PART II

POLICIES AND PROCEDURES FOR PSYCHOLOGICAL AND THERAPY SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

October 2024

Policy Revisions Record

Part II policies and Procedures Manual for Psychological and Therapy Services

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
01/01/2018		No revisions for this quarter		
04/01/2018		No revisions for this quarter		
07/01/2018		No revisions for this quarter		
10/01/2018	Appendix D	Georgia Families update	M	NA
01/01/2019	Section 802 Appendix B	**802. Covered Services** Psychological and Therapy Services are covered only for members under twenty-one years of age. Reimbursement for Psychological and Therapy Services is limited to no more than twenty-four (24) units per member, per calendar year. When the Department has made payment for twenty-four units (24) of Psychological and Therapy Services no further payment will be made without prior authorization. The annual twenty-four unit limitation will apply to any combination of current procedure terminology codes (CPT) 96130, 96131, 96132, 96133, 96136, 96137 (psychological diagnostic interview, evaluation and testing), *90832* (individual psychotherapy), 90834, 90837 (effective 8/1/2013) and *90853* (group psychotherapy). Codes 90832, 90834 and 90837 cannot be billed together and each count as one unit. CPT 96101 was deleted on 01/01/2019. **802.1** Psychological Codes and Rates	A, D, M	CMS
04/01/2019		No Revisions for this quarter	A	NA
07/01/2019		No Revisions for this quarter		
01/01/2020		No Revisions for this quarter		
04/01/2020		No Revisions for this quarter	NA	NA
07/01/2020		No Revisions for this quarter	NA	NA
10/01/2020		No Revisions for this quarter		

1/1/2022		Name change from Psychological Services to Psychological and Therapy Services	A	NA
1/1/2022		Added specialties Marriage and Family Therapist, Licensed Social Worker, and Counselor, Professional	A	NA
4/1/2022		No revisions for this quarter	N/A	N/A
7/1/2022		No revisions for this quarter	N/A	N/A
10/1/2022		No revisions for this quarter	N/A	N/A
1/1/2023		No revisions for this quarter	N/A	N/A
4/1/2023	601.2 802.2	"Please reference section 805 for restrictions on reimbursement for Auxiliary Personnel" Added procedure code 90791 Psychiatric diagnostic evaluation	A	N/A
7/1/2023		No revisions for this quarter	N/A	N/A
10/1/2023		No revisions for this quarter	N/A	N/A
1/1/2024	802.2	Added Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168.	A	CMS
4/1/2024	802.3	Removed the following verbiage August 1, 2013 Services are limited to one unit per date of service, per member and can only be provided by the enrolled Psychologist.	D	N/A
4/1/2024	802.5	Removed the following verbiage. Services are limited to a maximum of four (4) units per date of service, per member and can only be provided by the enrolled Psychologist.	D	N/A

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE A=Added D=Deleted M=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
7/1/2024	N/A	No revisions for this quarter	N/A	N/A
10/1/2024	N/A	No revisions for this quarter	N/A	N/A

PART II - POLICIES AND PROCEDURES
FOR
PSYCHOLOGICAL AND THERAPY SERVICES

CONTENTS

CHAPTER 600 SPECIAL CONDITIONS OF PARTICIPATION 3

CHAPTER 700 SPECIAL ELIGIBILITY CONDITIONS 5

CHAPTER 800 SCOPE OF SERVICES 6

CHAPTER 900 PRIOR APPROVAL 10

SECTION 802 COVERED SERVICES
SECTION 803 PATIENT RECORDS REQUIREMENT
SECTION 804 NON-COVERED SERVICES SECTION
SECTION 805 AUXILIARY PERSONNEL
SECTION 806 NURSING HOME REFERRAL REQUIREMENTS

CHAPTER 1000 BASIS FOR REIMBURSEMENT 11

APPENDIX A SAMPLE ID CARDS 12

APPENDIX B PROCEDURE CODES & RATES 13

APPENDIX C AHS REQUEST FORM (OUTPATIENT THERAPY) 14

APPENDIX D GEORGIA FAMILIES 15

APPENDIX E PROVIDER CONTACT 19

PART II - CHAPTER 600
SPECIAL CONDITIONS OF PARTICIPATION

601. In addition to those conditions of participation outlined in the Part I Policies and Procedures for Medicaid/Peachcare for Kids policy manual, Section 106, a Psychologist, Marriage and Family Therapist, Licensed Social Worker, and Counselor, Professional must:

601.1 Hold a current and valid license as a Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, Professional as required under Georgia Code Chapter 39 as amended.

601.2 Agree to bill the Department for only those services rendered by the enrolled Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, Professional or under direct supervision of the enrolled Psychologist. Please reference section 805 for restrictions on reimbursement for Auxiliary Personnel.

Direct supervision applies only to the salaried employees of Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, and Professional such as technicians, and assistant, etc., but does not apply to another Psychologist or individual practitioner who is eligible to enroll as a direct provider of services in a covered Medicaid program.

Direct supervision by the above Providers does not mean the Providers must be present in the same room; however, the Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, Professional must be present at the site of service (e.g., office suite, clinic, etc.) and be immediately available to confer with his or her salaried employee throughout the time services are performed. For Medicaid reimbursement purposes, an enrolled Psychologist may supervise and bill for the evaluation and testing services of no more than three salaried employees.

601.3 Agree to maintain records as necessary to demonstrate program compliance; and, must submit or make records available to the Department upon request for a minimum of five (5) years from the date(s) the service(s).

601.4 Agree not to bill for adjunctive services provided in a nursing facility unless prescribed by the Medicaid member's attending and prescribing physician as documented in the patient's medical record. Adjunctive services are defined as services provided by a physician or licensed practitioner other

than the patient's primary care physician who is legally responsible for the medical care of the patient. The attending and prescribing physician's name must appear on the patient's medical record.

601.4 Have a private practice which meets the following criteria:

a. Services rendered are the responsibility of the Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, Professional are free of any administrative or professional control of an employer such as a physician, institution, agency, etc.

b. The persons treated are the Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, Professional own patients; and

c. The Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, Professional have the right to bill directly for collect and retain payment for services.

NOTE: Notwithstanding the provisions of 601.5, medically necessary Psychological and Therapy Services provided by Psychologists licensed under OCGA 43-39.8 (2) are reimbursable when provided in facilities regulated by the State Board of Health.

PART II - CHAPTER 700
SPECIAL ELIGIBILITY CONDITIONS

Rev.4/3 Psychological and Therapy Services are available only to members who are under the age of twenty-one.

PART II - CHAPTER 800
SCOPE OF SERVICES

801. General

Psychological and Therapy services are defined as services involving the application of recognized principles, methods, and procedures of the science and profession of psychology, such as, but not limited to, diagnosing and treating mental and nervous disorders, interviewing, administering and interpreting tests of mental abilities, aptitudes, interests, and personality characteristics for such purposes as psychological classification or evaluation, or for education or vocational placement, or for such purposes as psychological counseling, guidance, or readjustment. Services are subject to the limitations described in Sections 802 and 804 without regard to diagnosis, type of illness or condition.

802. Covered Services

Rev. 4/15

Rev. 1/19

Psychological and Therapy Services are covered only for members under twenty-one years of age. Reimbursement for Psychological and Therapy Services is limited to no more than twenty-four (24) units per member, per calendar year. When the Department has made payment for twenty-four units (24) of Psychological and Therapy Services no further payment will be made without prior authorization. The annual twenty-four-unit limitation will apply to any combination of current procedure terminology codes (CPT) 96130, 96131, 96132, 96133, 96136, 96137 (psychological diagnostic interview, evaluation and testing), *90832* (individual psychotherapy), 90834, 90837 (effective 8/1/2013) and *90853* (group psychotherapy). Codes 90832, 90834 and 90837 cannot be billed together and each count as one unit. CPT 96101 was deleted on 01/01/2019.

802.1 Psychological Testing

Psychological testing (includes psych diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS) per hour of the psychologist’s or physician’s time, both face to face time administering test to the patient and time interpreting these test results and preparing the report. This may include history, mental status, disposition, psychometric, projective and/or developmental test, consultations with referral sources and other evaluation and interpretation of hospital records or psychological reports and other accumulated data for diagnostic purposes (with written report). The medical record must indicate the presence of mental illness for which psychological testing is indicated as in aid in diagnosis and therapeutic planning. The record must also show test performed, scoring, and interpretation as well as time involved. Only the Psychologist can make the selection and interpretation of psychological tests. The Psychologist must personally interview the patient when a diagnosis is made or is requested. In any written report, including psychological evaluations, the Psychologist must approve and sign the report. If the Psychologist's salaried employee does not participate in the actual writing of a report, but does administer and/or score psychological tests, the salaried employee is not required to sign the report, but his or her name must be

listed as the person who participated in the collection of the data in the report. When the salaried employee personally participates in the writing of any report, then both the Psychologist and the salaried employee must sign the report.

CPT codes 96130, 96131, 96132, and 96133 (**Testing Evaluation Services**) can only be billed and reimbursed by the enrolled Psychologist (category of service (COS) 570).

Rev. 4/1 **802.2 <u>90791 Psychiatric Diagnostic Evaluation</u>**

Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations the evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

802.3 <u>90832 Individual Psychotherapy</u>

Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with thirty minutes face-to-with the patient. This service is rendered in conjunction with continuing diagnostic evaluation as indicated, including psychoanalysis, insight orientation, behavior modification, supportive psychotherapy or other techniques.

<u>90834 Individual Psychotherapy</u>

Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with forty-five minutes face-to-face with the patient.

<u>90837 Individual Psychotherapy</u>

Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with sixty minutes face-to-face with the patient.

Rev. 1/1 **802.4 HEALTH BEHAVIOR ASSESSMENT and INTERVENTION**

Health Behavior Assessment and Intervention (HBAI) services Health behavior assessment and intervention services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems.

The patient’s primary diagnosis is physical in nature and the focus of the assessment and intervention is on factors complicating medical conditions and treatments. These codes describe assessments and interventions to improve the patient’s health and well-being utilizing psychological and/or psychosocial interventions designed to ameliorate specific disease-related problems.

<u>96156</u>

Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)

96158
Health behavior intervention, individual, face-to-face initial 30 minutes

96159
Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

96164
Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes

96165
Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

96167
Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes

96168
Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

802.5 90853 Group Psychotherapy

Insight oriented behavior modifying and/or supportive psychotherapy other than a multiple family group. This is a psychotherapy session in which there are no related patients in the session. Group therapy does not include socialization, music therapy, recreational activities, art classes, excursions, sensory, stimulation or eating together. Services are limited to a maximum of one (1) unit per date of service, per member and can only be provided by the enrolled Psychologist.

802.5.1 Guidelines for Selection of Group Therapy Patients

a) Patients must be alert, oriented to date, time and place and able to communicate;
b) Patients must not have loss of contact with reality or personality disintegration;
c) Patients with disabilities who need assistance, such as sign language for the deaf, must be provided the assistance required to allow them to participate in a meaningful manner in the group;
d) Patients cannot be related to any other member of the group.

802.5.2 Group Size

Group therapy sessions must be limited to no more than ten (10) patients.

803. Patient Records Requirements

Each patient's chart (medical record) must contain at a minimum the following information:

a) The patient's name, diagnosis and goals to be achieved in individual or group therapy.

Rev 7/12 b) The date and length of the therapy session (start and end time);

c) A statement summarizing the progress made toward reaching the projected goals; and

d) Charts and records must be in English.

804. Non-Covered Services

The following services are not reimbursable to Psychologists:

a) Sensitivity training, encounter groups, or workshops;

b) Sexual competency training;

c) Education testing and diagnosis (**NOTE**: Educational testing may be deemed medically necessary in a comprehensive workup when performed as a result of mental illness psychiatric disease: however, it is not reimbursable when performed to only test the member's IQ.)

d) Marriage counseling or guidance;

e) Biofeedback;

f) Transcutaneous nerve stimulation;

g) Hypnotherapy;

h) Adult Psychological and Therapy Services (21 years of age and over) see Physicians Services (COS 430);

I) Psychological and Therapy Services rendered through, by or in mobile units and/or facilities other than the psychologist's office, acute care hospitals, schools, psychological intensive care facilities approved by DHR, and nursing facilities. A mobile unit shall not constitute a Psychologist'soffice;

j) Telephone referrals or consultations; and

k) The Division of Medicaid does not directly reimburse psychological and psychiatric services rendered to individuals enrolled in the PRTF.

805. Auxiliary Personnel

The Department has no provision for direct enrollment of, or payment to, salaried auxiliary personnel employed by the Psychologist, such as technicians, therapists, mental health professionals, and other aides not enrolled in the Georgia Medicaid program. However, the Department will reimburse the Psychologist for services when the salaried employees of the Psychologist assist in rendering services and the charges are billed as part of the charge for the overall service provided by the Psychologist and other licensed behavioral health professionals. The services of the salaried personnel should be limited to providing evaluation and testing under the direct supervision of the Psychologist.

Employed auxiliary personnel may be part time or full-time employees of the enrolled Psychologist. In order to satisfy the employment requirement, the

auxiliary personnel must receive a W-2 form the Psychologist must pay the FICA. Services provided by auxiliary personnel not employed by the Psychologist are not covered.

Direct supervision by the Psychologist does not mean the Psychologist must be present in the same room; however, the Psychologist must be present at the site of the services and be immediately available to aid and direction throughout the time the services are performed.

The Department will not reimburse for psychotherapy (individual or group) performed by anyone other than the enrolled licensed Psychologist.

806. Nursing Home Referral Requirements

Covered nursing home patients (those under twenty-one years old) must be referred by their attending physician. The referral must be in writing and identify the patient referred and the Psychologist who will provide the service. The referral must be maintained in the patient's chart.

PART II - CHAPTER 900
PRIOR APPROVAL

Providers are required to submit a prior authorization request for medically necessary services, in excess of twenty-four (24) units per member, per calendar year, before the additional services are rendered. Failure to obtain the required prior approval will result in denial of reimbursement.

The prior approval requests can be submitted via the web to the Department's medical review agent, Alliant Health Solutions (AHS). The MEDICAID REQUEST FOR OUTPATIENT PSYCHOTHERAPY SERVICES form (located in Appendix C of this manual) should be submitted thirty (30) days prior to the exhaustion of the initial 24 units of therapy. If approved, the requested service is assigned an authorization number. The authorization number should be included on the CMS 1500 claim form in Field 23.

Authorizations are valid for six (6) months from the date of the final determination.

Providers have six (6) months from the date of service to bill for services rendered.

PART II - CHAPTER 1000
BASIS FOR REIMBURSEMENT

1000. Reimbursement Methodology

The Division will pay the lower of the physician's lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date(s) of service, the lowest price charged to other third party payers or the statewide maximum allowable reimbursement amount allowed for the procedure code reflecting the service rendered. Effective with dates of service October 1, 2003, the statewide maximum allowable reimbursement is 84.645% of the 2000 Resource Based Relative Value Scale (RBRVS) as specified by Medicare for Georgia Area 1 (Atlanta). All procedure codes recognized and adopted after the 2000 RBRVS are subject to the same level of reimbursement.

1001. Reimbursement Limitation

Reimbursement for Psychological and Therapy Services is limited to no more than twenty-four units per member, per calendar year. In those instances, in which a member is receiving services from more than one Psychologist, the basis for reimbursement up to the twenty-four-unit limitation will be the first correct claim received from any enrolled psychologist.

1002. Billing

1002.1 **Medicaid Claims**

The appropriate claim for reimbursement of Psychological and Therapy Services is the CMS 1500 claim form. Please see the Billing Manual, Appendix I in Policy Manual Part I for detailed instructions on completing the claim form.

1002.2 **Medicare/Medicaid**

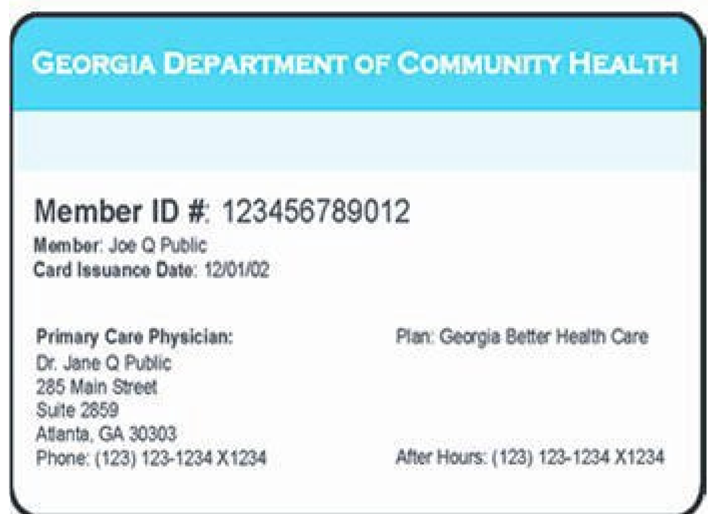
Please refer to Policy Manual Part I, Sections 301 and 302, and the Billing Manual for billing instructions for services rendered to members with dual eligibility for both Medicare and Medicaid. The Medicaid Secondary User Guide will also provide appropriate information for billing for dual eligible.

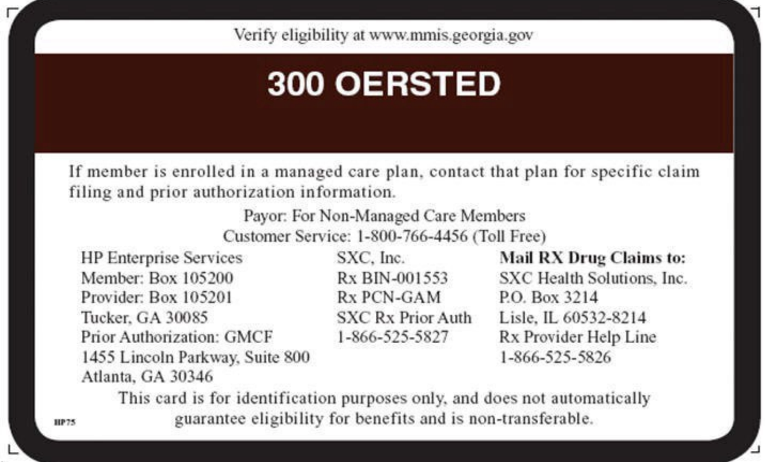
APPENDIX A

MEDICAL ASSISTANCE ELIGIBILITY CERTIFICATION
Medicaid & PeachCare for Kids Member Identification Card Sample

Rev. 1/2007 *This card replaces former member ID cards for both FFS Medicaid and PeachCare for Kids Plans.*

Rev. 7/2005
Rev. 1/2007





Note: Providers are required to verify member eligibility prior to rendering service before each visit.

APPENDIX B

PSYCHOLOGICAL AND THERAPY SERVICES PROCEDURE CODES AND RATES

90791: Psychiatric Diagnostic Evaluation ($128.24)

96130: Psychological testing evaluation ($100.88)

96131: Psychological testing evaluation (each additional 1 hour) ($76.71)

96132: Neuropsychological testing evaluation ($113.32)

96133: Neuropsychological testing evaluation (each additional 1 hour) ($86.45)

96136: Psychological or neuropsychological test administration ($40.59)

96137: Psychological or neuropsychological test administration (additional 30 min) ($37.51)

90832: Individual Psychotherapy (30 minutes)($53.22)

90834: Individual Psychotherapy (45 minutes)($68.44)

90837: Individual Psychotherapy (60 minutes) ($111.16)

90853: Group Psychotherapy ($28.92)

96156: Health behavior assessment, or re-assessment ($84.57)

96158: Health behavior intervention, individual ($57.70)

96159: Health behavior intervention, individual ($20.15)

96164: Health behavior intervention, group ($8.55)

96165: Health behavior intervention, group ($3.97)

96167: Health behavior intervention, family ($61.98)

96168: Health behavior intervention, family ($21.98)

.

APPENDIX C

Alliant Health Solutions

Prior Authorization Department
P.O. Box 105329
Atlanta, GA 30348
www.mmis.georgia.gov

PH 800-766-4456
FAX 678-527-3003
FAX 877-393-8226

Requests may be submitted via the above web address

MEDICAID REQUEST FOR OFFICE/OUTPATIENT PSYCHOTHERAPY SERVICES-Under Age 21

MEDICAID No. **NAME** **M/F DOB**____________________________

PROVIDER NAME___________________________________**PROVIDER MEDICAID ID No.**___________________

PROVIDER PHONE No. ___________________**EXT.** _______ **PROVIDER FAX No.**________________________

PLACE OF SERVICE:______Office ___________________ PHP/Day Treatment ______________________

Is this recipient receiving care under a DHR program? ____

1. Initial Presenting Problem ____

____

____

IQ (estimated)________Initial GAF Score______Highest GAF in past 12-18 months_______Date Treatment initiated ____________

Previous hospitalizations, treatment, or testing (hours) ____

____

2. Date of request and codes requested (96130, 96131, 96132,96133, 96136, 96137, 90832, 90834, 90837, 90853).

____

3. Frequency and length of each code session____

4. Progress to Date, Including Compliance ____

____

____

5. Current Clinical and Anticipated Goals for Additional Hours ___________________________

____

____

6. Complete Check List ______ **Current GAF Score (Required)**

___ 1. Currently Suicidal	___ 7. Physically Self-Destructive	_ 13. Substance Abuse
___ 2. Suicidal by History	___ 8. Specialized School Placement	___ 14. Psychotic

___ 3. Homicidal

___ 4. Sexually Aggressive

___ 5. Physically Aggressive

___ 6. Legal Issues

___ 9. Foster Home

___ 10. Multiple Foster Homes

___ 11. Severe Somatization

___ 12. History of Significant Psychological Trauma

___ 15. Serious Runaway Behavior

7. Medications____

Axis I ______________________________ Axis II ______________________________

Axis III ______________________________ Axis IV ______________________________

8. Enclose Psychological/Psychiatric Evaluations if Pertinent (optional)

Provider's Personal Signature______________________________ **Date** ________________

APPENDIX D

Georgia Families

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 three 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 three 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	

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 three CMOs are State-wide.**

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

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

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**
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

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 GAINWELL TECHNOLOGIES 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. GAINWELL TECHNOLOGIES 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 GAINWELL TECHNOLOGIES in error:
GAINWELL TECHNOLOGIES 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 are 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 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 GAINWELL TECHNOLOGIES in error:
GAINWELL TECHNOLOGIES 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
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 on Friday (except when a holiday falls on Friday, then mailed the next business day)	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.

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan
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.

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
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 the 24th day of the month are effective for the first of the following 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.

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.

Amerigroup Community Care	CareSource	Peach State Health Plan

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

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

Health Plan	PBM	BIN #	PCN #	GROUP #	Helpdesk
Amerigroup Community Care	IngenioRx	020107	HL	WKJA	1-833-235-2031
CareSource	Express Scripts (ESI)	003858	MA	RXINN01	1-800-416-3630
Peach State Health Plan	CVS	004336	MCAIDADV	RX5439	1-844-297-0513

If a patient does not have an identification card:
Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL TECHNOLOGIES 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
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes

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
1 (800) 454-3730	1 (855) 202-1058 1(866) 930-0019 (fax)	1 (866) 399-0929

APPENDIX E

PROVIDER CONTACT
www.mmis.georgia.gov

Member/Provider Correspondence
Gainwell Technologies Services
P.O. Box 105200
Tucker, GA 30085-5200

Prior Authorization & Pre-Certification
Alliant Health Solutions
P.O. Box 105329
Atlanta, GA 30348

Electronic Data Exchange (EDI)
877-261-8785
- Asynchronous
- Web Portal
- Physical Media
- Network Data Mover
- Systems Network Architecture
- Protocol (TCP/IP)

Numbers:

Provider Contact Center
Phone: 800-766-4456 (Toll Free)
Fax: 1 866 483-1044 and 1045

Member Contact Center
Phone: 866-211-0950 (Toll Free)

STATEMENT OF PARTICIPATION

The new Statement of Participation is available in the Provider Enrollment Application Package. Written request for copies should be forwarded to:

Provider Enrollment Access on-line at www.MMIS.georgia.gov

OR

Phone your request to 800-766-4456