawford Putnam Hancock Twiggs Houston Washington Jasper Wilkinson Jones	**Lisa Wiles** 201 Second St. Suite 1100 Macon, Georgia 31201 (478) 745-9200 Referral: 478-751-6117 FAX: (478) 745-9040 Lisa.Wiles@dph.ga.gov	**Teresa Sullivan** 201 Second St. Ste. 1100 Macon, GA 31201 (478) 752-3276 FAX: (478) 751-6429 Teresa.Sullivan@dph.ga.gov	**Belinda Hunt** 201 Second St. Ste. 1100 Macon, GA 31201 (478) 751-6359 FAX: (478) 751-6429 Belinda.Hunt@dph.ga.gov
6 Augusta East Central Health District	Burke Columbia McDuffie Emanuel Richmond Glascock Screven Jefferson Taliaferro Jenkins Warren Lincoln Wilkes	**Valeria Harrison** 1916 North Leg Road Augusta, GA 30909-4437 (706) 667-4279 Referral: 706-667-4280 FAX: (706) 667-4275 Valeria.Harrison@dph.ga.gov	**Kimberly Velez** 1916 North Leg Road Augusta , GA 30909-4402 (706) 667-4863 FAX: (706) 667-4555 Kimberly.Velez@dph.ga.gov	**Kimberly Velez** 1916 North Leg Road Augusta , GA 30909-4402 (706) 667-4757 FAX: (706) 667-4555 kimberly.velez@dph.ga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
7 Columbus West Central Health District	Chattahoochee Quitman Clay Randolph Crisp Schely Dooly Stewart Harris Sumter Macon Talbot Marion Taylor Muscogee Webster	**Kiara Loud** 2100 Comer Ave. Columbus, GA 31904 (706) 321-6362 FAX: (706) 327-1355 Kiara.Loud@dph.ga.gov	**Kiara Loud (Interim)** 2100 Comer Ave. Columbus, GA 31904 (706) 321-6324 FAX: (706) 327-1355 Kiara.Loud@dph.ga.gov	**Wendy Laney** **P.O. Box 2299** 2100 Comer Ave. Columbus, GA 31904 (706) 321-6314 FAX: (706) 327-1355 Wendy.Laney@dph.ga.gov
			Angela Gardner 604 Flemming Road Cordele, GA 31015-1439 (229) 276-2343 FAX: (229) 276-2717 Angela.Gardner@dph.ga.gov	
8-1 Valdosta South Health District	Ben Hill Irwin Berrien Lanier Brooks Lowndes Cook Tift Echols Turner	**Judy Threlkeld** 206 South Patterson Street 3rd Floor P. O. Box 1027 Valdosta, GA 31603-1027 (229) 245-6565 Toll Free (800) 247-6538 FAX: (229) 245-6561 Judy.Threlkeld@dph.ga.gov	**Sandee Simmons** 206 South Patterson Street P. O. Box 1027 Valdosta, Georgia 31603-1027 (229) 245-4310 FAX: (229) 245-4317 Sandee.Simmons@dph.ga.gov	**Reomona Thomas** 206 S. Patterson Street 3rd Floor PO Box 1027 Valdosta, GA 31602-1027 (229) 293-6286 FAX: (229) 293-6292 Reomona.Thomas@dph.ga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
8-2 Albany Southwest Health District	Baker Calhoun Colquitt Decatur Dougherty Early Grady Lee Miller Mitchell Seminole Terrell Thomas Worth	**Sharonda Barlow** 1306 South Slappy Boulevard Suite A – Colony Square South Albany, GA 31701 (229) 299-4447 FAX: (229) 420-1156 Sharonda.Barlow@dph.ga.gov	**Daneta Kegler** 1306 South Slappy Blvd. Albany, GA 31701 (229) 299-4447 Ext. 6708 FAX: (229) 430-4119/5145 Daneta.Kegler@dch.ga.gov	**Sherry Holman** 1306 South Slappy Blvd. Suite A – Colony Square South Albany, GA 31701 (229) 430-2740 FAX: (229) 430-1379 sherry.holman@dph.ga.gov
9-1 Savannah/Bruns wick Coastal Health District	Bryan Camden Chatham Effingham Glynn Liberty Long McIntosh	**Kimberly McAliley** 420 Mall Blvd Savannah, GA 31406 (912) 644-5809 FAX : (912) 349-2326 Kimberly.McAliley@dph.ga.gov	**Jodi Waters** 420 Mall Boulevard Savannah, GA 31406 (912) 644-5205 FAX: (912) 349-2326 Jodi.Waters@dph.ga.gov	**Jodi Waters** 420 Mall Blvd, Suite G Savannah, GA 31406 912-644-5811 FAX: 912-349-2326 jodi.waters@dph.ga.gov
9-2 Waycross Southeast	Appling Atkinson Bacon Brantley Bulloch Candler Coffee Evans Jeff Davis Pierce Tattnall Toombs	**Tracy Weeden** 1123 Church Street, Annex B Waycross, GA 31501 (912) 284-2552 Toll Free (800) 429-6307 FAX: (912) 287-6689 Tracy.Weeden@dph.ga.gov alternative contact: 3 West Altman Street Statesboro, GA 30458-5212 (912)688-6051 FAX: (912)681-0910	**Hollie Eckles** 1123 Church Street, Annex B Waycross, GA 31501 ((912) 285-6304 FAX: (912) 287-6644 Hollie.Eckles@dph.ga.gov	**Julie Prestenbach** 1123 Church Street, Annex B Waycross, GA 31501 (912) 287-4843 FAX: (912)338-5914 Jullie.Prestenbach@dph.ga.gov
	Charlton Clinch Ware Wayne		**Hollie Eckles** 3 West Altman Street Statesboro, GA 30458-5212 (912) 871-1850 FAX (912) 681-0910 Hollie.Eckles@dph.ga.gov	

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
10 Athens Northeast Health District	Barrow Madison Clarke Morgan Elbert Oconee Greene Oglethorpe Jackson Walton	**Sherol Scott** 202 Ben Burton Circle Bogart, GA 30622 (706) 369-6105 FAX: (706) 369-5709 Ruth.Newcomb@dph.ga.gov	**Jennifer Brown** 645 Meigs Street Athens, GA 30601-2435 (706) 389-6923 ext. 2703 FAX: (706) 552-4536 Jennifer.Brown@dph.ga.gov	**Robin O'Donnell** 202 Ben Burton Circle Bogart, GA 30622 (706) 227-7182 FAX: (706) 227-7184 Robin.O'Donnell@dph.ga.gov

State Staff Contacts

MCH Child Health Services					
Last Name	**First Name**	**Telephone Number**	**Email Address**	**Title**	**Location**
Brown	Samantha	404-651-7442	Samantha.Brown@dph.ga.gov	Coordinator, Children 1st	
Clark	Pamela	404-657-3153	Pamela.Clark@dph.ga.gov	Clinical Coordinator, NBS	11-484
Culpepper	Brandt	404-651-5482	Brandt.Culpepper@dph.ga.gov	Team Lead, EDHI	11-485
Harris	Jaquay	404-657-3173	Jaquay.Harris@dph.ga.gov	Data Entry Specialist, NBS	11-475
Hooper	Santita	404-651-5773	Santita.Hooper@dph.ga.gov	Team Lead, Children 1st	11-486
Kerr	Judith	404-657-2878	Judith.Kerr@dph.ga.gov	Sr. Program Manager, Child Health Screening	11-487
Parkins	Kristina	404-657-1890	Kristina.Parkins@dph.ga.gov	Team Lead, NBS	11-476
Summerour	Sherrita	404-651-7441	Sherrita.Summerour@dph.ga.gov	State Program Coordinator, Help Me Grow	11-493
Thornton	Yasmin	404-651-5493	Yasmin.Thornton@dph.ga.gov	Coordinator, EDHI	
MCH Early Intervention					
Buster	Debra	404-463-2196	Debra.Buster@dph.ga.gov	Regional Coordinator Team Lead, BCW	11-457
Byrd	Kevin	404-657-2853	Kevin.Byrd@dph.ga.gov	Regional Coordinator, BCW	11-455
Conner	Jackie	404-463-0812	Jackie.Conner@dph.ga.gov	Child Health EPI I	
Jones	Takieya	404-463-2191	Takieya.Jones@dph.ga.gov	Clinical Coordinator, CMS	11-463
Griswell	Synita	404-232-1630	Synita.Griswell@dph.ga.gov	Program Manager, Autism & Developmental Disabilities	11-472
Kizza	Florence	404-463-1255	Florence.Kizza@dph.ga.gov	Part C Data Manager/Child Health EPI II	11-112
Peart	Sharifa	404-657-2861	Sharifa.Peart@dph.ga.gov	Program Director, CYSHCN/CMS	11-462
Pennington	Lisa	404-651-5995	Lisa.Pennington@dph.ga.gov	Deputy Director/Part C Coordinator, Early Intervention	11-453
Rainey	Quondalynn	404-657-2874	Quondalynn.Rainey@dph.ga.gov	Program Coordinator, CMS	11-473
Reynolds	LaToya	404-651-7691	Latoya.Reynolds@dph.ga.gov	BCW Administrative Coordinator, Early Intervention	11-474

APPENDIX B
OTHER RELATED MEDICAID PROGRAMS
WHICH PROVIDE SERVICES TO CHILDREN

1. Durable Medical Equipment includes reimbursement for the purchase or rental of certain medical equipment and accessories and the purchase of certain medical supplies for member's use in a non-institutional setting. It includes such items as prescribed hospital beds, wheelchairs, oxygen equipment, ventilators, and ambulation devices such as crutches and walkers. The equipment must be used by the member in their residence or that of a relative and must have been prescribed by a physician. The equipment remains the property of the state throughout its useful life.

2. Early Intervention Service Coordination (Case Management)

   Service Coordination is an active, on-going process consisting of specific activities which are aimed at assisting parents in gaining access to the early intervention services designed to meet the developmental needs of each eligible child to age three (3) and the needs of the family related to enhancing the child's development.

3. Emergency Ambulance Services are for the emergency transportation of those eligible members whose lives or immediate health is in danger and who require the supplies, equipment or personnel provided in an emergency vehicle.

4. EPSDT Benefit and Services

   The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit includes comprehensive health screenings, diagnostic tests, referral and treatment for Medicaid and PeachCare for Kids® eligible children less than twenty-one (21) years of age. Treatments for abnormalities detected through the preventive health screenings include any needed medical services, dental services, prescription lenses and frames, and hearing aids.

5. Non-Emergency Medical Transportation Services and related expenses such as meals and lodging are reimbursed to providers who transport members in order to obtain medical treatment or examination under non-emergency circumstances.

6. Orthotics and Prosthetics include devices such as artificial limbs, hearing aids, braces, etc. which assist or replace physical impairments.

7. Physician Services are those services provided by or under the immediate supervision of an enrolled individual licensed under state law to practice medicine or osteopathy.

8. Psychology Services include diagnosis and evaluation, and individual and group therapy services that must be provided by enrolled licensed psychologists. Psychology services are available only to Medicaid members under twenty-one (21) years of age.

9. Vision Care Services are defined as services provided by a licensed practitioner, within the scope of practice as set out in the applicable State law, in the diagnosis and treatment of abnormal refraction, the diagnosis of ocular disease, or the dispensing of optical devices to

compensate for refractive errors. Refractive services and optical devices are reimbursable for eligible members under twenty-one years of age only. Medically necessary diagnostic services may only be billed if performed for medical reasons and not for refractive purposes for members twenty-one (21) years of age or older. Refractive services are not covered for members (21) years or older.

APPENDIX C

Ordering, Prescribing, and Referring (OPR) Update

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

For the NEW CMS-1500 claim form:
Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

For claims entered via the web:
Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:
The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

APPENDIX D
Georgia MMIS

The Web contact address is www.mmis.georgia.gov

Provider Correspondence
(Including claims submission)
PO Box 105200
Tucker, GA 30085-5200

Provider Contact Center

800-766-4456 (Toll free) or
770-325-9600

Provider Enrollment
PO Box 105201
Atlanta, GA 30085-5201

Alliant Health Solutions
Attn: CIS Reviews
PO Box 105300
Atlanta, GA 30348

Electronic Data Interchange (EDI)
877-261-8785 (Toll free) or 770-325-9590

- Asynchronous
- Web Portal
- Physical Media
- Network Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol (TCP/IP)

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MAKING HEALTH CARE BETTER

Provider Correspondence via the Workspace

Purpose

Provider Correspondence functionality allows Providers to submit questions to Georgia Medical Care Foundation (GMCF) reviewers via the *Provider Workspace*. The workspace includes the following features to accommodate this type of correspondence.

- **Contact Us:** This link is used to submit a correspondence and is found in the following workspace locations:
  - Bottom of the *Provider Workspace* page
  - Provider Inquiry Form (DMA-520A) submission page and search page
  - *Review Request* page for a PA request. Search for a PA, open the *Review Request* page, and click Contact Us.

- **Search My Correspondence:** A correspondence search link is available at the bottom of the workspace page and may be used to search for all correspondence associated with a provider's ID number.

- **Provider Messages:** A 'Provider Messages' drop list has been added to the top of the workspace. This list displays the last 10 processed and unprocessed correspondences submitted by the provider, or created and submitted to the provider by GMCF staff (see figure 1). Unprocessed correspondences are correspondences for which GMCF has not yet submitted a 'GMCF Response'; while processed correspondences are correspondences for which a 'GMCF Response' has been submitted.

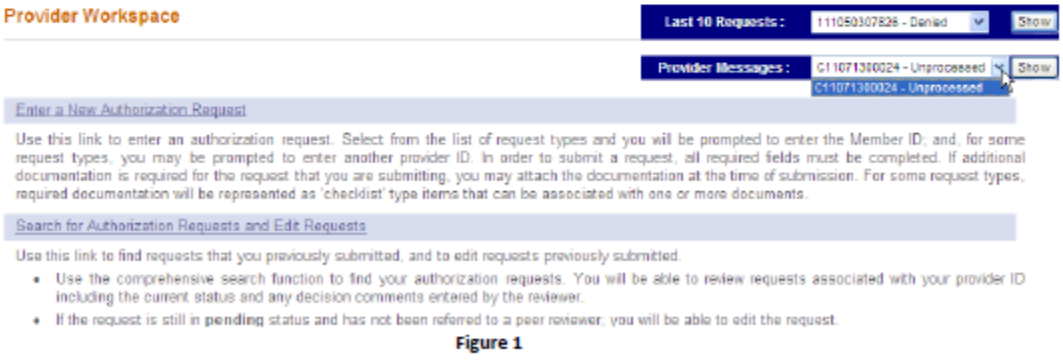


Figure 1

- **Notification Alert:** The following alert notification has been posted to the top of the workspace page announcing the new correspondence functionality. Providers can remove by clicking Close Notification.

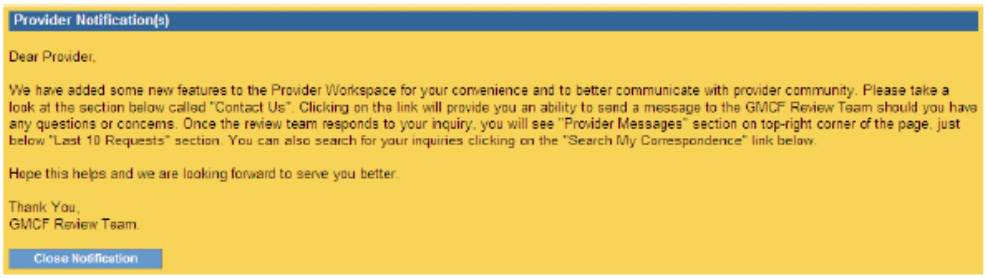


Figure 2

Instructions

Submit a Correspondence

Follow this procedure to submit a correspondence to GMCF:

1. Click Contact Us on the workspace to open the correspondence contact form.

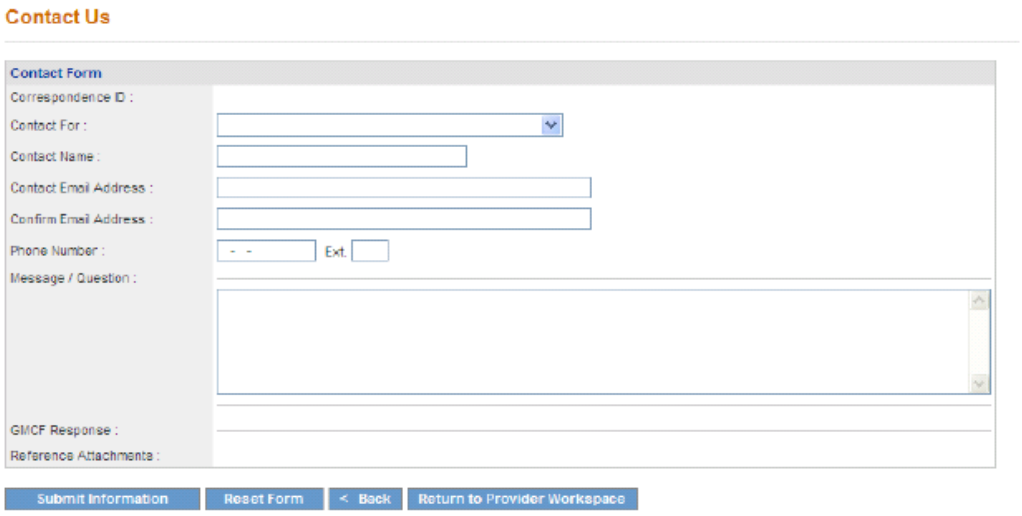


Figure 3

2. Select a 'Contact For' category:

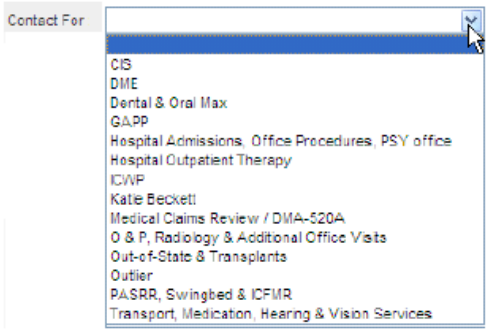


Figure 4

3. If the 'Contact For' category selected is for a prior authorization (PA)/waiver type or for Medical Claims, a box will display for the PA ID or Inquiry Number as shown in the following figures.

'Contact For' is a PA Type

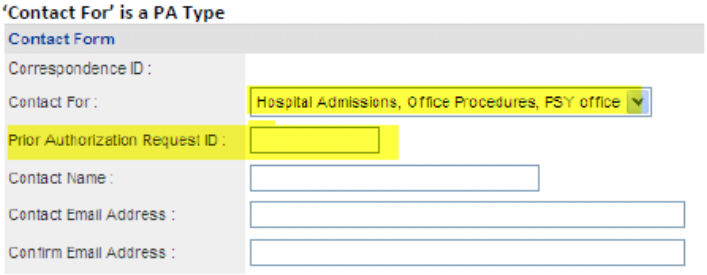


Figure 5

'Contact For' is Medical Claims

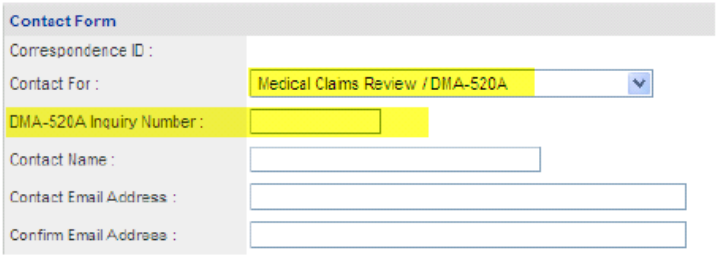


Figure 6

NOTE: If the contact form is opened from the *Review Request* page for a specific PA, or from the Inquiry appeals page for a specific appeal inquiry, then the 'Contact For' type and PA ID or Inquiry ID will be populated by the system. Otherwise, the 'Contact For' type and PA ID or Inquiry Number should be entered.

4. Enter the name of the person submitting the correspondence in the 'Contact Name' box.

5. Enter the contact person's email address in the 'Contact Email Address' box, and then enter again in 'Confirm Email Address' box to verify (required).

6. Enter the contact person's phone number in the 'Phone Number' box.

7. Enter the message or question in the 'Message/Question' box.

   (*GMCF Response and Reference Attachments*: Once GMCF submits a response; this section displays the GMCF response and any documents attached by staff.)

8. Click **Submit Information**. If the submission is successful, a message displays in red below the contact form. The message includes the correspondence ID. Providers can use the correspondence ID to later search for the correspondence and view the GMCF response.

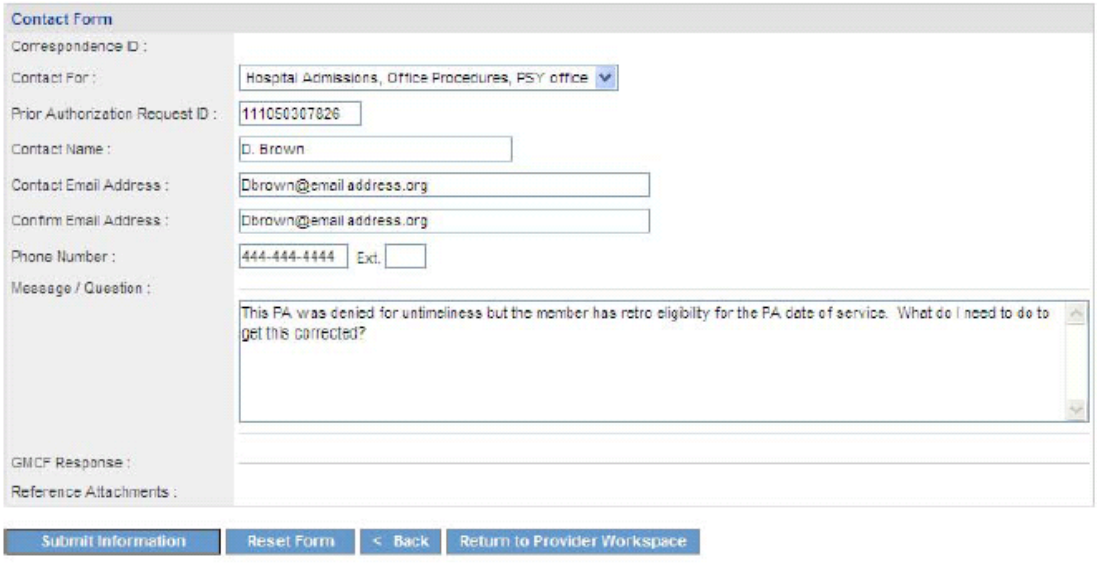
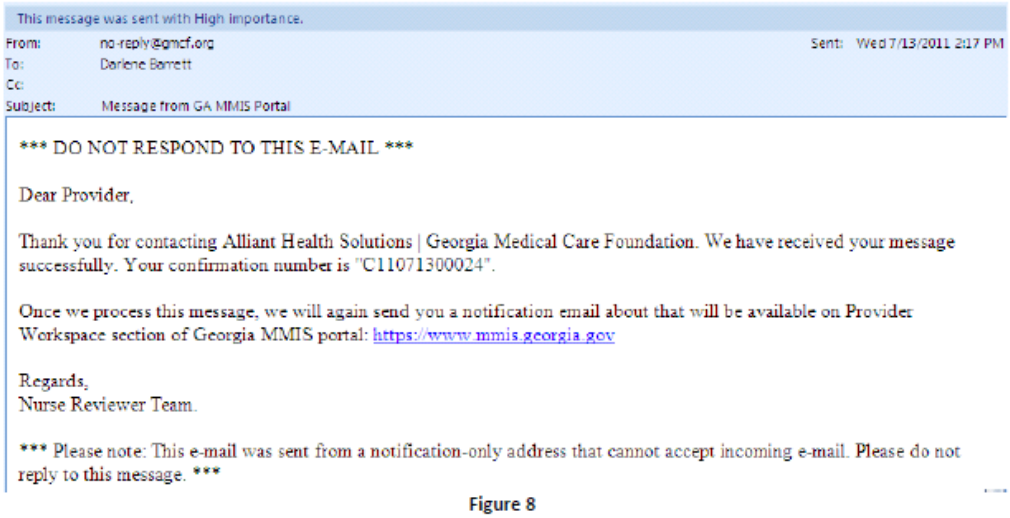


Figure 7

9. The message also indicates that an email has been sent to the contact email address. The email notifies the provider that the question has been received. This email is strictly a notification. Do not respond to the email.

   Here is a sample of the email:



This message was sent with High Importance.

From: no-reply@gmcf.org Sent: Wed 7/13/2011 2:17 PM
To: Darlene Barrett
Cc:
Subject: Message from GA MMIS Portal

*** DO NOT RESPOND TO THIS E-MAIL ***

Dear Provider,

Thank you for contacting Alliant Health Solutions | Georgia Medical Care Foundation. We have received your message successfully. Your confirmation number is "C11071300024".

Once we process this message, we will again send you a notification email about that will be available on Provider Workspace section of Georgia MMIS portal: https://www.mmis.georgia.gov

Regards,
Nurse Reviewer Team.

*** Please note: This e-mail was sent from a notification-only address that cannot accept incoming e-mail. Please do not reply to this message. ***

Figure 8

Search for Correspondence and GMCF Responses

Follow this procedure to find correspondences and view GMCF responses:

1. If the correspondence was submitted recently, first check the 'Provider Messages' drop list at the top of the workspace page. Find the 'Correspondence ID'; highlight the ID; and click **Show** to open the contact form.

   OR

2. Click **Search My Correspondence** at the bottom of the workspace to open the *Search Provider Inquiry/Correspondence* page. The provider ID is inserted by the system.

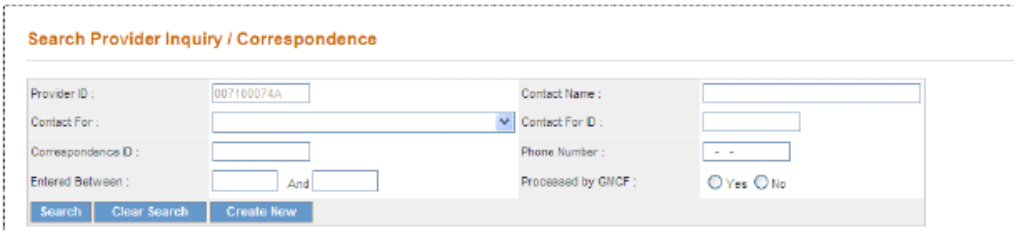


Figure 9

3. Although you may search using any of the search values, the best way is to use the correspondence ID provided in the email notification. Enter the correspondence ID in the 'Correspondence ID' box.

4. Click **Search**. The correspondence will display in the search results table.

Figure 10

5. Click the Corr ID number underlined in blue font to open the contact form and view the GMCF response.

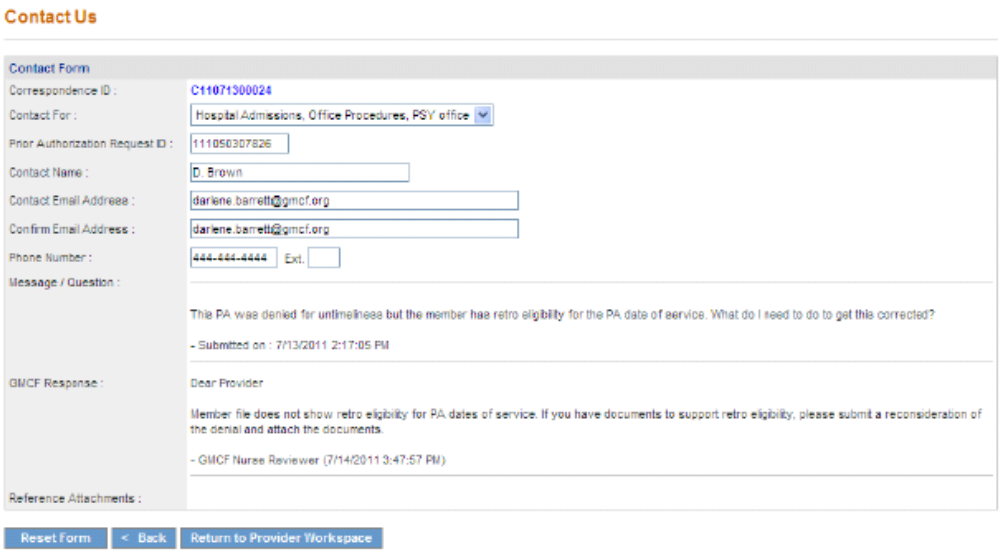


Figure 11

6. If staff attaches documents to the response, the files will be listed next to 'Reference Attachments'. Click the file name to open the attachment.

7. Click **Back** to return to correspondence search, or click **Provider Workspace** to return to the workspace page.

APPENDIX F
ADDITIONAL BILLING INFORMATION

1. Providers no longer need the authorization number of the primary care physician (PCP) to file a claim. Field 17 A is no longer required.

2. Prior approvals may be submitted via the web portal.

3. Travel is no longer a billable service.

4. Coordination and collaboration with the Primary Care Physician is required.

Dates of Service (DOS)
The "To" and "From" date of service is always the same. The date must contain month, day and year in MM/DD/YY format (e.g., enter April 1, 2003 as 04/01/03 to 04/01/03.

Place of Service (POS)
The only valid POS codes are 11 (office), 12 (home), 22 (outpatient hospital) and 99 (other).

Procedures Codes
See Part II-Chapter 1000 of the Children's Intervention Services Policies and Procedures manual for appropriate procedure codes. Only the procedure codes listed in the policy manual are covered codes.

Diagnosis Codes
Enter ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) diagnosis codes related to the services billed on the line. The special categories of codes that begin with the characters "E" and "M" are not accepted by DCH.

Effective October 1, 2015, use the Tenth Edition (ICD-10) code sets. ICD-10-CM replaces the ICD-9-CM (diagnosis) codes (Volumes 1-2) and ICD-10-PCS replaces the ICD-9-CM (procedure) codes (Volume 3).

Charges
Enter the cost of your "**usual and customary"** charge for the procedure multiplied times the units of service.

Days or Units
Enter the number of units provided

APPENDIX G

Field 32 on CMS 1500 Form

For services provided to Early Intervention (Babies Can't Wait) children, indicate the letters E.I. and the Health District number where the services were provided. (See Appendix A in the CIS Policies and Procedure Manual for listing of Health Districts). For Services provided to a child who is not an Early Intervention child, indicate the word "other" and the health district number where the services were provided.

Field 32 on the 1500 claim form is now the **Serial Number** on the software WINASAP. The information which is **Other and the Health District Number or EI and the Health District Number will have to be input into each line.** WINASAP has about four lines, so the information will have to be entered in the four lines.

When billing via the web**, Field 32** on the 1500 claim form via the Web is now the **Serial Number.** The information which is **Other and the Health District Number or EI and the Health District Number** is to be inputted in this field.

When billing Coordination of Benefits (COB), if the provider bills with PES Software or other software, the provider is required to fax in the attachment and identify the TCN on the attachment. Do not resubmit the claim. When billing via the web portal, no attachment is required and the provider can simply report a reason code.

If a member has private insurance (primary) and Medicaid (secondary), claims may be submitted electronically via the Web portal or PES Software or any other electronic data interface (EDI). If the primary insurance has paid, enter the correct amount in the appropriate field and the claim will adjudicate. If the primary insurance denied the claim, the following actions should be taken:

A) If using the Web portal—Complete the appropriate additional information screens to show who the primary plan insurance is and that it allowed and/or paid $0.00; enter the adjustment reason code used by the primary insurance to deny/adjust the claim along with the amount associated with that denial/payment adjustment. (Example: PR-1 the amount entered was applied to the annual deductible.)

B) If using PES Software (or other EDI)—enter as much information as available to you. The claim will suspend for thirty (30) calendar days while you send in the EOB, denial letter, or COB Notification Form (formerly known as the TPL Confirmation Statement). The associated TCN must be entered in the upper right corner of the attachment so that it can be re-associated with the claim and processed.

APPENDIX H

Software and Manuals

Electronic Claims Submission

This information is intended for all electronic claim submitters. HP Enterprise Services provides two free electronic claim submission options for providers. Both options create X12N compliant transactions for the following:

- 837 Dental
- 837 Professional
- 837 Institutional

- **Option 1:** Web Direct Data Entry (Web DDE) will provide online, real-time claim submission and processing. A claim can be submitted and within a few seconds the claim will adjudicate in the Georgia Medicaid Management Information System (MMIS). A response is returned to the submitter. If the claim is paid, details regarding the payment amount are provided. If the claim is denied, an explanation regarding any errors is provided. For claims that can be corrected, the claim can be immediately modified and resubmitted. A weekly financial cycle will continue to run for generating payments to providers (consistent with financial cycles that run in the current Georgia MMIS). Claim entry for the secure Web Portal is much simpler than the collection of data required to create an X12N transaction. No additional software is required for Web DDE submitters; everything is accessed through the secure Web Portal. More information on using the Web DDE can be found in the Provider Web Portal Navigational Manual in the Provider Manuals section under the Provider Information menu item on this site.

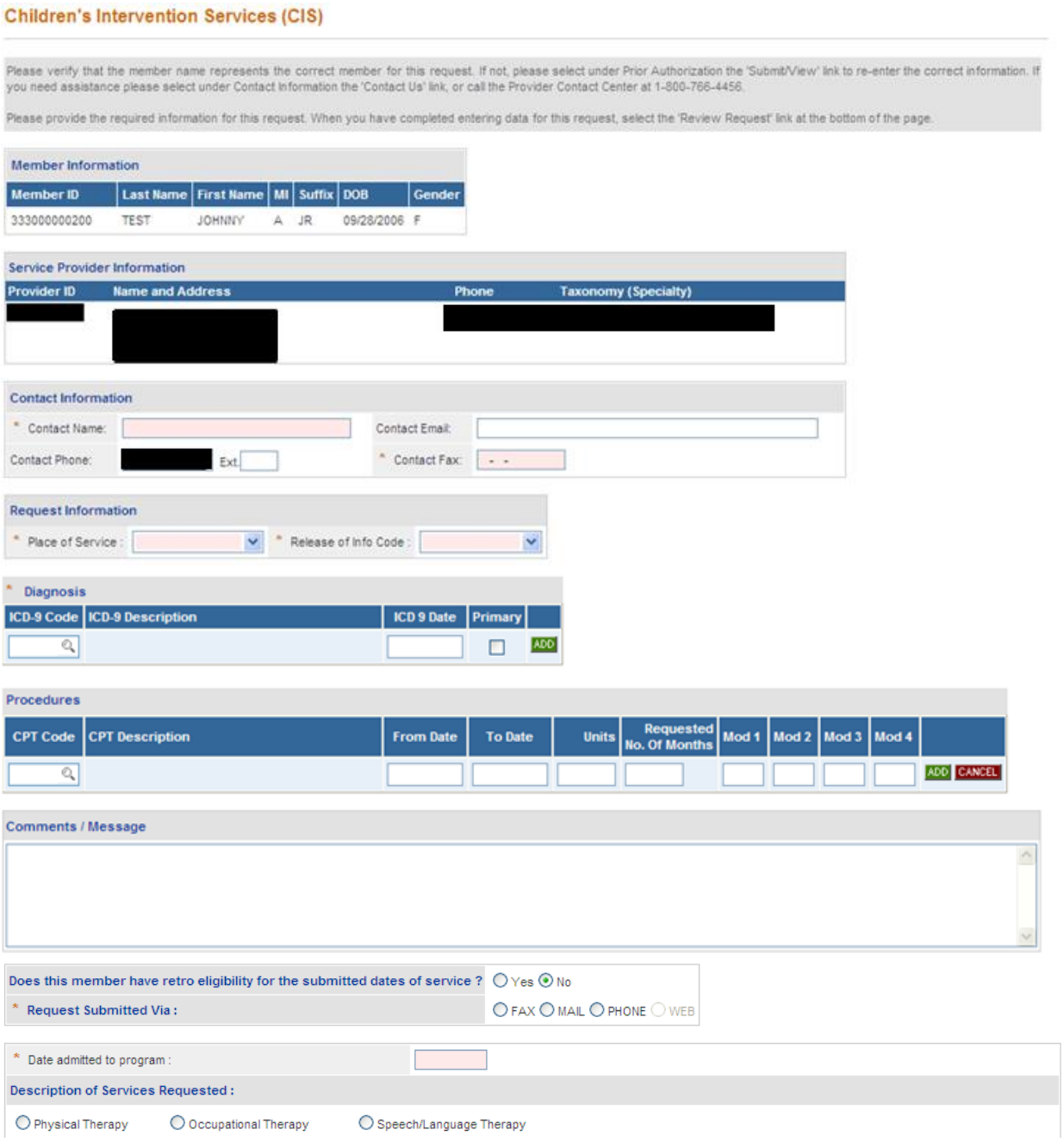
- **Option 2:** Provider Electronic Solutions (PES) software for submitters that choose to continue using a Personal Computer based option. When using PES, providers do not gain the real-time processing benefits of Web DDE. Rather, claims are submitted in batch mode either through a dial-up or internet connection.

The PES software, PES User Guide, the PES Computer Based Training (CBT), and Billing Guides customized for each claim type are available from this site. Individual PES virtual training may also be arranged if additional training is needed by calling the EDI Services Unit locally at (770) 325-9590 or toll free at (877) 261-8785. ***You are not obligated to use PES. If you choose to use PES, we encourage you to review the PES User Guide carefully prior to installing the software.*** Ultimately, you may choose to submit claims using the Web DDE functionality and avoid installing/learning the new PES software.

Please note: Many providers interested in using PES may also be interested in our Web Direct Data Entry (Web DDE) method of claim submission and correction. Web DDE is available to all enrolled providers on the secure Web Portal, and provides real-time, interactive processing. Claims can be entered online and submitted for immediate processing. A response is returned indicating the payment amount or any errors that occurred during the processing. If an error can be corrected, the claim can be immediately corrected and resubmitted. Web DDE provides a great alternative to installing and learning a new software package.

We hope you will find both Web DDE and PES provide efficient and accurate ways to submit claims electronically. For assistance with the PES software or Web Direct Data Entry (DDE) options and transaction testing, contact the EDI Services Unit toll-free at (877) 261-8785 or locally at (770) 325-9590.

APPENDIX I



Children's Intervention Services (CIS)

Please verify that the member name represents the correct member for this request. If not, please select under Prior Authorization the 'Submit/View' link to re-enter the correct information. If you need assistance please select under Contact Information the 'Contact Us' link, or call the Provider Contact Center at 1-800-766-4456.

Please provide the required information for this request. When you have completed entering data for this request, select the 'Review Request' link at the bottom of the page.

Member Information

Member ID	Last Name	First Name	MI	Suffix	DOB	Gender
333000000200	TEST	JOHNNY	A	JR	09/28/2006	F

Service Provider Information

Provider ID	Name and Address	Phone	Taxonomy (Specialty)
[redacted]	[redacted]	[redacted]	

Contact Information

* Contact Name: | Contact Email:

Contact Phone: [redacted] Ext. | * Contact Fax: - -

Request Information

* Place of Service : | * Release of Info Code :

* Diagnosis

ICD-9 Code	ICD-9 Description	ICD 9 Date	Primary	
				ADD

Procedures

CPT Code	CPT Description	From Date	To Date	Units	Requested No. Of Months	Mod 1	Mod 2	Mod 3	Mod 4	
										ADD CANCEL

Comments / Message

Does this member have retro eligibility for the submitted dates of service ? ○ Yes ◉ No

* Request Submitted Via : ○ FAX ○ MAIL ○ PHONE ○ WEB

* Date admitted to program :

Description of Services Requested :

○ Physical Therapy ○ Occupational Therapy ○ Speech/Language Therapy

Justification and Circumstances for Required Services :

Medical necessity and expected outcomes.

Primary Care Physician Name:

Outcomes

A. What would you like to see change as a result of early intervention ?

(Goals and Expectations)

B. What is happening now (Evaluation / Assessment information) ?

(Describe what is taking place at this time relative to the Goals and Expectations)

C. Progress Statement: How will we know we are making progress with this child ?

(What will be different relative to the Goals and Expectations ?)

Is this PA request a continuation from a previous PA?	○ Yes ○ No	If Yes, Previous PA#:	
Is there a current Individualized Education Plan (IEP)?	○ Yes ○ No	If Yes, IEP Date:	
		If No, please explain why :	
Is there a current Individualized Family Sevice Plan (IFSP) on file ?	○ Yes ○ No	Date Signed :	
Is there a current Attestation form attached (child does not have an IEP or IFSP)?	○ Yes ○ No	If Yes, date Attestation form was signed :	
Is there a current Letter of Medical Necessity, Written Service Plan or Plan of Care?	○ Yes ○ No	If Yes, LMN/WSP/POC date:	
Are current standardized testing results attached?	○ Yes ○ No	If Yes, standardized testing date:	
Are there current progress notes attached?	○ Yes ○ No	If Yes, most current progress note date:	
If No, is this a new patient?	○ Yes ○ No	If No, please explain why there are no progress notes :	
Is there a valid parental consent on file and the parent has not withdrawn consent ?	○ Yes ○ No	Date Signed :	
Name of Service Coordinator :		Title :	

Review Request

APPENDIX J

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	CareSource 1-855-202-1058 www.caresource.com
Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice

PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All four CMOs are State-wide.**

The Department of Community Health has contracted with four CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan
- WellCare of Georgia

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM

183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion

180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled

283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual

815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com	866-231-1821 www.wellcare.com

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact DXC at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid

eligibility and health plan enrollment. DXC will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to DXC in error:

DXC will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- •Saves time
- •Increases efficiency
- •Eliminates duplication of data needed for multiple CMOs
- •Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

HP provider reps will provide training and assistance as needed. Providers may contact HP for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to DXC in error:

DXC will deny the claim with a specific denial code. Prior to receiving this denial, you may go

ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy**: Checks are mailed to pharmacies weekly	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.	WellCare runs claims payment cycles up to six (6) times each week for **clean** claims. For further information, please refer to the WellCare website, the WellCare provider manual, or contact Customer Service at 866-231-1821

on Friday (except when a holiday falls on Friday, then mailed the next business day)			

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.	Members can change PCPs for any reason within the first 90 days of their enrollment. After the first 90 days, members may change PCPs once every six months.

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after	PCP changes made between the 1st and 10th of the month will go into effect right away. Changes made after the 10th of

		the 24th day of the month are effective for the first of the following month.	the month will take effect at the beginning of the next month

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com	866-300-1141 ProspectiveProviderGA@WellCare.com or https://www.wellcare.com/en/Georgia/Become-a-Provider

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	**PBM**	**BIN #**	**PCN**
Amerigroup Community Care	ESI	003858	MA
CareSource	CVS Caremark	004336	MCAIDADV Group: RX0835
Peach State Health Plan	Envolve Pharmacy Solutions Caremark (Claims Processor)	004336	MCAIDADV
WellCare of Georgia	Caremark	004336	MCAIDADV

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through DXC by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. DXC will

let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes	Yes, you may also use the WellCare subscriber ID

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates: Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

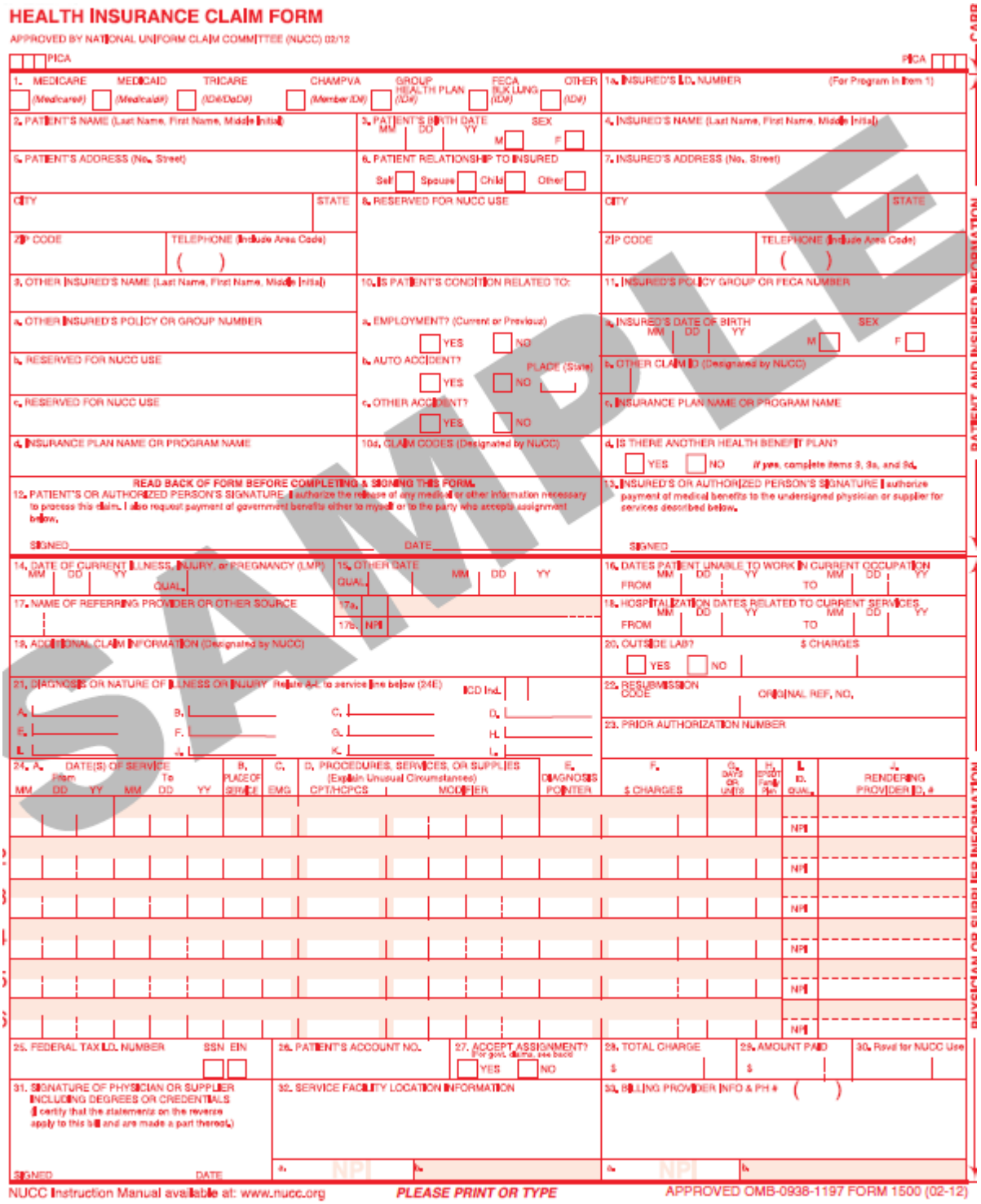
No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
1 (800) 454-3730	1 (855) 202-1058 1(866) 930-0019 (fax)	1 (866) 399-0929	1 (866) 231-1821 1 (866) 455-6558 (fax)

APPENDIX K

New CMS-1500 Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

- The following table outlines the **revised changes** on the above CMS 1500 claim form version 02/12:

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/HP:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?)
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)." Removed the arrow and text in the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier." **FOR DCH/HP: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date).**
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091

	(Report End [Relinquished Care Date); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/HP:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/HP:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. **(Do not bill ICD 10 code sets before October 1, 2015.)**
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. F **FOR DCH/HP**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

APPENDIX L

Instructions for Electronic Attachment of Supporting Documentation to a PA Request

(Refer to the Medicaid Medical Management Services, *Provider Workspace* User Manual available on the Georgia web portal for a complete list of all PA instructions.)

Georgia Medical Care Foundation

2.4 Attach Documentation to Requests

2.4.1 Purpose

Some request types require the submission of additional documentation. From the *Provider Workspace*, providers may attach the required information to PA request; and view documents that were previously attached. Electronic attachment of documents is quick and easy and can potentially speed up the review process. Once a document is attached to a request, GMCF staff has immediate access to the attachment and are able to view the information as part of the PA review process.

2.4.1.1 Attachment Guidelines

There are some restrictions/limitations that apply to attachments as follows:

- Documents may be attached to a PA request when the request is submitted, or to existing PA requests that are pending and not referred. Attachments may also be made via the *Change Request* or *Reconsideration Request* processes
- **Documents may not be attached to the following PA/review types unless the attachment is part of a change request or reconsideration request**: Hospital Outpatient Therapy; Medications PA (Physician and Facility); Radiology PA (Physician and Facility); Additional Psychiatric/Psychological Services; Additional Office Visits; and Swingbed requests. Additional documentation is not required for these request types; and all pertinent clinical information and justification for services should be entered on the request forms.
- In order to attach a document to a request, the document must be saved to one of the provider's system drives.
- The following file types are acceptable for attachments: TXT, DOC, DOCX, PDF, TIF, TIFF, JPG, JPEG, and JPE.
- **Do not** include the following symbols as part of the file name: \, /, #, <, >, ', ".
- The name of the file to be attached cannot have the same name of a file that is already attached.
- The file size for an individual attachment MUST be less than 20 MB in size; so if a file is especially large, divide the file into two files.
- Multiple documents may be attached to one PA request. However, the documentation that is attached should only relate to the member associated with the PA, and not relate to any other members.

2.4.2 Attachment Instructions

Follow these instructions to attach documents to existing requests or to requests upon initial submission.

1. **To attach a file to an existing request:**

   - Open the *Provider Workspace*.
   - Click **Attach Documentation to Existing Requests** OR click **Search for Authorization Requests and Edit Requests** to open the *PA Search* page.
   - Search for and open the PA request to which a document or documents are to be attached. If files have already been attached to the request, the files will display in the **Attached Files** table.
   - If the PA request meets attachment criteria, the **Attach File** link will be available.

Figure 37 Attach File Link

   - Click attach file, and on the page that displays, go to the **Create an Attachment** section.

2. **To attach a file when submitting the request:**

   - Complete the PA request and click **Submit Request**.
   - On the page that displays after clicking **Submit Request**, go to the **Create Attachment** section.

3. **Create an Attachment:**

   - Under create an attachment, click **Browse** to open the file directory.

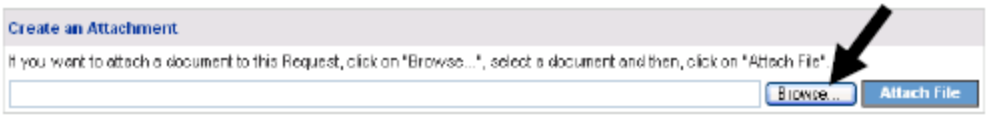


Figure 38 Create an Attachment

   - Find the file that is to be attached. Select the file by double clicking the file, or highlight the file and then click **Open**.

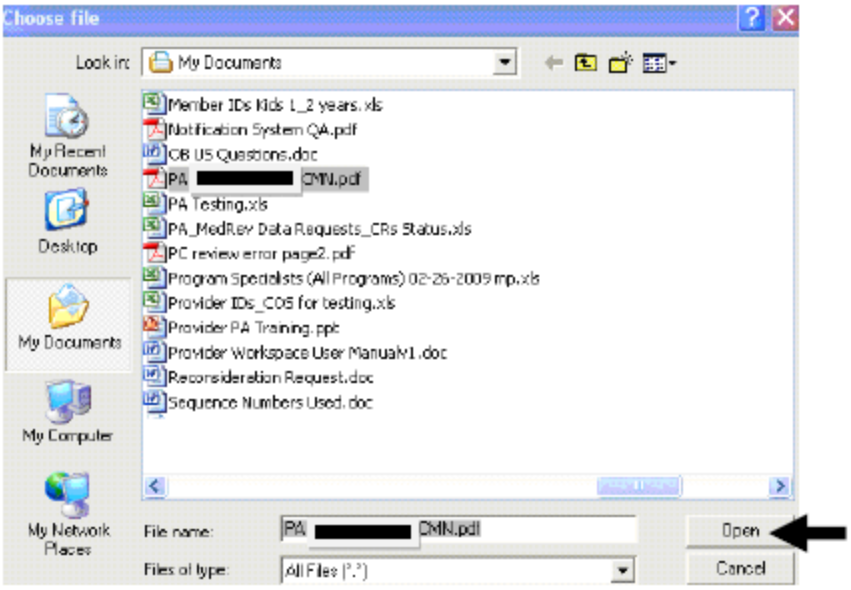


Figure 39 Find and Select File

- Once the file is selected, it will display in the box next to browse.

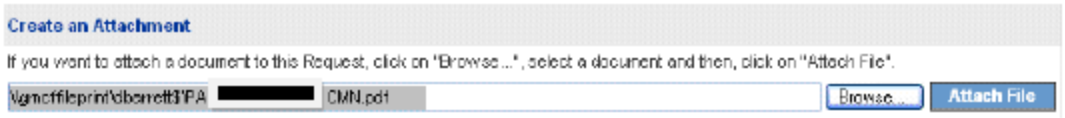


Figure 40 File Name Inserted

- To attach the selected document, click the **Attach File** button. If the file is uploaded, the 'File uploaded successfully' message displays, and a link to the attachment will display in the **Attached Files** table.

Figure 41 File Uploaded #1

4. Associate an Attachment type with a file:

For some request types and procedure codes, the 'type' of each required document displays next to a checkbox. The purpose of the checkbox is to associate the actual file attached with the specific additional information required by policy. Figure 42 shows the checkboxes for a Durable Medical Equipment request for oxygen services. Each procedure code on this request requires a *Certificate of Medical Necessity*; and procedures, E0431 and E1390, also require a copy of testing results.

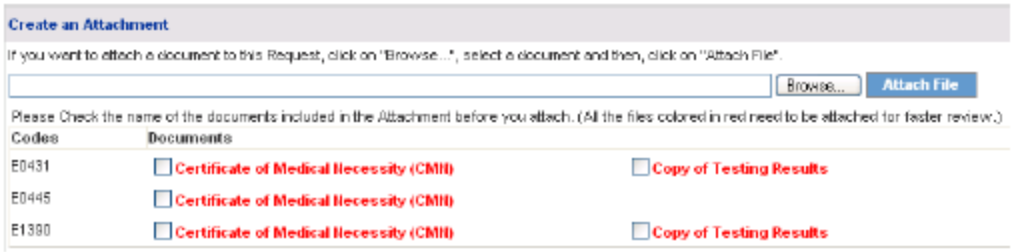


Figure 42 Document Checkboxes

5. To attach a file or files to a PA when checkboxes for documents types are available, first determine if one file that includes all the required information is to be attached, or individual files are to be attached.

***One Attachment for all Checkboxes*:**

- **If one file is to be attached** and that file includes all the required information, click all the checkboxes and then attach the one file.
- If the attachment is successful, a file upload message displays; the attached file is added to the **Attached File**s table; and the file is associated with each procedure code and document type.

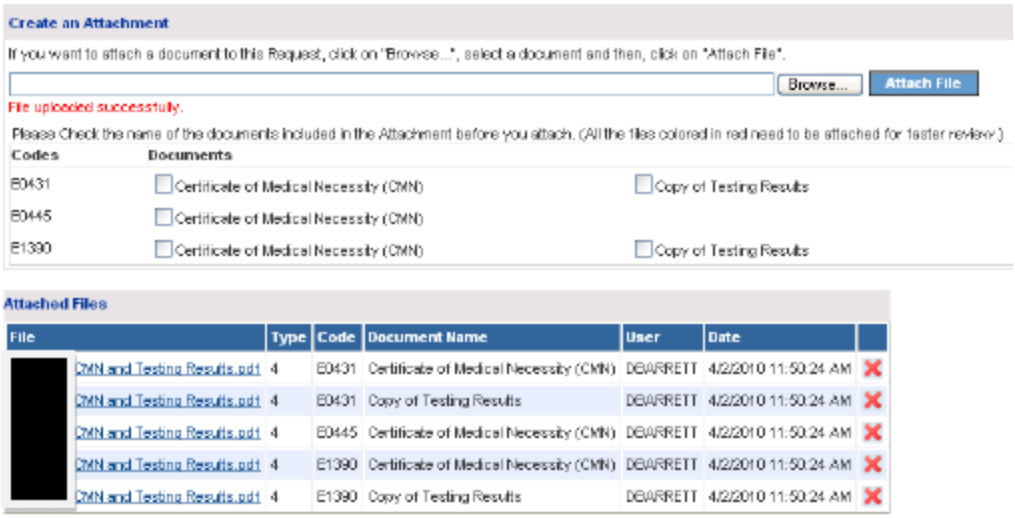


Figure 43 One File for All Checkboxes

One Attachment for Each Checkbox:

- When each file to be attached relates to a different required document, first click the applicable checkbox and then find/attach the file related to the checkbox selected.

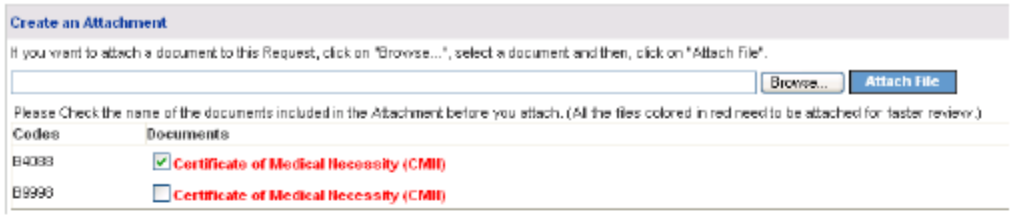


Figure 44 One File per Checkbox

- To attach additional files, repeat the same process. Select the check box or checkboxes and then attach the file. The checkbox that was not selected will still display in red, indicating that the required document still needs to be submitted.

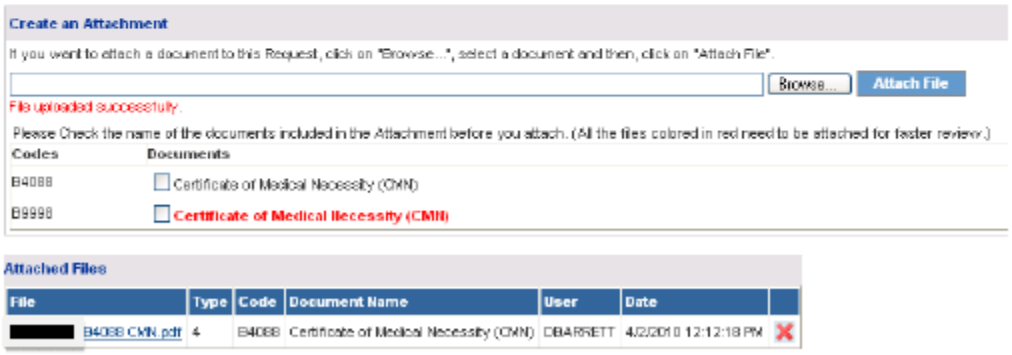


Figure 45 File Uploaded #2

APPENDIX M

Medicaid Non-Emergency Medical Transportation

People enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Medical Transportation Program (NEMT) provides a way for Medicaid recipients to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency medical transportation services?
If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m. All counties in Georgia are grouped into five regions for NEMT services. A NEMT Broker covers each region. If you need NEMT services, **you must contact the NEMT Broker serving the county you live in** to ask for non-emergency medical transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NEMT broker?
The Medicaid Division monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, **call the Member Contact Center toll free at 866-211-0950.**

Region	Broker / Phone number	Counties served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Clarke, Cobb, Dade, Dawson, Douglas, Elbert, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Greene, Gwinnett, Habersham, Hall, Haralson, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Newton, Oglethorpe, Oconee, Paulding, Pickens, Polk, Rabun, Rockdale, Stephens, Towns, Union, Walker, Walton, White, Whitfield
Atlanta	Southeastrans Local 404-209-4000	Fulton, DeKalb
Central	Southeastrans Toll free 1-866-991-6701 Local 404-305-3535	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Crawford, Dodge, Fayette, Hancock, Heard, Henry, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Pulaski, Putnam, Spalding, Telfair, Treutlen, Troup, Twiggs, Upson, Washington, Wheeler, Wilcox, Wilkinson

East	LogistiCare Toll free 1-888-224-7988	Appling, Atkinson, Bacon, Brantley, Bryan, Burke, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Columbia, Effingham, Emanuel, Evans, Glascock, Glynn, Jeff Davis, Jefferson, Jenkins, Liberty, Lincoln, Long, McDuffie, McIntosh, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Ware, Warren, Wayne, Wilkes
Southwest	LogistiCare Toll free - 1-888-224-7985	Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Webster, Worth

APPENDIX N
Submit CIS Reconsideration Request

.

Provider Quick Reference: Submit a CIS Reconsideration Request

Overview

Providers may submit requests for reconsideration of a Children's Intervention Services (CIS) prior authorization (PA) request via the web portal *Provider Workspace*. Once the reconsideration request is submitted and accepted by a GMCF reviewer, the provider is sent a faxed notification indicating that the *'request has been received and is awaiting review'*. **This notification does not mean that the reconsideration request has been reviewed only that it has been received.**

CIS Reconsideration Request Guidelines

The following guidelines for requesting reconsiderations apply to Children's Intervention Services PAs.

- Reconsiderations are allowed when the PA has one or more procedure lines that are:
  - Approved but not for all units requested. Requests must be submitted within **30** calendar days of the decision.
  - Peer consultant denied. Requests must be submitted within **30** calendar days of the decision.
  - Tech Denied but **NOT** Final Tech Denied. Requests must be submitted within **10** calendar days of the decision.

- Providers must attach additional documentation to support the reconsideration request. It is not necessary to re-submit all information sent with the original request but only the information that supports the request for reconsideration.

CIS Reconsideration Submission Instructions

Follow these instructions to enter a request for reconsideration of a CIS PA:

1. From the *Provider Workspace*, select **Submit CIS Reconsideration Requests**.

2. Search for the PA request and open the *Review Request* page. **Note**: When the *Review Request* page is opened for a request, which does not meet the reconsideration request guidelines, a message will appear at the top of the page indicating that reconsideration cannot be entered.

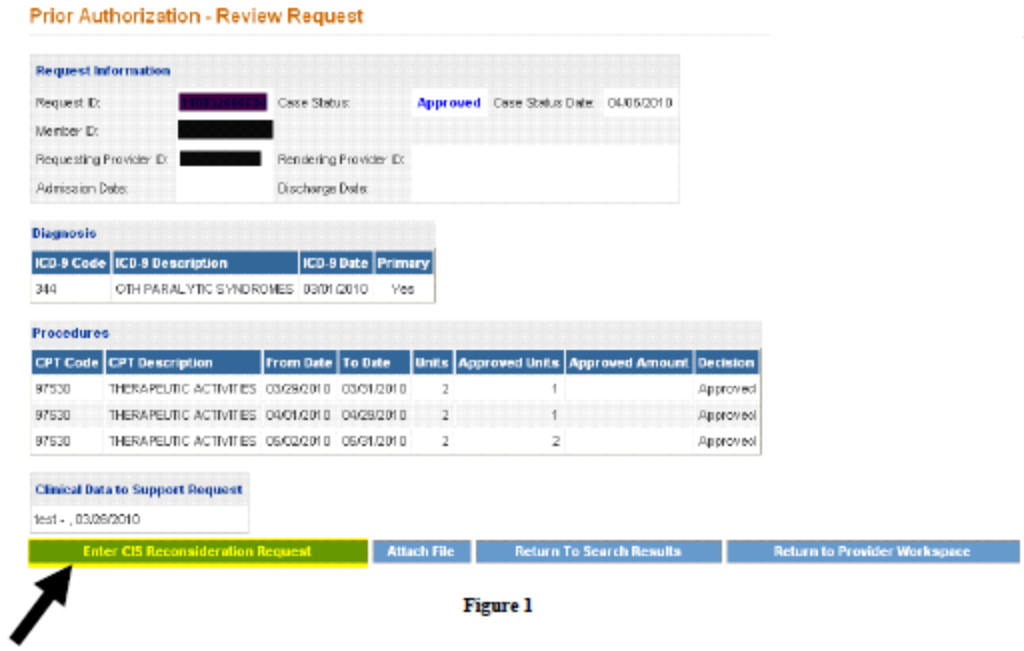


Figure 1

3. Click **Enter CIS Reconsideration Request** at the bottom of the page to open the *CIS Reconsideration Request Information* page.

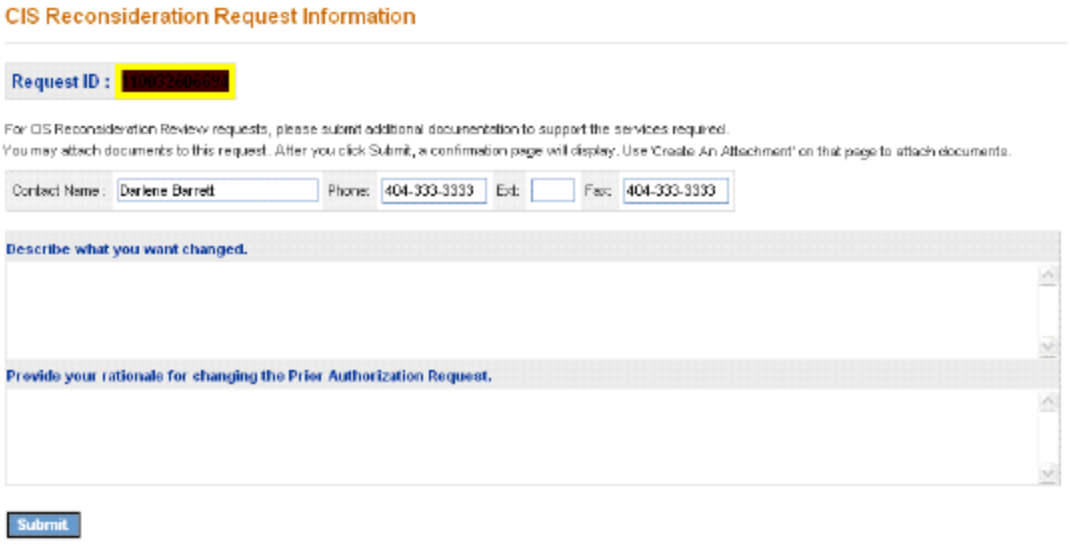


Figure 2

4. The contact information for the requesting provider is inserted by the system. Verify that the information is correct. If not correct, edit the information. This is important since the contact name/fax number is used for the faxed notification.

5. **What you want changed**: In the first text box, clearly describe what you want changed as a result of the reconsideration review: indicate the codes; dates of service and the units required.

6. **Rationale**: In the second text box, provide additional clinical information that supports the request for reconsideration review and specifically addresses the need for the services requested.

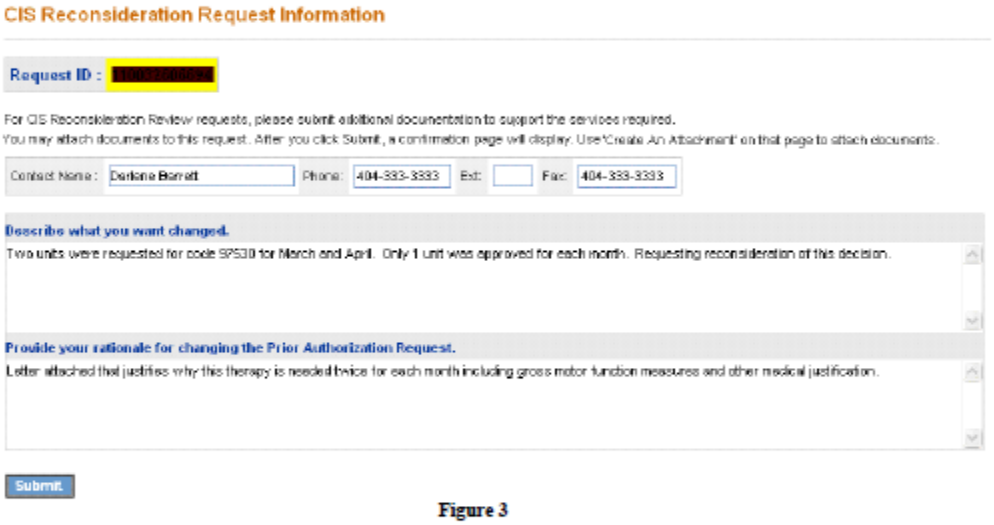


Figure 3

7. Click **Submit**. If the submission is successful, a page displays confirming that the reconsideration has been entered successfully. Additional supporting documentation may be attached at this point.

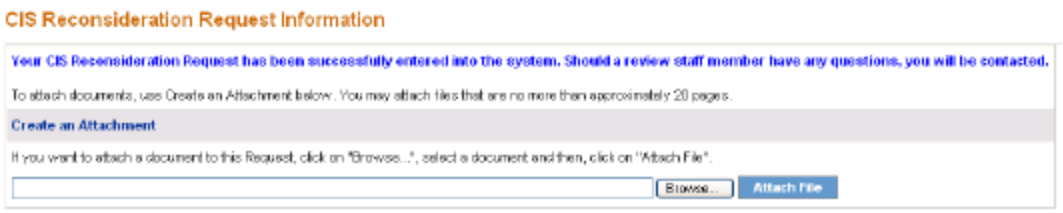


Figure 4

8. Click **Browse** to find the file to be attached.

9. To select a file, highlight the file and click **Open,** or double click the file.

10. The file name will appear in the box next to browse.

11. Click **Attach File**. If the file is uploaded, the 'File uploaded successfully' message displays, and a link to the attachment will display in the **Attached File**s table.

APPENDIX O
Submit/View PA Change Requests

2.5 Submit/View PA Change Requests

2.5.1 Purpose

This functionality allows providers to find and view change requests previously submitted, and submit new change requests. Once staff processes the change request, an automatic fax notification is sent to the contact name and fax number entered on the change request. The notification indicates that the change request was granted or was not granted. If not granted, an explanation is provided.

2.5.1.1 Change Request Guidelines

Change requests are permitted for all review types except ICWP DMA-6 and GAPP DMA-6A. In general, change requests must be submitted within 30 calendar days of the PA request date or date of service whichever is greater. For most PA types, only three (3) change requests per PA may be submitted. However, there are exceptions to these rules based on review type as noted below:

- Children's Intervention Services PAs: There are no restrictions to the number of change requests per PA; or when change requests may be submitted. Change requests may be submitted at any time as long as the case has not received a Final Tech Denial. In addition, change requests must met the following criteria:
  - A significant change in condition must be documented by submission of an updated treatment plan signed by the physician and therapist.
  - If a change in modality is requested, the units to be withdrawn (for substitution) must be specified.
  - Change requests may be submitted for PAs for which reconsideration has not been requested.

- Durable Medical Equipment PAs: There is no time restriction for submission of change requests for DME PAs.

- Medications Prior Authorizations: There is no time restriction for submission of change requests for Medications PAs.

- PASRR: Change requests may be submitted for a PASRR Level I if the Level I decision is pending (not referred for OBRA - Level II).

2.5.2 Change Request Submission Instructions

Follow these instructions to enter a change request:

1. From the *Provider Workspace*, select **Submit/View PA Change Requests**.

2. Search for the PA request and open the *Review Request* page. **Note:** When the *Review Request* page is opened for a request which does not meet the change request criteria, a message will appear at the top of the page indicating that a change request cannot be entered.

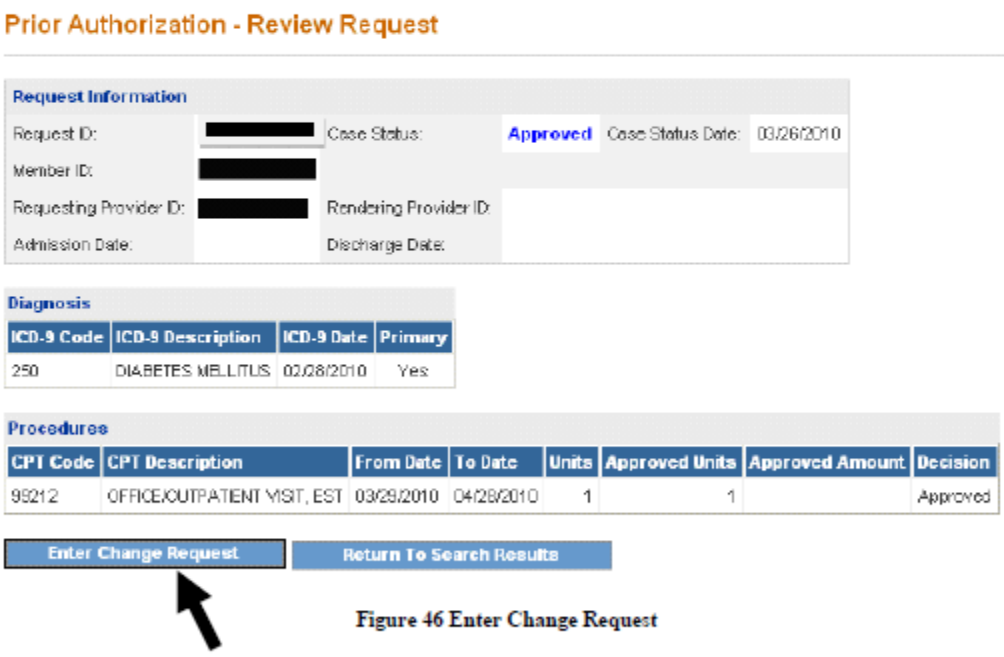


Figure 46 Enter Change Request

3. Click **Enter Change Request** at the bottom of the page to open the *Change Request Information* page.

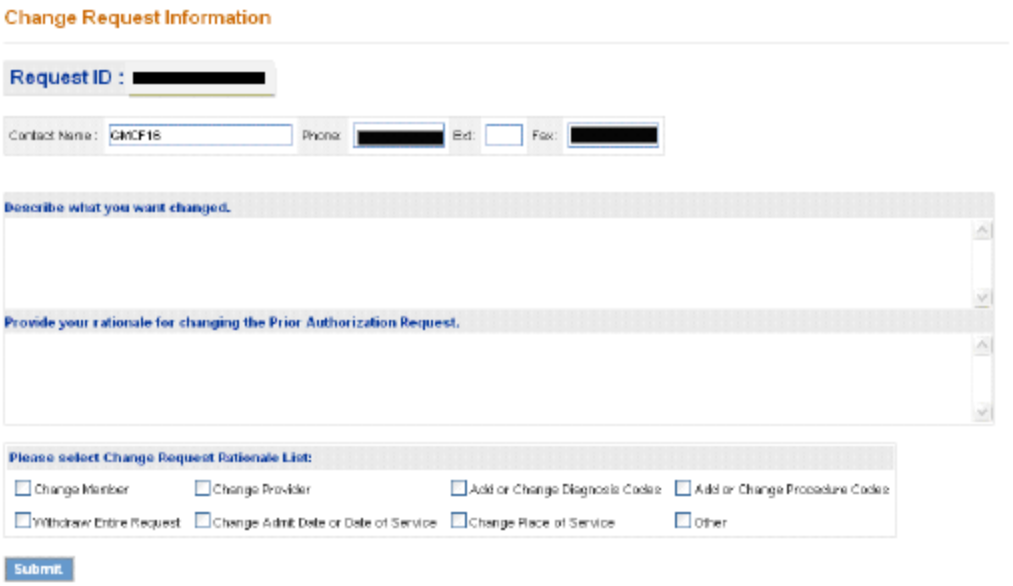


Figure 47 Change Request Information Page

4. On the *Change Request Information* page, the provider's contact person name, phone and fax number are inserted by the system. If this information is not correct, change the information to ensure that the change request notification is sent to the correct contact person.

5. **Describe the change needed**. In the textbox provided, describe specifically what needs to be changed.

6. **Rationale for change**. In the textbox provided, provide justification for the requested change.

7. Next, select one or more checkboxes from the 'Rationale List' corresponding to the change(s) requested. If none apply to the change requested, select 'Other'.

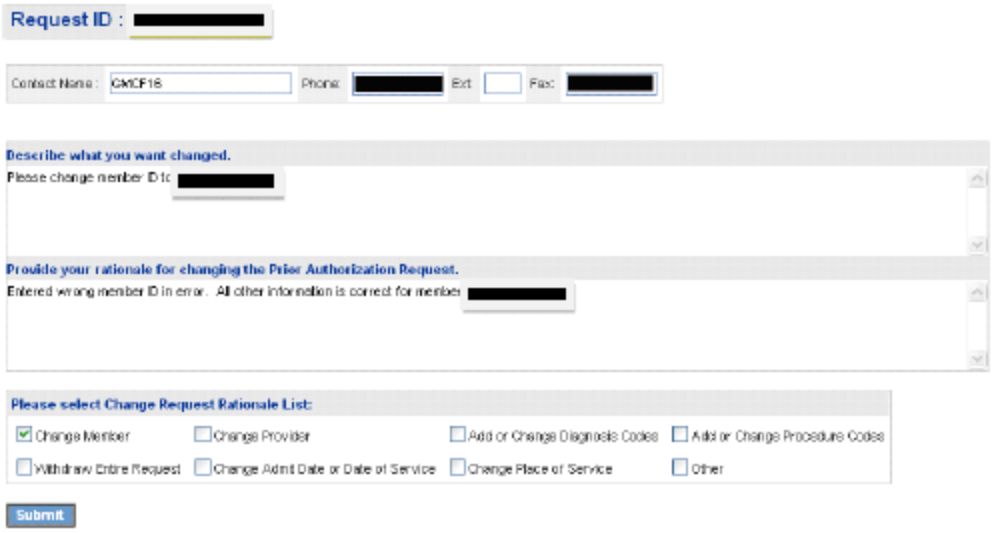


Figure 48 Completed Change Request

8. Click **Submit** to submit the request. If the submission is successful, a page displays confirming that the change request has been entered successfully. Additional supporting documentation may be attached at this point. Follow the same attachment procedures as described in **Section 2.4.2**.

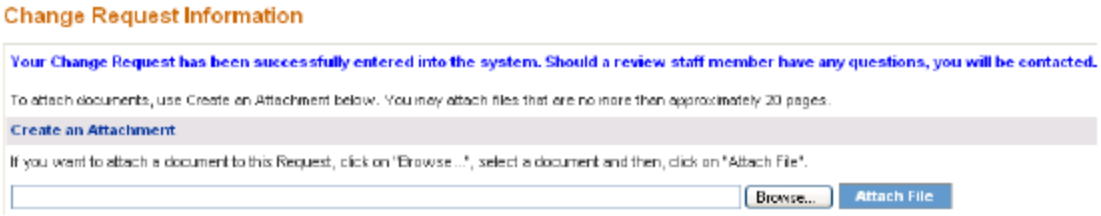


Figure 49 Change Request Submitted

APPENDIX P

Provider Attestation Regarding IEP/IFSP for Outpatient Therapy Services

_____

Member Name

_____

Member ID Number

I have conducted a reasonable review of the facts regarding the therapy services recommended for the above referenced member, including a discussion with the parent regarding other services that are currently provided. Based upon my review and attestation from the parent, the member does not have an existing Individualized Educational Plan (IEP) or Individualized Family Service Plan (IFSP).

I understand that under my provider participation agreement, applicable regulators including the Centers for Medicare and Medicaid Services, and the Georgia Department of Community Health or their representatives may inspect and evaluate my records related to members and the provision of and payment for services to audit compliance with this review requirement, and other contractual requirements and federal and state laws and regulations.

NOTE: If the member does have an existing IEP or IFSP, it should be submitted, along with the request for treatment. Providers must date this form as of the date of signature.

_____
Provider Signature

_____
Print Name

_____
Title

_____
Provider Medicaid Identification Number

_____
Date

_____
Contact Phone Number

_____
Contact Fax Number

APPENDIX Q

How to Check the Status of Your Prior Authorization

2.3.2 PA Search Instructions

Follow these instructions to search for requests:

1. Click **Search for Authorization Requests and Edit Requests** from the *Provider Workspace* to open the *Prior Authorization Request Search* page. The Provider ID, associated with the web portal login credentials, is populated by the system.

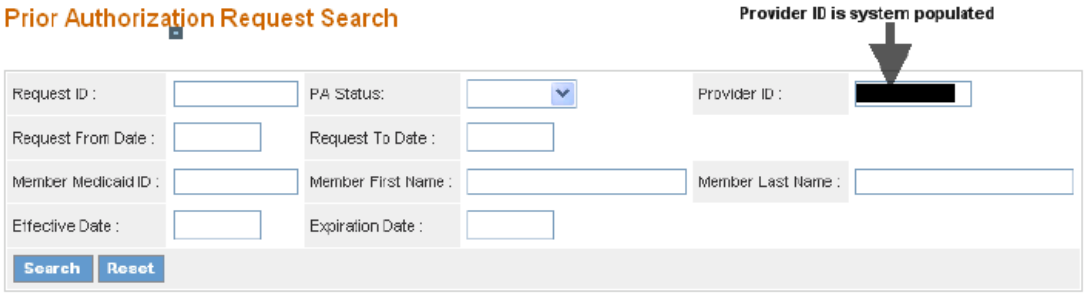


Figure 28 PA Search Page with Provider ID

2. Enter search parameters and click **Search** to activate the search process. In the following figure, the search parameters are 'Provider ID' and 'Request ID' (blacked out), and, as a result, the search returns one request.

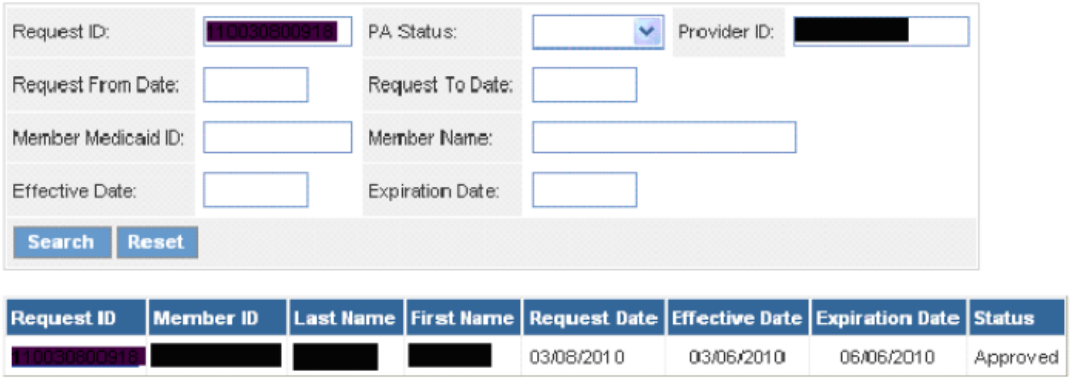


Figure 29 Provider and Request ID Search

3. When the request ID is not used, the search may return multiple results depending on the search criteria used. The search parameters in the following example are 'Provider ID' and 'Request From Date'.

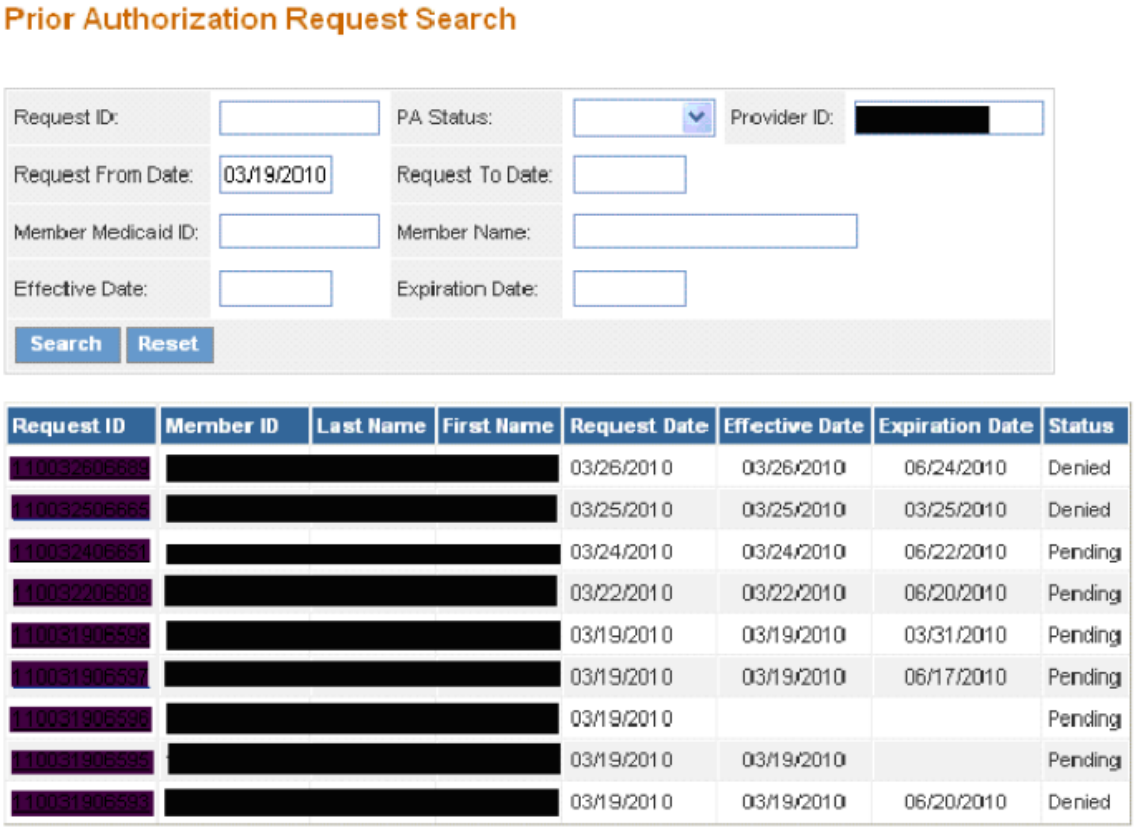


Figure 30 Multiple Search Results

4. To view one of the requests in the search results, click the **Request ID** (in the screen shot above, the request IDs have been blacked out). When a request ID is selected, the *Review Request* 'summary' and decision page displays. This page provides a quick overview of the request information and displays the case status and procedure decision status.

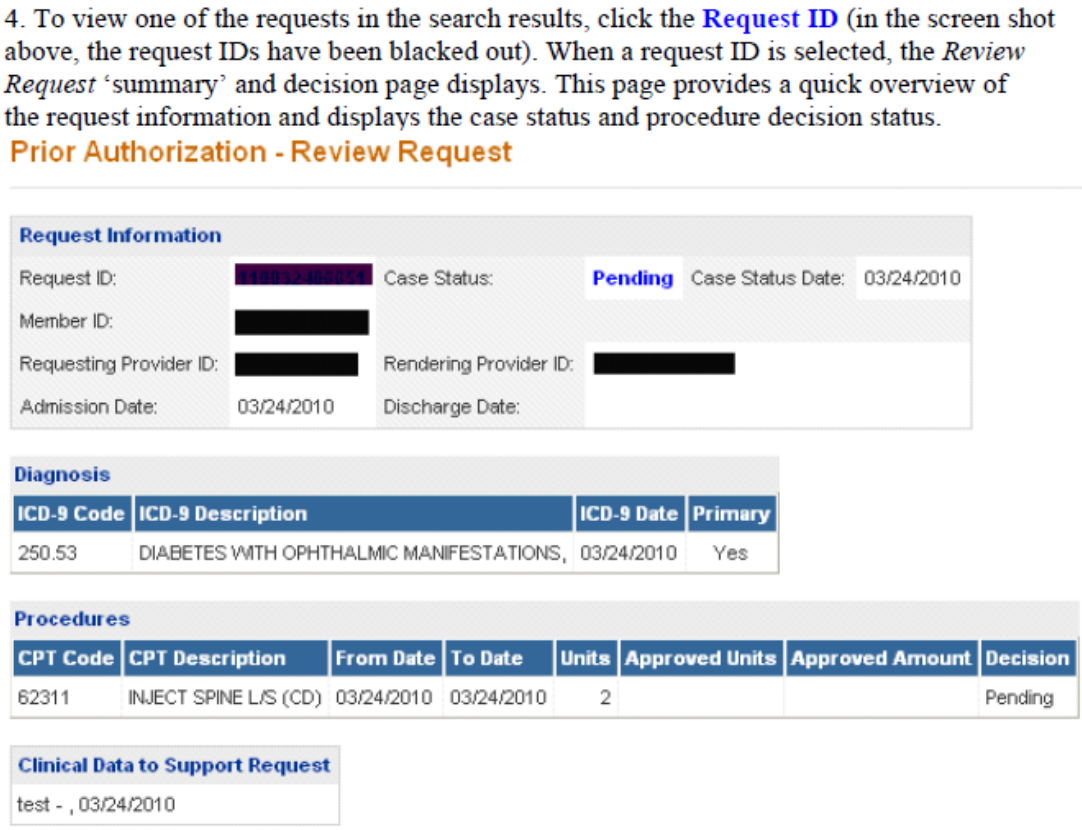


Figure 31 Review Request Summary

5. To review all the information initially entered on the request; click the **Request ID** in the **Request Information** section.

Figure 32 Review Detail PA Information

6. When the request ID is selected, the *Review Request* 'detail' page opens and displays all the information entered on the request. Click **Back** to return to the summary and decision page.

7. If the PA selected from search results is denied, the denial reason code and specific denial reasons display on the summary and decision page. **If the PA has procedure codes, hold the mouse pointer over the denial reason code at the end of a procedure line to display the specific denial rationale for that procedure line.**

Figure 33 View Denial Rationale

Taken from the Medicaid Medical Management Services, *Provider Workspace,* User Manual Version 1.7.

APPENDIX R

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APPENDIX S

Information for Providers Serving Medicaid Members
in the Georgia Families 360º SM Program

Georgia Families 360º SM, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible through its provider network for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360^{0}_{SM} Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360º SM Every member in Georgia Families 360^{0} is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov.