PART III

POLICIES AND PROCEDURES

FOR

SUPPORT COORDINATION SERVICES
AND
INTENSIVE SUPPORT COORDINATION SERVICES
(COMP & NOW Waiver Programs)



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAL ASSISTANCE

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Part III, Policies and Procedures Manual
For
Support Coordination Services
And
Intensive Support Coordination Services

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PART III - POLICIES AND PROCEDURES
FOR
Support Coordination and Intensive Support Coordination Services (COMP & NOW Waiver Programs)

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This manual is to be used with the Department of Behavioral Health and Developmental Disabilities OPERATING PRINCIPLES FOR SUPPORT COORDINATION & INTENSIVE SUPPORT COORDINATION, found at: https://gadbhdd.policystat.com/
for supplemental information and standards.

PART III - CHAPTER 600

SPECIFIC PROGRAM REQUIREMENTS FOR SUPPORT COORDINATION SERVICES

SCOPE OF SERVICES

This chapter 600, Part III of the New Options Waiver and the Comprehensive Supports Waiver Programs replaces Chapter 2800 in the NOW Waiver Policy, Part III and Chapter 2900 in the COMP Waiver Policy, Part III.

600 General

Rev 01 2020

Support Coordination services are a set of interrelated activities for identifying, coordinating, and overseeing the delivery of services to enhance the health, safety and general wellbeing of waiver individuals within the context of the person's goal(s) toward maximum independence. Support Coordination services include the following:

1. **Facilitating the Service Planning Process and Individual Service Plan Development**

2. **Coordinating Waiver Services**

3. **Coordinating Non-Waiver Services, Community Engagement and Resource Development**

4. **Evaluating the Quality and Outcome of Services and Identifying Unmet Needs**

5. **Assessment and Evaluation Related Tasks**

601 Special Requirements of Participation

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the COMP Program, Support Coordination Services agency providers must meet the following requirements:

Agency Experience

Provider agencies rendering Support Coordination services must:

1. Have at minimum five (5) years' experience in providing home and community-based case management services for individuals with disabilities or similar HCBS populations, and demonstrate success in supporting individuals in community inclusion and person-centered planning;

2. Have established or will establish working relationships with local community and advocacy groups, experience advocating for individuals in the community, and preparing individuals for self-advocacy;

3. Have experience and demonstrated success with outcome-based planning, and developing plans based on the individual's goal(s), choices and direction;

4. Have experience with measuring quality of services and satisfaction with services, ensuring that the services that are provided are consistent with quality measures and expectations of the individual;

5. Demonstrate experience in serving diverse cultural and socioeconomic populations.

6. Assure compliance with the conflict-free case management requirement outlined in the 2014 HCBS Rule.

Rev 01 2017

As a care management entity, you are required to adhere to the following characteristics of conflict-free case management:

- ***Separation of case management from direct services***: Structurally or operationally, care coordinators should not be employees of any organization that provides direct services to the individuals. Ideally, conflict-free case management agencies are stand-alone and provide **no** other direct services. This prevents financial pressure for care coordinators to make referrals to their own organization or "trade" referrals.

- ***Separation of eligibility determination from direct services***: Eligibility for services is established separately from the provision of services so assessors do not feel pressure to make individuals eligible to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the individual. In our system, this occurs through the level-of-care determination process.

- ***Case managers do not establish funding levels for the individual:*** In the Georgia model, the care coordinator/manager's responsibility is to develop a recommended plan of supports and services based on the individual's assessed needs. Ultimately, DCH staff and its agencies will determine whether the care plan is medically necessary.

- ***Individuals performing evaluations, assessments and plans of care cannot be*** related by blood or marriage to the individual or any of the individual's paid caregivers, or financially responsible for the individual.

602 Staff Qualifications and Responsibilities

Rev 07 2016

Provider agencies rendering Support Coordination Services must have staffing the meets the following requirements:

1. One individual may perform one or more of the following functions for the agency.

A designated agency director: responsible for management oversight of the agency with the following qualifications:

A bachelor's degree and five (5) years of experience in service delivery to persons with developmental disabilities, with at least two (2) of the years serving in a supervisory capacity.

Duties of the Agency Director include, but are not limited to:

a. Oversees the day-to-day operation of the agency;

b. Manages the use of agency funds;

c. Ensures the development and updating of required policies of the agency;

d. Manages the employment of staff for the agency; and

e. Designates another agency staff member to oversee the agency, in his or her absence.

2. At least one employee with the agency must:

    a. Have responsibility for overseeing the quality of Support Coordination Services to individuals.
    b. Be a Developmental Disability Professional (DDP)

3. Have a sufficient number of supervisory staff to train, support and supervise Support Coordinators.

4. Have a sufficient number of quality assurance staff to review a sample of ISPs for quality and outcome indicators and to provide oversight to Support Coordinators in instances where health and safety risks are identified for individuals in effort to improve health outcomes.

5. The agency must have an adequate number of Support Coordinators to meet the needs of the assigned individuals. Support Coordinators provide the covered services in Section 603 at a minimum. The agency is responsible for documenting support coordinator's qualifications and maintaining that documentation in individual personnel files prior to provision of waiver services. Support Coordinators must meet the following qualifications:

    a. Be at least 21 years of age;

    b. Have a minimum of a bachelor's degree in a human service field, such as social work, psychology, special education, nursing, or closely related field.

    c. Have at least one year of experience in serving persons with Intellectual and Developmental Disabilities (I/DD) or related disabilities in a case management or coordination role;

6. Have for each DBHDD region served a designated on-call system which:

    a. Provides liaison assistance to the DBHDD Field Office 24 hours a day, 7 days a week.
    b. Provides emergency assistance as directed by the DBHDD Field Office in coordination of services and supports
    c. Provides supervision to support coordinators while on call

7. Must have a current Organization Chart showing lines of authority and responsibility for all staff within the agency and includes position descriptions for all staff.

603 Covered Services

Rev 10 2019 Reimbursable Support Coordination Services include the following based on the assessed need of the individual and as specified in the approved ISP:

1. Facilitating the Service Planning Process and Individual Service Plan Development
    a. Utilizing person-centered planning in all areas to include pre-meetings with individual, their selected support network, and service providers for development of the annual Individual Service Plan (ISP) to respond to the assessed needs of the individual.

2. Coordinating Waiver Services
    a. Assisting the individual with choice of service provider agencies to deliver the services and supports and achieve goal(s) identified by the individual in the ISP. This includes arranging and attending meetings, as necessary, to coordinate with other providers and/or community organizations.
    b. Consistently inquiring about satisfaction with service providers and offering choice of other service providers upon request.

3. Coordinating Non-Waiver Services, Community Engagement and Resource Development
    a. Participating in activities and gather information that help link eligible individuals with medical, social, and/or educational providers or other programs and services that can provide needed services to address identified needs and to achieve goal(s) specified in the ISP.

Rev 10 2019

4. Evaluating the Quality and Outcome of Services and Identifying Unmet Needs
    a. Contacting individuals and any authorized representative as needed to address any identified health and safety

risks and progress toward personal goal(s).

b. Referral for additional or different services, request for clinical validation of a change in need, and follow-up activities.
c. Monitoring of the health and welfare of the individual, through direct observation, review of documents, and follow up to ensure that service plans have the intended effect and that approaches to address challenging behaviors, medical and health needs, and skill acquisition are coordinated in their approach and anticipated outcome

5. Assessment and Evaluation Related Tasks
   a. Submit requests for completion of a new Supports Intensity Scale (SIS) assessment, as needed, based on notable changes in support needs,
   b. Review the Health Risk Screening Tool (HRST), including all service considerations, clinical considerations, and training recommendations, in order to incorporate assessed needs into service and support planning.

Rev 10 2019

   c. Review all healthcare plans, Positive Behavior Support Plans (PBSPs), crisis plans and safety plans, including a review of tracking documentation maintained by providers to determine if it meets standards.
   d. Complete the annual DMA-7 level to facilitate level of care re-evaluation for each individual.

604 Non-Covered Services

1. Support Coordinators cannot provide other direct waiver services, including Community Guide Services, to any waiver individual.

2. Payment is not made, directly or indirectly, to members of the individual's immediate family.

3. Services provided to individuals during full-month periods of institutionalization may not be billed unless specified as transition coordination. Discharge planning during periods of institutionalization must continue in order to safely and effectively transition individuals from institutions back into community settings.

4. The provision of services to enrolled individuals in Institution for Mental Diseases (IMD) units.

5. Services that duplicate case management services provided to an eligible individual through a Targeted Case Management Program as prohibited by Medicaid.

6. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

605 Individual Service Plan Requirements

Rev 07 2016

1. It is a requirement that each waiver individual to have an Individualized Service Plan (ISP) written on the document specified by DBHDD Division of DD. The plan is to be developed by a planning team of appropriate persons to include, but not be limited to, the individual, the Support Coordinator, and the individual's parent, guardian or other natural support representative.

2. This plan, developed based on assessed needs identified through the Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST), clinical assessments, and additional documents as needed, identifies the individual's outcomes and planning goal(s) and describes the services and supports needed to assist the individual in attaining the goal(s) and outcomes identified in the plan.

3. An approved ISP authorizes the provision of safe, secure, and dependable support and assistance in areas that are necessary to promote achievement of full social inclusion, independence, and personal and economic well-being for the individual.

606 Documentation Requirement

Rev 10 2019
Rev 01 2020

Support Coordination documentation should reflect the course of services/supports in a person-centered manner to, including risks identified and efforts made to mitigate risks, the individual's interests, outcomes for the individual, barriers that presented and efforts to resolve barriers. It is used to communicate between agencies contributing to the individual's support.

All documentation must be HIPAA compliant. Support notes are a part of the individual's record and available for open records requests and for use in any litigation or appeals as the legal record.

Information gathered during any contact with the individual or ancillary informants must be documented. The ISP must be revised (ISP Version Change) as necessary to include changes in the individual's support needs, services and goal(s).

Support Coordination Documentation is captured through the following methods:

1. Demographic Information Update

Contact must be made with the individual's next-of-kin, family member or other informal supporter annually at a minimum.

All contacts added to the online case management system must be accompanied by a current release of information form, signed by the individual or authorized legal representative.

If the individual has a legal guardian, the guardian must verify all contact information annually at a minimum and the support coordinator indicates guardianship status on the online case management system demographic page. If any changes are necessary to the guardianship status or guardian information, e.g. change of guardian, the support coordinator uploads the following documents to the individual's electronic file:

- Letter of guardianship, and
- Copy of the probate court order appointing the guardian and specifying what powers have been removed from the individual.

1. Individual Quality Outcome Measures Review

2. Support Coordinators will evaluate outcomes for all waiver recipients through use of the *Individual Quality Outcome Measures Review*. This review will be completed at a minimum of quarterly for all waiver individuals, based on a face-to-face visit.

3. Referral Follow Up Tracking

4. Any contacts made, information received, or actions taken in reference to an identified concern must be documented within *Referral Follow Up Tracking* in the online case management system, such that a chronological record of these activities is held within the same section of the individual's record.

5. Support Notes

A Support Note must be entered at minimum monthly documenting contact in the online case management system, based on either a successful face-to-face visit or a successful ancillary contact.

Support Notes are to be entered into the online case management system for all contacts made on behalf of the individual, including:

- Face to face visits with the individual that occurred outside the quarterly IQOMR requirement
- Face to face visits with the individual's natural supports, the individual's provider agency (if the individual was discussed)
- Phone calls to the individual, the individual's natural supports, the individual's provider agency (if the individual was discussed)
- Emails with the individual, the individual's natural supports, the individual's provider agency (if the individual was discussed)
- Research conducted or contacts made to seek resources for the individual
- Contact made to the DBHDD Field Office or Central Office about the individual

6. Individual 360: Health and Wellness

The online case management system includes a module dedicated to individual specific health, safety and wellness information. Information from the HRST, SIS and additional clinical assessments populates sections of the Health and Wellness tab. Support Coordinators are to add key information in absence of or in addition to an updated HRST or HRST Nursing Assessment.

607 Quality Outcome Evaluation – Recognize, Refer and Act

Rev 10 2019

The Recognize, Refer, and Act Model is based on the interaction of case management skills involved in recognizing unmet needs and impending risks and responding by either providing coaching, making referrals to an appropriate party, or directly linking or advocating on behalf of the individual to obtain the most appropriate resources.

A primary goal of the Recognize, Refer and Act Model is to encourage a collaborative relationship between the Support Coordinator, provider agency staff, natural supports and DBHDD staff. This collaboration serves as a pathway to effectively identify any unmet needs for the waiver individual, work together to reduce or eliminate any associated risks, and ultimately achieve the best outcomes for the waiver individual. The Quality Outcome Measures Review document, included as Appendix F, facilitates the implementation of the Recognize, Refer and Act model by prompting recognition through a series of questions and providing information about referral and intervention strategies.

608 Prior Approval

Rev 10 2016
Rev 01 2020

Support Coordination Services must be authorized prior to service delivery by the applicable DBHDD Field Office at least annually in conjunction with the Individual Service Plan development and with any ISP Version Change(s).

609 Basis for Reimbursement

Rev 01 2020

Reimbursement is based on a monthly unit of service. A unit of service is individually defined for each member in their Individualized Service Plan. A minimum unit must include contacts made based on the frequency requirements and documentation completed based on guidelines indicated in Section 606. Some ISP's may dictate that a member must be seen at a higher frequency. The provider must bill only for the months of service during which the specified contacts and documentation are delivered.

The rate of reimbursement for a unit of service is a flat fee of $152.88 per month with a limit of 12 units per year per member ($1,834.56 annual maximum).

Support Coordination – T2022	$152.88 per member per month

PART III - CHAPTER 700

SPECIFIC PROGRAM REQUIREMENTS FOR INTENSIVE SUPPORT COORDINATION SERVICES

SCOPE OF SERVICES

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700. General

Rev 01 2020

Intensive Support Coordination is a waiver service that includes all of the activities of Case Management Support Coordination but the activities reflect specialized coordination of waiver, medical and behavioral support services on behalf of waiver individuals with exceptional medical and/or behavioral needs**.** The need for Intensive Support Coordination is determined at initial and annual assessments and is provided as an alternative to traditional Support Coordination. Intensive Support Coordinators assist waiver individuals with complex needs through: identifying and addressing barriers to care; accessing needed resources and services offered through the waiver as well as the larger healthcare system; taking active measures to address complex needs; and fostering and maintaining family and other informal relationships and support.

The provision of intensive support coordination requires advanced training, knowledge and skills required to address the severity of medical, behavioral and related needs that present in the management of physical and behavioral health, as well as interventions and activities that foster prevention of health deterioration and prevention of exacerbation of medical/behavioral conditions.

Documentation must support the presence of continued need with the expectation that Intensive Support Coordinators will work closely with physicians, other healthcare providers, and waiver service providers in the management of complex conditions. The condition must support frequent and enhanced level of monitoring, intervention and follow-up which is described and clearly documented. The need for Intensive Support Coordination is determined at the initial assessment, change in condition, and annual review. Intensive Support Coordination services may be provided to individuals scheduled for transition from institutions for a period of sixty (60) to ninety (90) days prior to the discharge date; however, community-based claims will not be submitted for reimbursement until after the waiver individual has been transitioned to the community.

For maintenance of provider eligibility, providers must meet conditions established by Department of Human Services, Department of Behavioral Health and Developmental Disabilities and contained in the DBHDD Provider Manual as well as all conditions specified in the contract with the DBHDD.

701. Member Eligibility

Services are targeted for Medicaid eligible members who have a intellectual or developmental disability and who currently receive or are on the short-term planning list to receive community-based services through the State of Georgia, DHS, and DBHDD.

The following criteria must be met for admission to service:

1. The member is a categorically eligible recipient of Medicaid and

2. The member meets the requirements for the DBHDD Most-In-Need status, and

3. The member has a diagnosis of intellectual disability and/or developmental disability; and

4. Two or more of the following:

   a. The member is currently receiving services that are financially supported by the Department of Human Services, Department of Behavioral Health and Developmental Disabilities (DBHDD)

   b. The member has multiple needs as documented in the intake and assessment process and requires coordination of those multiple needs

   c. The member has a lack of or inadequate level of natural supports as documented in the intake and assessment process

   d. The member is currently placed on the DBHDD planning list awaiting services

Rev 10 2016

5. Evidence substantiating the need for Intensive Support Coordination is found based on one of the following:

   a. Member has a Health Risk Screening Tool (HRST) HCL score of 5 or 6; **or**
   b. Member has a Supports Intensity Scale rating of 16 to 26 in the Exceptional Medical Support Needs or Exceptional Behavioral Support Needs section; **or**
   c. Member has transitioned from a state hospital into the community since July 1, 2010; **or**
   d. Member is on the active list to transition from an institutional setting into a community residence (mandatory enrollment upon transition); **or**

e. Member has been admitted to a crisis respite home and is not otherwise eligible for the service. Intensive Support Coordination is to be provided from time of crisis admission until 30 days following discharge to the community or

Rev 07 2018

f. Member met at least one of the preceding criteria within the past year or is determined through assessment to be stabilizing and continues to require oversight to prevent further deterioration in condition.

702 Special Requirements of Participation

Rev 01 2020

An Intensive Support Coordination Agency is selected through the enrollment process described in *Part II Chapters 600 – 1200 Policies and Procedures for Comprehensive Supports Waiver Program (COMP), and New Options Waiver Program (NOW), Sections 602, 603 and 604.* Enrolled members and their Families will be able to choose any provider authorized to provide Intensive Support Coordination in Georgia if the provider agrees to provide services in the region in which the consumer lives and has the clinical expertise to meet the specific needs of the individual. The provider must meet the conditions established by the Department of Community Health as outlined in The Policy and Procedures Manual Part I, Part II cited above, and the Provider Manuals for Community Developmental Disabilities Providers found via policy #02-1201 at https://gadbhdd.policystat.com/.

In addition to the general provider enrollment criteria outlined in Part II, Comprehensive Waiver Program (COMP) and New Options Waiver Program (NOW), the Intensive Support Coordination provider agency must meet the following enrollment criteria specific to the provision of Intensive Support Coordination.

1. A minimum of five (5) years of experience in:

   a. the health care, behavioral health or case management field;

   b. providing home and community-based case management services for individuals with disabilities or similar HCBS populations, and demonstrate success in supporting individuals in community inclusion and person centered planning;

   c. serving individuals at risk due to medical, functional, and/or behaviorally complex conditions;

2. Have established or will establish working relationships with local community and advocacy groups, experience advocating for individuals in the community, and preparing individuals for self-advocacy;

3. Have experience and demonstrated success with outcome based planning, and developing plans based on the individual's person centered goal(s), choices and direction;
4. Have experience with measuring quality and satisfaction with services, ensuring

that the services that are provided are consistent with quality measures and expectations of the individual;

5. Demonstrate experience in serving diverse cultural and socioeconomic populations.

6. The applicant agency must assure compliance with conflict free case management as outlined in 42 CFR §441.301(b) (1).

7. Meets all DBHDD provider requirements as specified either through DBHDD contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DBHDD.

8. If licensed, the agency will maintain their license as applicable in home health, private homecare, neurobehavioral center, or other. If out-of-state, must provide a letter of recommendation from current oversight agency along with the last audit/review.

Rev 04 2018

9. The provider must have access to a Medical/Clinical Director (MD or Psychologist), with consultation expertise for both Medical and Behavioral Intensive Support Coordination available. The Medical/Clinical Director need not be an employee of the agency or on retainer with the agency but the nature of the business relationship should be outlined in any type of written agreement, including but not limited to a contract, a memorandum of understanding, a letter of agreement, etc. as long as terms are clearly defined.

10. Proof of licensure is required for Intensive Support Coordination Clinical Supervisors in the designated specialty area.

Payment for Intensive Support Coordination services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Rev 01 2017

National accreditation is preferred, as indicated in *COMP Part II Medicaid Policy Manual*, or other national accrediting body relevant to the provision of case management or coordination of services.

As a care management entity, you are required to adhere to the following characteristics of conflict-free case management:

- ***Separation of case management from direct services***: Structurally or operationally, care coordinators should not be employees of any organization that provides direct services to the individuals. Ideally, conflict-free case management agencies are stand-alone and provide **no** other direct services. This prevents financial pressure for support coordinators to make referrals to their own organization or "trade" referrals.

- ***Separation of eligibility determination from direct services***: Eligibility for services is established separately from the provision of services so assessors do not feel pressure to make individuals eligible to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the individual. In the NOW and COMP Waiver Programs, this occurs through the level-of-care determination process.
- ***Case managers do not establish funding levels for the individual:*** In the Georgia model, the care coordinator/manager's responsibility is to develop a recommended plan of supports and services based on the individual's assessed needs. Ultimately, DCH staff and its agencies will determine whether the care plan is medically necessary.
- ***Individuals performing evaluations, assessments and plans of care cannot be related by blood or marriage to the individual or any of the individual's paid caregivers, or financially responsible for the individual.***

703 Staff Qualifications and Responsibilities

In addition to the base requirements for Support Coordination Services, Intensive Support Coordination in Section 602, the following staff qualifications and patterns represent requirements specific to Intensive Support Coordination Services:

- **Medical/Clinical Director:**
  The provider must have access to a Medical/Clinical Director (MD, Licensed Nurse Practitioner or Licensed Psychologist), with consultation expertise for both Medical and Behavioral Intensive Support Coordination available. The Medical/Clinical Director need not be an employee of the agency or on retainer with the agency but the nature of the business relationship should be outlined in any type of written agreement, including but not limited to a contract, a memorandum of understanding, a letter of agreement, etc. as long as terms are clearly defined.

Rev 04 2018

Roles of the Medical/Clinical Director:

- **Episodic Clinical Conferences:**

Rev 04 2018

The Medical/Clinical Director assuming a consultative relationship will participate in case conferences on behalf of intensive support coordination individuals as requested by the intensive support coordination agency. Case conferences are held to discuss individuals in any of the following situations:

  - Those identified at high risk of or experiencing health or behavioral decline, particularly in the case of sudden onset when communication with the individual's primary care provider has been delayed or challenging.
  - Individuals with unique clinical challenges who require interpretation of medical or behavioral findings, treatment plans or follow up needs to assist providers, intensive support coordinators and other stakeholders in assisting with compliance.
  - Individuals who may require additional referrals, coordination of healthcare or behavioral healthcare services, or communication with the larger healthcare system.

- **Clinical Consultation for Hospitalizations:**

The admission of I/DD individuals to acute care medical facilities has, at times resulted in premature requests for end of life planning, or discharge without the proper supports. The DD primary care physicians and psychiatrist assigned to regional hospitals are reservoirs of clinical experience from which expertise could be drawn and shared with community clinicians now charged with treating DD individuals in acute care medical centers. The ISC Medical/Clinical Director will coordinate consultative clinical coverage with surrounding regional physicians.

Intensive Support Coordination Clinical Supervisor:
Intensive support coordination agencies will employ at least one Clinical Supervisor in each specialty. Specialized Clinical Supervisors will provide technical assistance and support to any intensive support coordinator as needed regardless of direct supervision assignment.

ISC-Medical Clinical Supervisor:

- Registered Nurse, physical or occupational therapist, physician assistant, or other mid-level healthcare provider
- Minimum of 2 years' experience in acute care, ICF/ID long term care, or medical rehabilitation.
- Must have at minimum three (3) years' experience providing home and community-based case management services for individuals with disabilities or other related disabilities.

Rev 01 2021

ISC-Behavioral Clinical Supervisor:

Must be one of the following: Board Certified Behavior Analyst, Psychologist, Licensed Professional Counselor, Licensed Associate Professional Counselor, Licensed Clinical Social Worker, Licensed Master Social Worker, Licensed Marriage and Family Therapist or a Registered Nurse.

- Must have a minimum of 2 years professional experience with individuals with complex behavioral issues in a behavioral health setting related to individuals with ID/DD (i.e. ICF/IDD, psychiatric inpatient hospital/facility, specialty clinics, or other rehabilitation/habilitation settings.
- Must have at minimum three (3) years' experience providing home and community-based case management services for individuals with disabilities or other related disabilities.

Continuing Education:

- Thirty (30) hours of continuing education in supervision and support coordination topics will be required annually, with record of continuing education maintained by the agency.

Developmental Disabilities Professional

At least one employee with the agency must:

1. Be a Developmental Disability Professional (DDP
   Duties of the DDP include, but are not limited to:

   a. Overseeing the Intensive Support Coordination services provided to individuals;
   b. Document and report on any identified health and safety issues for individual; and
   c. Providing training and support to intensive support coordinators.

3. Have sufficient number of supervisory staff whose duties include, but are not limited to, training, support, and supervision of intensive support coordinators.

4. Have sufficient number of quality assurance staff whose duties include, but are not limited to:

a. Reviewing a 10% sample Individual Service Plans for quality and outcome indicators;
b. Providing oversight to intensive support coordinators in instances where health and safety risks are identified for individuals in effort to improve health outcomes.

Intensive Support Coordinator

Minimum bachelor's degree in human service field, such as, social work, psychology, special education, nursing, or closely related field required.

- Minimum two years of experience serving persons with DD/IDD or related disabilities and two years' experience in a healthcare, habilitative/ rehabilitative, behavioral health setting, such as ICF/IDD, psychiatric inpatient hospital/facility, specialty clinic or program, special education department, residential or similar setting required. Experience providing care management/coordination preferred.

Continuing Education:

Twenty (20) hours of continuing education in support coordination topics will be required annually, with record of continuing education maintained by the agency.

Staff Responsibilities

ISC Clinical Supervisor Responsibilities:

- Has administrative authority over a small team of Intensive Support Coordinators. Each ISC Clinical Supervisor may oversee a supervisory caseload of no more than 100 ISC individuals, served by the Intensive Support Coordinator who provides the direct oversight and coordination of services for waiver individuals.
- Act as a clinical consultant for each of the ISC Coordinators and each of the individuals served within the ISC team's caseload.
- Responsible for conducting a minimum of one annual joint visit with each ISC individual on their supervisory caseload.
- Provide ongoing consultation to determine risks and unmet needs and collaborate in identifying and securing resources.
- Follow up, either telephonically or on site, during and following acute changes in an individual's medical, behavioral or functional status. Provide continuous consultation to the ISC Coordinator following such acute changes in condition. Collaborate with the Field Office relative to additional or immediate needs.
- Actively participate in hospital transition and discharge planning.
- Maintain familiarity with nursing or behavioral health care plans developed by provider agencies to ensure that ISC Coordinators understand the purpose and evaluate the efficacy of the plans.
- Hold monthly supervisory sessions with each of the ISC Coordinators assigned to review their caseload and the level of risk of each individual served.
- Maintain availability between supervisory sessions to help Intensive Support Coordinators solve problems around key individual issues, resolve service problems, and visit individuals as part of their interdisciplinary team for clinical consultation and planning.

- Complete a review of 25% of ISC caseloads on a quarterly basis to determine if all ISC services and protocols are being followed. This review will be documented and available for review by DBHDD staff.
- Act as a resource for ISC's in navigating Medicaid State Plan/Medicare and coordinating services within the healthcare and/or behavioral services system
- Actively seek new community-based resources that ISC's can offer to their individuals
- Establish working relationships with local advocacy groups. Advocate for community inclusion of individuals with disabilities and preparing individuals for self-advocacy.
- Offer guidance to ISC Coordinators on outcome-based person-centered planning and developing plans based on the individual's assessed needs, goal(s), choices and direction.

704 Covered Services

Rev 01 2020

Intensive Support Coordination Services includes those tasks related to assessment, development of the individual service plan and documentation requirements as described in Support Coordination Services, Sections 603, 604 and 605 of this document. In additional to those requirements, Intensive Support Coordination services include:

1. Identifying and/or recruiting a primary care physician, medical or behavioral health specialists and any ancillary health professionals that are indicated.

2. Including healthcare or behavior support plans in the ISP development and follow up considerations.

3. Providing information and referrals for community services, healthcare and behavioral/psychiatric services and other supports identified in the ISP.

4. Monitoring the individual's on-going needs and quality of the services outlined in the ISP. This includes monitoring, evaluation and determining quality of additional behavioral supports or health care services.

5. Continuous evaluation of any changes in individual's health and well-being that indicate a need for intervention, including coordination of crisis services, reassessment and any subsequent revision of the ISP.

6. Aligning ISP development with annual clinical evaluations by the DBHDD Field Office, to include attending clinical evaluations, when possible, to facilitate inclusion of the clinical recommendations.

7. Conducting visits and other contacts.

- All individuals who receive waiver services in the residence, including CLS in the family or individual's home or any service delivered in a Community Residential Alternative setting, must minimally receive one face-to-face home visit.
- If the individual does not receive any waiver services in the residence, a face-to-face visit must be conducted monthly, however a visit to another location can occur in lieu of a home visit.
- All individuals must minimally receive one ancillary contact per month from their Intensive Support Coordinator in addition to the required face to face visit.
- Additional points of contact may be needed based on the following conditions:

    - Within 3 business days of a known hospitalization, any other significant condition change, a known crisis admission, family or provider emergency, or other known risk to the health and safety of an individual.
    - The interdisciplinary team determined that more contact was needed and documented an increased ancillary contact or visit frequency in the support notes.
    - Based on case consultation, joint visit with the ISC Coordinator, or contact with a healthcare provider the ISC Clinical Supervisor determined that increased ancillary contact or visit frequency is needed.

8. Assisting the DBHDD Field Office staff to move or remove a member from harm's way in a crisis or emergency.

9. Providing focused oversight to individuals admitted to crisis homes, for the purpose of supporting stabilization, identifying potential providers, coordinating discharge to a community residence and providing aftercare to promote continued stabilization in the community.

10. Coordinating the transition of specific individuals institutionalized in a nursing facility (NF) or Individuals with Intellectual Disabilities (ICF/ID)) who are targeted and funded for placement in home and community-based services within 90 days. Additionally, the Intensive Support Coordinator is responsible for engagement in discharge planning efforts for any ISC individual who is admitted to an acute care or rehabilitation facility to facilitate a safe return to the community.

705 Non-Covered Services

1. Services provided in nursing homes or prisons with the covered exception as designated in #10 listed above.

2. Separately reimbursed counseling services for individuals or family members.

3. The provision of services to enrolled members in an Institution for Mental Diseases (IMD) Units.

4. Services that duplicate case management services provided to eligible members through other Targeted Case Management Programs as prohibited by Medicaid.

706. Prior Approval

Rev 01 2020

Prior approval (PA) for Intensive Support Coordination services is authorized by the Department of Behavioral Health and Developmental Disabilities' (DBHDD) Regional Field Offices and is found on the approved ISP and PA.

707. Basis for Reimbursement

Rev 01 2020

Reimbursement is based on a monthly unit of service. A unit of service is individually defined for each member in their Individualized Service Plan. A minimum unit must include one face-to-face contact per month, but some ISP's may dictate that a member must be seen at a higher frequency. The provider must bill only for the months of service during which the specified contacts are delivered.

The rate of reimbursement for a unit of service is a flat fee of $461.00 per month with a limit of 12 units per year per member ($5,532 annual maximum). The Intensive Support Coordinator must meet and document the frequency of contacts defined in the ISP in order to bill for the services.

Intensive Supports Coordination – T2022 U1: $461.00 per member per month

The following apply to both Support Coordination Services and Intensive Support Coordination Services:

Contact Frequency

1. Minimum Ancillary Contact Requirements
    a. All SC's and ISC's are required to complete a minimum of one ancillary contact on behalf of the individual every month. This contact must be captured in a Support Note monthly, in order to bill for services.
    b. If SC or ISC visits occur at a greater frequency than required, that visit may take the place of the required ancillary contact.
2. Minimum Face-to-Face Visit Requirements
    a. At a minimum, all waiver individuals receive a quarterly face-to-face visit whereby the SC/ISC completes an Individual Quality Outcome Measures Review.
    b. In addition, the following circumstances require a SC/ISC face-to-face visit on a monthly basis whereby a comprehensive support note is entered to document the visit:
        i. For Support Coordination individuals receiving CRA services, a face-to-face visit to the residence is required monthly.
        ii. A Support Coordination visit must occur monthly to any individual who resides in a setting operated through the exclusive use of paid CLS staff (with no on-site natural supports).
        iii. For Intensive Support Coordination individuals receiving any combination of services, a minimum of one face-to-face visit to the residence is required monthly. On a quarterly basis, a face-to-face visit to the individual at another site of service can occur in lieu of a visit to the residence.
    c. A Support Coordination or Intensive Support Coordination visit to the overnight respite setting is required for any length of stay 7 calendar days or greater, during the time of out-of-home respite support. This visit must be documented in a Support Note.

For Intensive Support Coordination individual admitted to an institutional healthcare setting or crisis support home, face-to-face visits are required while in that setting. Visits and contacts occur in effort to facilitate transition coordination to a community residence.

Participant-Direction Option

Support Coordination and Intensive Support Coordination Services are required for delivery through the participant-direction option. Support Coordination and Intensive Support Coordination Services shall follow the same contact frequency schedule as traditional service provisions.

Incident Reporting Requirements: Support Coordination Providers must complete a critical incident report if it is questionable that a service provider completed the necessary report.

Fair Hearings Notification Requirements: Support Coordination Providers must require Support Coordinators to provide notification to individuals of their rights to request a Fair Hearing if there are any denials, suspensions, reductions or terminations of waiver services, as a result of Support Coordination action.

Agency Policies and Procedures: Support Coordination Providers must develop written policies and procedures to govern the operations of Support Coordination services in accordance with all requirements for these services. These policies and procedures must address how the agency assures Support Coordination services meet individual and family preferences.

DBHDD Contract/LOA and DBHDD Community Service Standards: Support Coordination Providers must adhere to DBHDD Contract/LOA, all applicable DBHDD Community Service Standards and other DBHDD Standards, including certification by the DBHDD

General Reimbursement Guidelines for Support Coordination and Intensive Support Coordination

General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

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.

The following resources are available for more information:

- Access the department's DCH-i newsletter and FAQs at http://dch.georgia.gov/publications
- Search to see if a provider is enrolled at https://www.mmis.georgia.gov/portal/default.aspx

Click on "Provider Enrollment/Provider Contract Status." Enter Provider ID or NPI and provider's last name.

CMS 1500 Claim Form

Effective May 1, 2015, the Department will only accept electronic claims. Any paper claims submitted to the fiscal agent for payment will be returned to the provider. Please refer to the Medicaid and PeachCare for Kids Part I Policies and Procedures manual, Section 112, for more information." Providers will be required to use the revised CMS 1500 claim form (version 02/12) for claims. The revised CMS 1500 form contains a number of changes. These changes include but are not limited to references to ICD-10 codes, identification of Ordering, Prescribing, and Referring providers, and the expansion of number of possible diagnosis codes on a claim.

APPENDIX A

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

Electronic Data Interchange (EDI)
1-877-261-8785

- Asynchronous
- Web portal
- Physical media
- Network Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol/ Internet Protocol (TCP/IP)

Provider Inquiry Numbers:

~ 800-766-4456 (Toll free) The web

contact address is http://www.mmis.georgia.gov

APPENDIX B

DBHDD FIELD OFFICE OF DBHDD
CONTACT LIST

DBHDD Region 1	DBHDD Region 2	DBHDD Region 3
Regional Services Administrator – DD	Regional Services Administrator – DD	Regional Services Administrator – DD
Elise Beumer	Josie Baker	Vivia Black
Elise.Beumer@dbhdd.ga.gov	Josie.Baker@dbhdd.ga.gov	Vivia.Black@dbhdd.ga.gov
1230 Bald Ridge Marina Road	3405 Mike Padgett Highway	3073 Panthersville Rd
Suite 800	Building 3	Building 10
Cumming, Georgia 30041	Augusta, Georgia 30906	Decatur, Georgia 30034
Phone: (678) 947-2818	Phone: (706) 792-7741	Phone: (404) 244-5050 or
Fax: (678) 947-2817	Fax: (706) 792-7740	Phone: (404) 244-5056
Toll Free:1 (877) 217-4462	Toll Free: 1 (877) 551-4897	Fax: (404) 414-3048

DBHDD Region 4	DBHDD Region 5	DBHDD Region 6
Regional Services Administrator – DD	Regional Services Administrator – DD	Regional Services Administrator – DD
Timothy Hester	Ramona Pullin	Valona Baldwin
Timothy.Hester@dbhdd.ga.gov	Ramona.Pullin@dbhdd.ga.gov	Valona.Baldwin@dbhdd.ga.gov
400 South Pinetree Blvd	1915 Eisenhower Dr., Building 7	3000 Shatulga Rd., Building 4
P.O. Box 1378	Savannah, GA 31406	P.O. Box 12435
Thomasville, Georgia 31799-1378	Phone: (912) 303-1649	Columbus, Georgia 31907-2435
Phone: (229) 225-5099	Fax: (912) 303-6309	Phone: (706) 565-7835
Fax: (229) 227-2918	Toll Free: 1 (800) 348-3503	Fax: (706) 565-3565
Toll Free: 1 (877) 683-8557		Toll Free: 1 (877) 565-8040

APPENDIX C

Georgia Families

Rev 07 2017

Rev 10 2018

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:

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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 heal
th 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):

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Georgia Families

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

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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	Inter-conceptional 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

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Georgia Families

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

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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/ Georgia Medicaid	866-874-0633 (general information)	866-231-1821 www.wellcare.com

Georgia Families

		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 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

Georgia Families

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 when a holiday falls on Friday, then	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

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 the 24th day of the month are effective for the first of the following month.	PCP changes made between the 1st and 10th of the month will go into effect right away. Changes made after the 10th of the month will take effect at the beginning of the next month

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Georgia Families

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	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:

APPENDIX C

Georgia Families

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 D

Rev.
04/01/14

Limitations on Billing of Case Management

Definition

Case Management Services means services which will assist Medicaid eligible individuals to gain access to needed medical, social, educational and other services. Such services include but are not limited to, the following:

- Assessment of eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical educational, social or other services.
- Development of a specific care plan based on the information collected through assessment; that specifies the goal(s) and actions to address the medical, social, educational and other services needed by eligible individuals.
- Referral and related activities to help and individual obtain needed services.
- Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the individual.

Duplication of Case Management Services

Federal policy and the Department of Community Health (DCH) prohibit the reimbursement for case management services to more than one agency or Medicaid provider that renders case management services to an individual. This policy is set forth according the federal Requirements and Limits Applicable to Specific Services defined in the State Medicaid Manual, section 4302.

It is the responsibility of the case manager to ensure that the member is not receiving case management services from any other agency. The case manager must obtain from the member information regarding any and all other services that he/she may be receiving prior to enrolling the member in a case management program. If the case manager should learn that the member is enrolled in another case management program, the case manager is advised not to render any case management services until it is verified that his/her case management services are primary. This may require termination of the member from another case management provider before case management from the new provider can be billed. It is the case manager's responsibility to advise the member of the various case management choices available to the member and to allow the member to make an affirmative choice among them.

Basis for Reimbursement

DCH will reimburse only one provider agency for case management services. The Department has established the case management hierarchy below to define which case management is primary and will be reimbursed. The Department's billing system has been modified to include edits to ensure the hierarchy is followed in the case of billing from more than one case management provider. The case management provider highest on the hierarchy will be reimbursed if 2 case managers should submit claims for the same month of service.

APPENDIX D

1) COS 830 - (Case Management Organization – CMO)
2) COS 851 - (SOURCE Case Management)
   COS 930 - (SOURCE Case Management)
3) COS 660 - (Independent Care Waiver)
   COS 680/681 (New Options Waiver/Comprehensive Supports Waiver)
4) COS 442 - (C-Bay)
5) COS 764 - (Child Protective Services Targeted Case Management)
6) COS 800 - (Early Intervention Case Management)
7) COS 765 - (Adult Protective Services Targeted Case Management)
8) COS 763 - (At Risk of Incarceration Targeted Case Management)
9) COS 762 - (Adults with AIDS Targeted Case Management)
10 COS 790 - (Rehab Services/DSPS)
11) COS 960 - (Children Intervention School Service)

NOTES: Persons enrolled in hospice have case managers who manage all of their care and may not receive case management from any other program while enrolled in hospice. The Department's hospice lock-in system will automatically cause any other claims for case management to be denied.

APPENDIX E

Georgia Families 360^{0} SM,



Information for Providers Serving Medicaid Members
in the Georgia Families 360^{0} SM Program

Georgia Families 360^{0} SM, the state's (took out "new") 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 360^{0} 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

APPENDIX F

Individual Quality Outcome Measures Review

Individual Information

Individual's Name

Physical Address Location of Visit Date & Time of Visit

ADA Population Funding Source

	Focus Area: Environment	Select:	Comments/Actions Needed: Concerns, Barriers, Successes
1	The home/site is accessible to the individual.	Select	
2	The individual has access to privacy for personal care.	Select	
3	The individual has a private place in the home to visit with friends or family.	Select	
4	The individual has access to privacy for phone discussions with friends or family.	Select	
5	The individual has access to receive and view their mail/email privately.	Select	
6	The individual is able to have private communications with family and friends through other means.	Select	
7	The home setting allows the individual the option to have a private bedroom.	Select	
8	All assistive technologies are being utilized as planned.	Select	
9	All assistive technologies are in good working order.	Select	
10	The individual has adequate clothing to accommodate the individual's needs or preferences/choices.	Select	

11	The individual has adequate food and supplies to accommodate the individual's needs or preferences/choices.	Select	
12	The Residential/Day setting is clean according to the individual's needs and preferences.	Select	
13	The Residential/Day setting is safe for the individual's needs.	Select	
14	The Residential/Day setting is appropriate for the individual's needs and preferences.	Select	
Focus Area: Appearance/Health		**Select:**	**Comments/Actions Needed: Concerns, Barriers, Successes**
15	The individual appears healthy. Describe any observations regarding health since the last review.	Select	
16	The individual appears safe. Describe any observed changes related to safety since the last review.	Select	
17	There have been no reported changes in health since the last review.	Select	
18	The HRST aligns with current health and safety needs.	Select	
19	The ISP is available to staff on site. If there have been ISP addendums, they are available to staff on site.	Select	
20	Staff are knowledgeable about all information contained within the individual’s ISP.	Select	
21	Indicated healthcare plans are current and have been reviewed by a nurse within the past year.	Select	
22	Indicated healthcare plans are available to staff on site in all applicable settings.	Select	
23	All staff are knowledgeable about all of the individual’s healthcare plans.		

24	Indicated healthcare plans are being implemented.	Select	
25	Skilled nursing hours are being provided, as ordered.	Select	
26	All medical/therapeutic appointments have been scheduled and attended.	Select	
27	All follow-up appointments have been scheduled and attended.	Select	
28	All physician/clinician recommendations are being followed.	Select	
29	All prescribed medications are being administered, as ordered, and documented accurately.	Select	
30	All required assessments/evaluations have been completed.	Select	
31	The individual has had no hospital admissions, emergency room, or urgent care visits since the last review.	Select	
32	If applicable, hospital/ED/urgent care discharge plan instructions have been followed.	Select	
Focus Area: Supports and Services		**Select:**	**Comments/Actions Needed: Concerns, Barriers, Successes**
33	The individual's paid staff appear to treat them with respect and dignity.	Select	
34	The individual's natural supports appear to treat them with respect and dignity.	Select	
35	Supports and services are being delivered to the individual, as identified in the current ISP.	Select	

36	The individual is being supported to make progress in achieving their goals (both ISP goals and informally expressed goals). Indicate the status of the individual's progress toward achieving established goals.	Select	
37	There are no needs for additional services/supports at this time.	Select	
Focus Area: Behavioral & Emotional		**Select:**	**Comments/Actions Needed: Concerns, Barriers, Successes**
38	Since the last visit, there are no emerging or continuing behavioral/ emotional responses for the individual.	Select	
39	Current supports and behavioral interventions are adequate to prevent engaging external interventions.	Select	
40	The individual has no active Behavioral Support Plan, Crisis Plan, and/or Safety Plan relating to behavioral interventions.	Select	
41	If applicable, the plan(s) is/are available on site for staff review.	Select	
42	There is evidence of implementation of the Behavioral Support Plan, Crisis Plan, and/or Safety Plan. Staff are knowledgeable about the plan(s) and able to describe how they are implementing the plan.	Select	
43	Since the last visit, there have been no needs to access GCAL or the Mobile Crisis Response Team in response to a behavioral emergency If GCAL/MCT has been accessed, describe reason, frequency, duration of any admissions, and if discharge recommendations have been followed. If applicable, the BSP/ Safety Plan/ Crisis Plan has been adapted to reflect any new recommendations or	Select	

	interventions needed.		
44	Since the last visit, the individual has had no contact with law enforcement. If they have, describe reason and length of involvement. If applicable, the BSP/ Safety Plan/ Crisis Plan has been adapted to reflect any new recommendations or interventions needed.	Select	
Focus Area: Home/ Community Opportunities		**Select:**	**Comments/Actions Needed: Concerns, Barriers, Successes**
45	The individual has unpaid community connections. If not, describe steps being taken to further develop community connections.	Select	
46	The individual is receiving services in a setting where he/she has the opportunity to interact with people who do not have disabilities (other than paid staff).	Select	
47	The individual is being offered/provided documented opportunities to participate in activities of choice with non-paid community members.	Select	
48	The individual has the opportunity to participate in activities he/she enjoys in their home and community. Describe steps being taken to increase opportunities to meet this objective and allow choices to be offered while in services.	Select	
49	If desired, the individual is actively supported to seek and/or maintain employment in competitive and integrated settings and/or offered customized opportunities. If applicable, note how he/she is supported to do so. If no, indicate how the issue is being addressed.	Select	
50	The individual has the necessary access to transportation for employment and community activities of his/her choice.	Select	
Focus Area: Financial		**Select:**	**Comments/Actions Needed: Concerns, Barriers, Successes**

51	There are no barriers in place that limit the individual's access to spend his/her money, as desired.	Select	
Focus Area: Satisfaction		**Select:**	**Comments/Actions Needed: Concerns, Barriers, Successes**
52	Overall, the individual is satisfied with their life activities since the last review.	Select	
53	Overall, the individual is satisfied with their service providers since the last review.	Select	
54	Overall, the individual is satisfied with the type of services received since the last review.	Select	
55	Overall, the individual is satisfied with their family relationships/natural supports since the last review.	Select	

Observations / Comments:

Outcome Review Support Note:

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APPENDIX G

Non-Emergency Medical Transportation

Non-Emergency Medical Transportation (NEMT) services are defined as medically necessary transportation for any eligible Medicaid member and companion, if required, who have no other means of transportation available to any Medicaid-reimbursable service for the purposes of receiving treatment, medical evaluation, obtaining prescription drugs or medical equipment.

How do I get NEMT services?

If you are a qualifying Medicaid recipient and have no other means of transportation for your medical care or services covered by Medicaid, you may contact a transportation broker for transport to and from your appointment. The member must contact the Broker to request NEMT services at least three (3) business days prior to a non-urgent, scheduled appointment. The three (3) day advance scheduling includes the day of the call but not the day of the appointment. Advance scheduling will be mandatory for all NEMT services except urgent care and follow-up appointments when the timeframe does not allow advance scheduling. Urgent care or same day reservations may require verification from your direct provider of service confirming you must be seen that day. Each broker has a toll-free telephone number to schedule transportation services, and 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. Contact Southeastrans for Atlanta and North Regions and ModivCare, formerly LogistiCare, for Central, East and Southwest 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 provider or broker?

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. If you have a question, comment, or complaint about a NEMT provider or broker that has not been resolved with the broker, you may contact the Georgia Department of Community Health, NEMT unit.

NEMT REGIONS & COUNTIES SERVED

Region	NEMT Broker & Phone Number	Counties Served
North	**Southeastrans** *Toll free* 1-866-388-9844 *Local* 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	**Southeastrans** 404-209-4000	Fulton, DeKalb, and Gwinnett

	Note: For Georgia Families 360° 1-866-991-6701	
Central	**ModivCare** **(*formerly LogistiCare)*** *Toll free* 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	**ModivCare** **(*formerly LogistiCare)*** Toll free 1-888-224-7988 *Note: For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities* 1-800-486-7642 Ext. 461 or 436	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	**ModivCare** **(*formerly LogistiCare)*** Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth