

PART II

**POLICIES AND PROCEDURES
FOR
PSYCHOLOGICAL SERVICES**



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID
July 1, 2019

Policy Revisions Record
Part II policies and Procedures Manual for Psychological Services

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added D=Deleted M=Modified	(Revision required by Regulation, Legislation, etc.)
01/01/2017	N/A	No revisions for this quarter		
04/01/2017	Appendix D	Georgia Families update	M	NA
07/01/2017		No revisions for this quarter		
10/01/2017		No revisions for this quarter		
01/01/2018		No revisions for this quarter		
04/01/2018		No revisions for this quarter		
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10/01/2018	Appendix D	Georgia Families update	M	NA
01/01/2019	Section 802	802. Covered Services Psychological services are covered only for members under twenty-one years of age. Reimbursement for psychological 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 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 counts as one unit. CPT 96101 was deleted on 01/01/2019. 802.1 Psychological	A, D, M	CMS
01/01/2019	Appendix B	Codes and Rates	A	NA
04/01/2019		No Revisions for this Quarter		
07/01/2019		No Revisions for this Quarter		

**PART II - POLICIES AND PROCEDURES
FOR
PSYCHOLOGICAL 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 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 must:

601.1 Hold a current and valid license as a Psychologist, 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 or under direct supervision of the enrolled Psychologist. Direct supervision applies only to the salaried employees of the enrolled Psychologist, such as technicians, an 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 Psychologist does not mean the Psychologist must be present in the same room; however, the Psychologist 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.

The Division of Medicaid, effective July 1, 1997, does not directly reimburse psychological and psychiatric services rendered to individuals enrolled in the Psychiatric Residential Treatment Facility (PRTF).

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.

601.5 Have a private practice which meets the following criteria:

a. Services rendered are the responsibility of the Psychologist, free of

Psychology Services

any administrative or professional control of an employer such as a physician, institution, agency, etc.

- b. The persons treated are the Psychologist's own patients; and
- c. The Psychologist has the right to bill directly for, collect and retain payment for services.

NOTE: Notwithstanding the provisions of 601.5, medically necessary psychological 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.4/03 Psychological services are available only to members who are under the age of twenty-one.

PART II - CHAPTER 800 SCOPE OF SERVICES

801. General

Psychological 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

Psychological services are covered only for members under twenty-one years of age. Reimbursement for psychological 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 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 counts as one unit. CPT 96101 was deleted on 01/01/2019.

802.1 Psychological Testing

Rev. 01/06

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 96130, 96131, 96132, 96133, 96133 and 96137 (Testing Evaluation Services) can only be billed and reimbursed by the enrolled Psychologist (category of service (COS) 570).

802.2 90832 Individual Psychotherapy

Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with thirty minutes face-to-face 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. Beginning August 1, 2013 Services are limited to one unit per date of service, per member and can only be provided by the enrolled Psychologist.

90834 Individual Psychotherapy

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.

90837 Individual Psychotherapy

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

802.3 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 four (4) units per date of service, per member and can only be provided by the enrolled Psychologist.

802.3.1 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.

802.3.2 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 7/12b) 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 services (21 years of age and over) see Physicians Services (COS 430);
- i) Psychological 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's office;
- 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. 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 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 provide assistance 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 or by mail 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. The form may be photocopied. Please submit to completed form(s) to:

Alliant Health Solutions
Prior Authorization and Pre-certification
P.O. Box 105329
Atlanta, Georgia 30348
www.mmis.georgia.gov

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 Psychology Services

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 July 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 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 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 eligibles.

APPENDIX A

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

Rev. 01/2007

This card replaces former member ID cards for both FFS Medicaid and PeachCare for Kids Plans.

Rev. 07/2005

Rev. 01/2007

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Member ID #: 123456789012
Member: Joe Q Public
Card Issuance Date: 12/01/02

Primary Care Physician:
Dr. Jane Q Public
285 Main Street
Suite 2859
Atlanta, GA 30303
Phone: (123) 123-1234 X1234

Plan: Georgia Better Health Care

After Hours: (123) 123-1234 X1234

Verify eligibility at www.mmis.georgia.gov

300 OERSTED

If member is enrolled in a managed care plan, contact that plan for specific claim filing and prior authorization information.

Payor: For Non-Managed Care Members
Customer Service: 1-800-766-4456 (Toll Free)

HP Enterprise Services	SXC, Inc.	Mail RX Drug Claims to:
Member: Box 105200	Rx BIN-001553	SXC Health Solutions, Inc.
Provider: Box 105201	Rx PCN-GAM	P.O. Box 3214
Tucker, GA 30085	SXC Rx Prior Auth	Lisle, IL 60532-8214
Prior Authorization: GMCF	1-866-525-5827	Rx Provider Help Line
1455 Lincoln Parkway, Suite 800		1-866-525-5826
Atlanta, GA 30346		

HP75 This card is for identification purposes only, and does not automatically guarantee eligibility for benefits and is non-transferable.

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

APPENDIX B

PSYCHOLOGICAL SERVICES PROCEDURE CODES AND RATES

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)

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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 |

Psychology Services

- | | | |
|------------------------------|---|----------------------------------|
| ___ 3. Homicidal | ___ 9. Foster Home | |
| ___ 4. Sexually Aggressive | ___ 10. Multiple Foster Homes | ___ 15. Serious Runaway Behavior |
| ___ 5. Physically Aggressive | ___ 11. Severe Somatization | |
| ___ 6. Legal Issues | ___ 12. History of Significant Psychological Trauma | |

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 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 on Friday (except	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for <u>clean</u> claims that have been adjudicated. <u>Pharmacy:</u> 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

when a holiday falls on Friday, then mailed the next business day)			
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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 24 th 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 24 th 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
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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_cvY0ohqT2VXYod	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	US Script (PBM) 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 E

PROVIDER CONTACT

www.mmis.georgia.gov

Provider Correspondence

DXC Enterprise Services
P.O. Box 105200
Tucker, GA 30085-5200

Provider Enrollment

DXC Enterprise Services
P. O. Box 105201
Tucker, GA 30085-5201

Provider Claims Submission

DXC Enterprise Services
P.O. Box 105202
Tucker, GA 30085-5202

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:

DXC Enterprise Services
Provider Enrollment Unit
P. O. Box 105201

Tucker, GA 30085-5201

OR

Phone your request to: 800-766-4456