PART II

POLICIES AND PROCEDURES
FOR
FAMILY PLANNING SERVICES
AND
PLANNING FOR HEALTHY BABIES (P4HB)



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: October 1, 2021

Policy Revisions Record

Part II Policies and Procedures Manual for Family Planning Services and Planning for Healthy Babies

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE A=Added D=Deleted M=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
1/1/20	Appendix H	Update to eligibility language for IPC/RM	M	CMS, Special, terms, and conditions
4/1/20		No Revisions		
7/1/20		No Revisions		
7/30/20	901.1	Corrected typo- Changed 92215 to the correct code of 99215 for established patient comprehensive visit	M	
9-16-20	Appendix C; CMS 1500 Field Locator Instructions Items 14, 17, 19 and 24A-24G; Health Care Providers, pages F-7, F-8, F-11; Appendix H, pages I-9 and I-10	Changed all references to DXC to Gainwell Technologies	M	Name change effective 1-1-21
2/16/2021	IX-7	Removed codes 90649 and 90650 and replaced with 90651	M	HCPS 2020 cycle change
2/16/2021	All	Updated dates	M	
2/18/2021	Appendix G	Updated Logisticare's name	M	
5/26/21	Appendix F	Updated Georgia Families Information	M	Peach State/Wellcare Merger
5/26/21	Appendix H	Updated 60 days postpartum reference to 6 months	M	Legislation changed postpartum period to 6 months
6/28/2021	901.6: Liletta and Mirena	Updated to 6 years	M	Manufacturer update

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PREFACE

This manual contains basic information concerning coverage levels, eligibility and billing procedures for the Family Planning and Planning for Healthy Babies (P4HB) Programs and is intended for use by all participating providers in conjunction with the Part I Policies and Procedures Manual for Medicaid and PeachCare for Kids®. The Part I Manual outlines the Statement of Participation in the Georgia Medicaid program and this manual outlines the terms and conditions for receipt of Medicaid reimbursement for Family Planning and Planning for Healthy Babies (P4HB).

Amendments to this manual will be necessary from time to time due to changes in federal and state laws and the Department of Community Health (DCH) policy. When such amendments are made, they will be posted on the Gainwell Technologies web portal at www.mmis.georgia.gov, which shall constitute formal notice to providers. The amended provisions will be effective on the date of the notice or as specified by the notice itself, and all providers are responsible for complying with the amended manual provisions as of their effective dates.

Thank you for your participation and interest in Georgia's Medicaid and PeachCare for Kids® programs. Your service is greatly appreciated.

PART II- CHAPTER 600

SPECIAL CONDITIONS OF PARTICIPATION

601. In addition to the general conditions of participation identified in the Part I Manual, Section 106, providers of Family Planning and Planning for Healthy Babies (P4HB) must adhere to the state and federal guidelines pertaining to the provision of the Family Planning and Planning for Healthy Babies (P4HB) provided personally and directly by licensed practitioners of the healing arts within the scope of their licensure under state law.

Chapter 600 in the following provider manuals provides the Special Conditions of Participation for providers delivering family planning services. Family planning providers must ensure they meet the qualifications associated with their provider specialty or category.

- Advanced Nurse Practitioner Services
- Federally Qualified Health Center Services
- Nurse Midwife Services
- Physician Services
- Rural Health Clinic Services

Local Health Departments and Title X Clinics also deliver office-based Family Planning and Planning for Healthy Babies (P4HB). In delivering those services, they must also adhere to the state and federal guidelines pertaining to the provision of the family planning services identified in this manual.

Information pertaining to participation in the Planning for Healthy Babies Program®, can be found in Appendix H.

PART II – CHAPTER 700

SPECIAL ELIGIBILITY CONDITIONS

Rev. 01/11
Rev. 10/12
Rev. 10/15

Family planning services are provided to eligible Medicaid members who wish to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy. Women who are not able to become pregnant or are currently known to be pregnant are not eligible to receive services under the Family Planning program.

The Special Eligibility Conditions pertaining to the Planning for Healthy Babies® Program, can be found in Appendix H.

PART II – CHAPTER 800

PRIOR APPROVAL

Rev. 01/11
Rev. 10/12

Office-based Family Planning and Planning for Healthy Babies (P4HB) do not require prior approval. Family planning services provided in the outpatient hospital, inpatient hospital and ambulatory surgical center settings may require prior approval/pre-certification.

PART II – CHAPTER 900

SCOPE OF SERVICES

Rev. 01/11
Rev. 10/12
Rev. 07/14

Family planning services are provided to eligible Medicaid members who wish to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy.

Rev. 10/12

901. Covered Services

Covered services include at a minimum:

- Education and counseling (including behavioral counseling) necessary to make informed choices and understand contraceptive methods;
- Initial and annual complete physical examinations including a pelvic examination and Pap test;
- Follow up brief and comprehensive visits;
- Pregnancy testing;

Rev. 10/12
Rev. 07/16

- Contraceptive methods, supplies, insertion and removal of long acting reversible contraceptive types, and follow-up care;
- Sterilizations for members at least twenty-one (21) years of age at the time consent is obtained who are mentally competent and who voluntarily give informed consent in accordance with state policies and procedures;
- Diagnosis of sexually transmitted infections;
- Treatment of sexually transmitted infections; and
- Infertility assessments – Infertility assessments are not covered under the Planning for Healthy Babies program.

901.1 Initial and Annual Comprehensive Family Planning Visits

Initial and annual comprehensive visits typically allow 40 minutes of face-to-face time with the patient. These visits include the following:

- Comprehensive medical history;
- Comprehensive physical examination including;
    - height and weight;
    - vital signs including a blood pressure check;
    - breast examination;
    - pelvic examination;
    - hemoglobin or hematocrit;
    - urinalysis

- Pap smear as indicated;
- serological test for syphilis when appropriate;
- tests for gonorrhea when appropriate;
- chlamydia testing when appropriate;
- Human Immunodeficiency Virus (HIV) testing;
- intrauterine device (IUD) monitoring, if IUD present

- Medical decision making of high complexity
- Counseling and/or coordination of care with other providers including:
  - provision and explanation of a contraceptive method;
  - education on a reproductive life plan;
  - referral and/or treatment of an abnormal finding

Only one initial or annual comprehensive visit is available per member per twelve months. The initial or annual comprehensive visit cannot be billed on the same date of service with a general comprehensive medical visit. Providers should use CPT codes 99204 (for new patient) or 99215 (for an established patient) when conducting the initial or annual comprehensive visit. The FP Modifier must be used with either of these codes.

901.2 Brief Medical Visit

Rev. 10/12
Rev. 01/15

A follow-up visit that occurs after the initial or annual comprehensive visit. Typically, 10 minutes of face-to-face time with the patient. The visit includes the following:

- Problem focused history;
- Problem focused examination including;
  - hemoglobin or hematocrit check;
  - vital signs including blood pressure check;
  - screening for sexually transmitted infections (as indicated)
- Straightforward medical decision making
- Counseling and/or coordination of care with other providers including:
  - review of Pap smear results;
  - provision and explanation of a contraceptive method;
  - referral for sterilization; and

- referral and/or treatment of an abnormal finding

Providers should use CPT code 99212 (for an established patient) when conducting the Brief Medical Visit. The FP Modifier must be used with this code.

Rev. 10/12

901.3 Comprehensive Medical Visit

A follow-up visit that occurs after the initial or annual comprehensive visit. Typically, 15 to 25 minutes of face-to-face with the patient. The visit includes the following:

- Expanded problem focused or detailed history
- Expanded problem focused or detailed examination including:
  - vital signs including blood pressure check;
  - repeat Pap smear (as indicated); (see note below)
  - urinalysis;
  - screening for sexually transmitted infections (as indicated);
  - wet mount
- Medical decision making of low to moderate complexity
- Counseling and/or coordination of care with other providers including:
  - prescription for the treatment of a diagnosed sexually transmitted infection;
  - review of Pap smear results;
  - referral for sterilization; and
  - referral and/or treatment of an abnormal finding
- Providers should use CPT codes 99213 (for an established patient; typically a 15 minute visit) or 99214 (for an established patient; typically a 25 minute visit) when conducting the Comprehensive Medical Visit. The FP Modifier must be used with either of these codes.

Rev. 03/12
Rev. 10/12
Rev. 10/14
Rev. 01/15

NOTE

Providers cannot bill for an initial exam or the annual exam on the same date of service with the comprehensive medical visit or brief medical visit.

NOTE
Refer to the two websites below for detailed information on the New Cervical Cancer Screening Guidelines by the United States Preventive Services Task Force (USPSTF) and the American Cancer Society (ACS): http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm and http://www.cancer.org/Cancer/news/new-screening-guidelines-for-cervical-cancer .

Rev. 01/15

901.4 Supply Visit

The purpose of the supply visit is to allow the patient to obtain additional contraceptives and counseling if indicated. Typically, 5 minutes are spent performing or supervising these services. The presenting problems are minimal. The visit may not require the presence of a physician. Providers should use CPT code 99211 when conducting this office visit. The FP modifier must be used with this code.

Rev. 01/15
Rev 07/16

901.5 Implantable Contraceptive Capsules

Physicians, nurse practitioners, midwives and physicians' assistants will be reimbursed for the insertion and removal of implantable contraceptive capsules only after their training requirements have been completed. Staff training should be conducted according to the manufacturer's guidelines. Documentation of training must be maintained in the provider's personnel or training record. The insertion, management and removal of the capsule must be accomplished according to the manufacturer's recommendations.

Providers should use the codes below when billing for this service. The FP modifier must be used with these codes.

J7307 Etonogestrel (Implanon/Nexplanon) Implant System - Modifier FP
11981 Insertion, Implantable Contraceptive Device – Modifier FP
11976 Removal, Implantable Contraceptive Capsule – Modifier FP
11982 Removal, non-biodegradable drug delivery implant – Modifier FP
11983 Removal with reinsertion, non-biodegradable drug delivery implant – Modifier FP

Insertions are limited to one within a three-year period.

The insertion or removal may be billed in conjunction with one of the above-mentioned visits.

901.6 Intrauterine Devices

Physicians, nurse practitioners, midwives and physicians' assistants will be reimbursed for the insertion and removal of intrauterine devices only after their training requirements have been completed. Staff training should be conducted according to the manufacturer's guidelines. Additional training is required for the insertion of intrauterine devices immediately postpartum. Documentation of training must be maintained in the provider's personnel or training record. The insertion, management and removal of these devices must be accomplished according to the manufacturer's recommendations.

Providers should use the codes below when billing for this service. The FP modifier must be used with these codes.

Rev. 07/15
Rev. 01/16
Rev. 07/16
Rev. 01/18

J7300 Paragard / Intrauterine copper contraceptive – Modifier FP
J7296 Kyleena Levonorgestrel-Releasing Intrauterine Contraceptive System, 19.5 MG – Modifier FP
J7297 Liletta IUD Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG, 6 year - Modifier FP
J7298 Mirena IUD Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG, 6 year - Modifier FP

Rev. 01/17

J7301 Levonorgestrel-Releasing Intrauterine Contraceptive System (Skyla), 13.5MG- Modifier FP.
58300 Insertions, Intrauterine Device – Modifier FP
58301 Removal of intrauterine device – Modifier FP

The insertion or removal may be billed in conjunction with one of the above-mentioned visits.

901.7 Injectable Contraceptives

Rev. 01/15
Rev. 04/15

The Depo-Provera injection may be billed with any type of visit code. Coverage is limited to one injection every three months or one every 12-13 weeks.

Providers should use the code below when billing for this service. The FP modifier must be used with this code.

J1050 Medroxyprogesterone Acetate 1 mg (Injection) - Modifier FP
1 mg = 1 unit. Provider must bill the appropriate units administered to the patient.

901.8 Other Contraceptive Methods

Rev. 01/15

Oral contraceptives are available as a Pharmacy Benefit.

Providers should use the codes below when billing for Other Contraceptive Methods services. The FP modifier must be used with these codes.

57170 Diaphragm or cervical cap fitting with instructions – Modifier FP
A4267 Contraceptive Supply, Condom, Male, - Modifier FP

Condoms may be billed with any type visit code.

901.9 Infertility Assessment

The infertility assessment includes an infertility interview, education, physical examination, appropriate lab testing, counseling and referral. This is conducted during the initial, comprehensive or annual family planning visit.

901.10 Clinical Laboratory and Anatomical Pathology Services

Pregnancy Test:
The pregnancy test may be billed through the Family Planning Program only when the test is family planning related under the following circumstances:

A) it is performed at the time family planning services are initiated for an individual;

B) it is performed at a visit after the initiation of family planning services where the patient may not have used the particular family planning method properly or where the patient is having an unusual response to the method; or

C) it is performed during the infertility assessment.

Providers should use CPT code 81025 when billing for the urine pregnancy test.

The FP modifier must be used with this code.

Gonorrhea Testing:
Refer to Part II Policies And Procedures For Independent Lab Services Program for detailed information on all specimen for gonorrhea testing.

Syphilis Testing:
Refer to Part II Policies And Procedures For Independent Lab Services Program for detailed information on all specimen for syphilis testing.

HIV Testing:
Refer to Part II Policies And Procedures For Independent Lab Services Program for detailed information on all specimens for HIV testing.

NOTE: Fee for Service (FFS) providers may submit specimen for Gonorrhea, Syphilis and HIV Testing to the Georgia Public Health Laboratory (GPHL) or to any Medicaid enrolled laboratory. Please refer to Part II Policies And Procedures For Independent Lab Services Program for additional information.

NOTE: Please Use the FP modifier for all Family Planning related Laboratory services.

Rev. 10/15

901.11 FFS Medicaid Coverage of Plan B One-Step®

FFS Medicaid allows coverage in the Outpatient Pharmacy program for Plan B One Step® emergency contraception for members <18 years old only. A prescription is required for coverage. Plan B One Step® prescription will not be available for members 18 years and older due to its over the counter designation.

901.12 FFS Medicaid Coverage of Human Papilloma Virus (HPV) Vaccine

Rev. 10/15

Fee For Service (FFS) Medicaid allows coverage of the Human Papilloma Virus (HPV) vaccine (CPT code 90651).

Refer to Appendix C of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program manual for ages 9 through 20 and Appendix B-1 of the Physician Services manual for ages 21 through 26.

902. Referral for Sterilizations

In compliance with federal regulations, the Division may reimburse for sterilizations only if the requirements listed below are met:

A) The individual is at least twenty-one (21) years old at the time consent is obtained.

B) The individual is mentally competent.

C) The individual voluntarily gives informed consent in accordance with the provisions of this Section, and a properly executed "Informed Consent for Voluntary Sterilization" form (DMA-69) is prepared. See Appendix B.

D) At least thirty days, but not more than one hundred and eighty days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery, an individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least seventy-two hours have passed since informed consent for sterilization was signed (the expected date of delivery must be provided on the consent form).

E) An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to an individual who is blind, deaf or otherwise disabled.

F) The individual is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

G) Local Public Health Departments and Title X Clinics are not provider locations that offer sterilization services, therefore women receiving family planning services through these providers should be referred to providers who can perform sterilizations. Please see Appendix B for the consent form, DMA-69.

903. Services not covered under the Family Planning Services Program

- Abortions or abortion-related services performed for family planning purposes.
- Indirect services to members, such as telephone contacts
- Case management
- Family Planning services provided to a woman who is known to be pregnant.

Rev. 03/12

- Sterilization of recipients institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities
- Hysterectomies performed for family planning purposes

904. Co-payment

Rev. 01/15

Members receiving family planning services are not subject to co-payment requirements. Family planning services are exempt.

PART II - CHAPTER 1000

BASIS FOR REIMBURSEMENT

Reimbursement Methodology

Rev. 07/14

Rev. 10/14

Family Planning Services are reimbursed at 84.645% of the January 1, 2000 Medicare fee schedule; used as the statewide maximum allowable amount for initial, annual, and follow-up family planning visits using covered CPT codes (99204 and 99211 through 99215). CPT codes opened after January 1, 2000, are reimbursed at 84.645% of the Medicare fee schedule in place at the time the code was opened.

Rev. 04/15

Rev. 10/15

Rev. 01/17

Reimbursement rates for contraceptive supplies, including intrauterine devices and hormonal implants (referred to as long acting reversible contraceptives or LARCs), are the lesser of the provider's usual and customary charge; the average sales price plus 6% as defined January 1st of each year or average sales price plus 6% upon the drug's initial availability in the marketplace whichever is later; the actual 340B acquisition cost of contraceptives purchased through the 340B program; or average wholesale price minus 11% for drugs that do not have an average sales price until such time the average sales price plus 6% pricing becomes available.

Reimbursement rates for clinical laboratory and anatomical pathology services are the lesser of the laboratory's usual and customary charge or the statewide maximum allowable amount.

Effective January 1, 2014, providers MUST enter Y ("YES") or N ("NO") in the bottom, UNSHADED area of Field 24 H of the new CMS 1500 claim form for all Family Planning services.

APPENDIX A

Rev. 09/10
Rev. 10/11
Rev. 07/14
Rev. 01/15

REIMBURSEMENT RATES FOR FAMILY PLANNING SERVICES

Please reference the following Schedules or Manual for Reimbursement Rates: Schedule of Maximum Allowable Payments For Physicians, Schedule of Maximum Allowable Payments for Clinical Laboratory and Anatomical Pathology, and Part II Policies and Procedures for the Physicians' Injectable Drug List manual.

APPENDIX B

INFORMED CONSENT FOR VOLUNTARY STERILIZATION, DMA-69

Important points for preparing and submitting a properly executed Form DMA-69 and Form DMA-69A are listed below:

A) In the section labeled, "Physician's Statement," either paragraph one (1) or paragraph two (2) must be designated. Cross out the paragraph that is not used.

Paragraph 1: At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

Paragraph 2: This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances:

- If paragraph 2 is designated, the applicable box must be checked and the information requested must be entered.
- If the box indicating “premature delivery” is checked, the individual’s date of expected delivery must be given on the line provided.
- If the box indicating “emergency abdominal surgery” is checked, the circumstances of the emergency surgery must be described on the line provided.
- The physician who performs the surgery must sign and date the consent form after the surgery is performed. Signature stamps are not acceptable.

B) All lines on the consent form must be completed, with the exception of the interpreter’s statement. The interpreter’s statement does not need to be completed unless a language other than English was used to explain the sterilization procedure to the member.

C) The method used to calculate the 30-day wait is as follows: Begin the count with the first day after the date the member signs the consent form and count forward 30 days. The sterilization may be performed as early as the 30th day.

D) The only consent forms acceptable to the Division are the “Informed Consent for Voluntary Sterilization (DMA-69)” and the Spanish version (DMA-69A). No other form can be used. A copy of the properly executed "Informed Consent for Voluntary Sterilization" must be attached to the physician's claim form when submitted to the

fiscal agent for payment. In addition, a copy of the consent form must accompany any other claims for services rendered in conjunction with the sterilization (i.e., hospital, anesthesiology, etc.). The attending physician is responsible for providing a copy of the properly executed consent form to each Medicaid provider associated with the case.

Supplies of "Informed Consent for Voluntary Sterilization", DMA-69, may be ordered by completing the "Request for Forms," which you can find in the Georgia Department of Community Health Billing Manual UB 04 or at www.mmis.georgia.gov.

APPENDIX C

GAINWELL TECHNOLOGIES TECHNOLOGY

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

Rev. 10/10
Rev. 10/15
Rev. 01/16

Member and Provider Correspondence
Provider Contact Center
PO Box 105200
Tucker, GA 30085-5200
800-766-4456 (Toll free)

Electronic Data Interchange (EDI)
877-261-8785 (Toll free)

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

APPENDIX D

Rev. 10/15

SAMPLE CLAIM For Billing J7301

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID [X] (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, MARY J.	3. PATIENT'S BIRTH DATE MM DD YY: 03 25 2013 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 1234 ANY STREET	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: ANY CITY STATE: GA	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE: 00000-0000 TELEPHONE (Include Area Code): (404) 123-4567		ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authoriz payment of medical benefits to the undersigned physician or supplie services described below. SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 12 28 2013 QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATIO MM DD YY FROM TO MM DD Y
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD Y
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. Z30.09 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID
1 10 01 15	10 01 15	99	N	J7301		1			Y	NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [9] NO	28. TOTAL CHARGE 45	29. AMOUNT PAID $ 9 45	30. Rsvd for N
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.	

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500

SAMPLE

CMS 1500 Field Locator Instructions

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

FLD Location	**NEW Change**
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/GAINWELL TECHNOLOGIES:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to

	accommodate a 2-byte qualifier
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?)
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)." Removed the arrow and text in the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier." **FOR DCH/GAINWELL TECHNOLOGIES: Use Qualifiers: 431 (onset of current illness); 484 (LMP).**
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/GAINWELL TECHNOLOGIES:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/GAINWELL TECHNOLOGIES:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."

Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable value (0). ICD -10 diagnoses (CM) codes = value 0. **(Bill ICD 10 code sets effective October 1, 2015.)**
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. **FOR DCH/GAINWELL TECHNOLOGIES**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

Rev. 04/14

APPENDIX E

Rev. 07/13

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 current 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.

Rev. 04/17
Rev. 10/18

APPENDIX F
Georgia Families

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

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

The three licensed CMOs:

Amerigroup RealSolutions in healthcare Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	peach state health plan Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	CareSource CareSource 1-855-202-1058 www.caresource.com

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

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)

Resource Mothers Outreach	

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

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

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

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

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

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

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child

510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged

225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind

306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

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

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

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

Registering immunizations with GRITS:

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

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

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

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

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

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. GAINWELL TECHNOLOGIES will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

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

Billing the health plans for services provided:

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

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

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

Credentialing

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

Credentialing and recredentialing services 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.

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES 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 GAINWELL TECHNOLOGIES in error:

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

Receiving payment:

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

Health plans payment of clean claims:

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

Amerigroup Community Care	CareSource	Peach State Health Plan
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks	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.

	due to moral or religious objections • PCP moves, retires, etc.	

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

Amerigroup Community Care	CareSource	Peach State Health Plan
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.

PHARMACY

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

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

Amerigroup Community Care	CareSource	Peach State Health Plan
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com

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

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL TECHNOLOGIES will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

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

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

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:

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

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

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

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan
1 (800) 454-3730	1 (855) 202-1058 1 (866) 930-0019 (fax)	1 (866) 399-0929

APPENDIX G
Non-Emergency Transportation

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

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

What if I have problems with a NET 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. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, **call the Member CIC at 866-211-0950.**

Region	Broker / Phone number	Counties served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, 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
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

Rev. 01/13

Rev. 04/18

Rev. 01/20

Appendix H

PLANNING FOR HEALTHY BABIES

Program Overview:

The Center for Medicare and Medicaid Services (CMS) approved a 10-year extension in August 2019 to the Planning for Healthy Babies Program® (P4HB®) which an 1115 Medicaid Demonstration Wavier that expands the provision of family planning services to women who are Georgia residents, women between the ages of 18 and 44, who do not qualify for other Medicaid benefits and any other insurance coverage with the exception of vision or dental insurance, including Medicare or Peach Care for Kids®. This program became effective on January 1, 2011.

The overall goals of the Planning for Healthy Babies Program are to:

- Reduce Georgia's low birth weight (LBW) and very low birth weight (VLBW) rates;
- Reduce the number unintended pregnancies in Georgia;
- Reduce Georgia's Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services;
- Provide access to Interpregnancy Care (IPC) health services for eligible women who have previously delivered a VLBW infant; and,
- Increase child spacing intervals through effective contraceptive use.

Rev. 10/11

Rev. 10/15

P4HB eligible women will be enrolled in one of three components of the P4HB family planning program:

A. Family Planning Only - family planning and family planning related services for eligible participants for the duration of the demonstration.
B. Inter-pregnancy Care - family planning and additional services for women who have delivered a VLBW (<1500 grams or 3.3 pounds) baby for a 24 months duration.
C. Resource Mother Outreach – inclusive of a specially trained case manager to women on traditional **Medicaid** plans who have delivered a VLBW baby for a 24 months duration.

P4HB eligible women must enroll in a care management organization (CMO) and its affiliated provider network will provide the family planning and inter-pregnancy care services. There will be no fee-for-service coverage for any family planning services provided. The CMOs will make reasonable efforts to contract with all family planning clinics, including those funded by Title X of the Public Health Services Act, for the provision of family planning services. The CMOs shall not limit the P4HB enrollees' freedom of choice for family planning services to in-network providers and the CMOs shall cover services provided by any qualified provider regardless of whether the provider is in-network. The CMOs shall not require a referral if a P4HB enrollee chooses to receive family planning services and supplies from outside of the network.

Eligibility and Enrollment:
P4HB eligible women must be enrolled in a CMO to receive services under the demonstration. In addition, each woman must:

- Be a US citizen or person with qualified proof of citizenship
- Be ages 18 through 44 years
- Be a Georgia resident
- Be able to become pregnant
- Not be eligible for any other Medicaid program or managed care program
- Meet family gross income requirements of no more than 211% of the federal poverty level (FPL)
- If losing Medicaid pregnancy coverage at the conclusion of 6 months postpartum, not otherwise be eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Women who delivered a very low birth weight (VLBW) baby (less than 1500 grams or 3 pounds, 5 ounces) within three years of the application date, you will qualify for the Interpregnancy Care (IPC) component of the P4HB program

If you currently receive Medicaid and delivered a very low birth weight (VLBW) baby (less than 1500 grams or 3 pounds, 5 ounces) within three years of the application date, you will qualify for the Resource Mother component of the P4HB program.

P4HB Required Verification for IPC/RM

Rev. 04/17

- ☐ Physician's Statement for P4HB Inter-Pregnancy Care
- ☐ Hospital Confirmation of Birth Record that includes birth weight
- ☐ Care Management Organizations (CMO) Report

Women enrolled in the family planning demonstration are eligible to receive benefits throughout the demonstration period which began on January 1, 2011. Eligibility is re-determined on an annual basis.

Women are eligible for the IPC component for 2 years (24 months) following the delivery of a VLBW baby.

Women no longer eligible for the IPC component may still be eligible for family planning only benefits under the demonstration.

Rev. 04/17 **Once the woman begins participating in the program through the utilization of services, she is considered a P4HB participant.**

SCOPE OF SERVICES

Family Planning Only Services

1. **Family planning initial or annual exams (one per year)**
    - Initial comprehensive and Annual Examinations (See 901.1, 901.1b for detailed description)
    - Infertility assessment services, including infertility review, education, physical examination, appropriate lab testing and counseling and referral related to infertility are **excluded** benefits for P4HB participants.

- **Follow up family planning or family planning related service visits**

  Follow up family planning visits are covered under the P4HB program. Services are generally performed as part of, or as follow-up to, a family planning service for **contraception, or for a family planning-related problem** identified/diagnosed during **a routine/periodic family planning visit.** Follow-up visits occur after the initial or annual examination and include services outlined in sections 901.2 and 901.3. In addition under the P4HB® demonstration program, enrollees receive:

    - Contraceptive services and supplies clearly provided or performed for the primary purpose of family planning
        - Method initiation (see 901.4 Supply visit for details)
        - See Section 901.5 Implantable Contraceptive Capsules; 901.6 Intrauterine Devices; 901.7 Injectable Contraceptives; 901.8 Other Contraceptive Methods.
        - Procedures or services clearly provided or performed for the primary purpose of family planning
            - periodic or inter-periodic contraceptive management
            - patient education and counseling
    - Follow-up on abnormal testing during a family planning visit. For example:
        - Rescreening for an abnormal pap smear
        - Screening or rescreening for a Sexually Transmitted Infection (STI)
        - Colposcopy (and procedures done with/during a colposcopy).
        - A LEEP procedure.
        - Treatment/drugs for STIs, except for HIV/AIDS and hepatitis, when the STI's were identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs will also be covered.
        - Treatment/drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, when these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs will also be covered
        - Treatment of major complications such as:
            - A perforated uterus due to an intrauterine device insertion;
            - Severe menstrual bleeding caused by a Depo-Provera; injection requiring a dilation and curettage

        - Surgical or anesthesia-related complications during a sterilization procedure.

- **Referrals**
    - Primary care services are not covered for women enrolled in the Family Planning Only component of the demonstration. Women should be referred for **conditions identified during a family planning visit** to a primary health care provider who can offer affordable primary care services. These include FQHCs, RHCs and free clinics.
    - P4HB enrollees should be referred to community resources such as WIC and DFCS.

- **Family planning lab tests** may be performed to address family planning problems when those problems are identified during a family planning visit (see 901.1 – 901.3).
    - Pregnancy tests (see 901.10 for details)
    - Pap Smear
    - STI tests

- **Tubal Ligation (Sterilization)**

  Sterilizations are covered when provided in a family planning setting and when the P4HB enrollee:
  - Is at least twenty-one (21) years of age at the time consent is obtained;
  - Is mentally competent;
  - Voluntarily gives informed consent in accordance with the State Policies and Procedures for Family Planning Clinic Services. This includes the completion of all applicable documentation;
  - Is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.
  - Additionally:
      - At least thirty (30) Calendar Days, but not more than one hundred and eighty (180) Calendar Days, have passed between the date of informed consent and the date of sterilization.
      - An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a P4HB enrollee who is visually impaired, hearing impaired or otherwise disabled; and
      - A hysterectomy is not considered a covered service for P4HB enrollees.
  - Please see section 902 for referral requirements
  - Please see Appendix B for the consent form for sterilizations, DMA-69

- **Pharmacy services** for prescriptions for family planning related services and devices and for multivitamins with Folic Acid only.

- **Hepatitis B, tetanus-diphtheria (Td),** and combined tetanus, diphtheria and pertussis (TdAP) vaccinations for P4HB enrollees ages eighteen (18) to twenty (20).

- There is no coverage under the P4HB program for Human Papilloma Virus (HPV) vaccine.

- **Abortions or abortion-related services** are not considered a covered service for P4HB enrollees.

Interpregnancy Care Component:

In addition to the family planning and family planning-related services described above, women enrolled in the IPC component of the P4HB program are eligible for primary care services. The PCP is responsible for supervising, coordinating and providing all primary care to each assigned IPC P4HB enrollee and/or initiating referrals for non-CMO paid or provided specialty care. A list of services other than family planning and family planning-related services available to the IPC enrollee is provided below.

Services	Notes/ Limitations
Primary care	PCP coordinates care for the enrollee and makes referrals to CMO and non-CMO specialty care as needed. Five office/ outpatient visits per year.
Management and treatment of chronic diseases	
Substance abuse treatment (detoxification and intensive outpatient rehabilitation)	Enrollees can self-refer to an in-network provider for an initial mental health or substance abuse visit but prior authorization may be required for subsequent visits. Enrollees may also receive detoxification and intensive outpatient rehabilitation services only.
Case management/ Resource Mother Outreach	See Resource Mother Outreach below
Limited Dental	A list of covered procedures is available on the CMO plan web portal.
Prescription Drugs (non-family planning)	

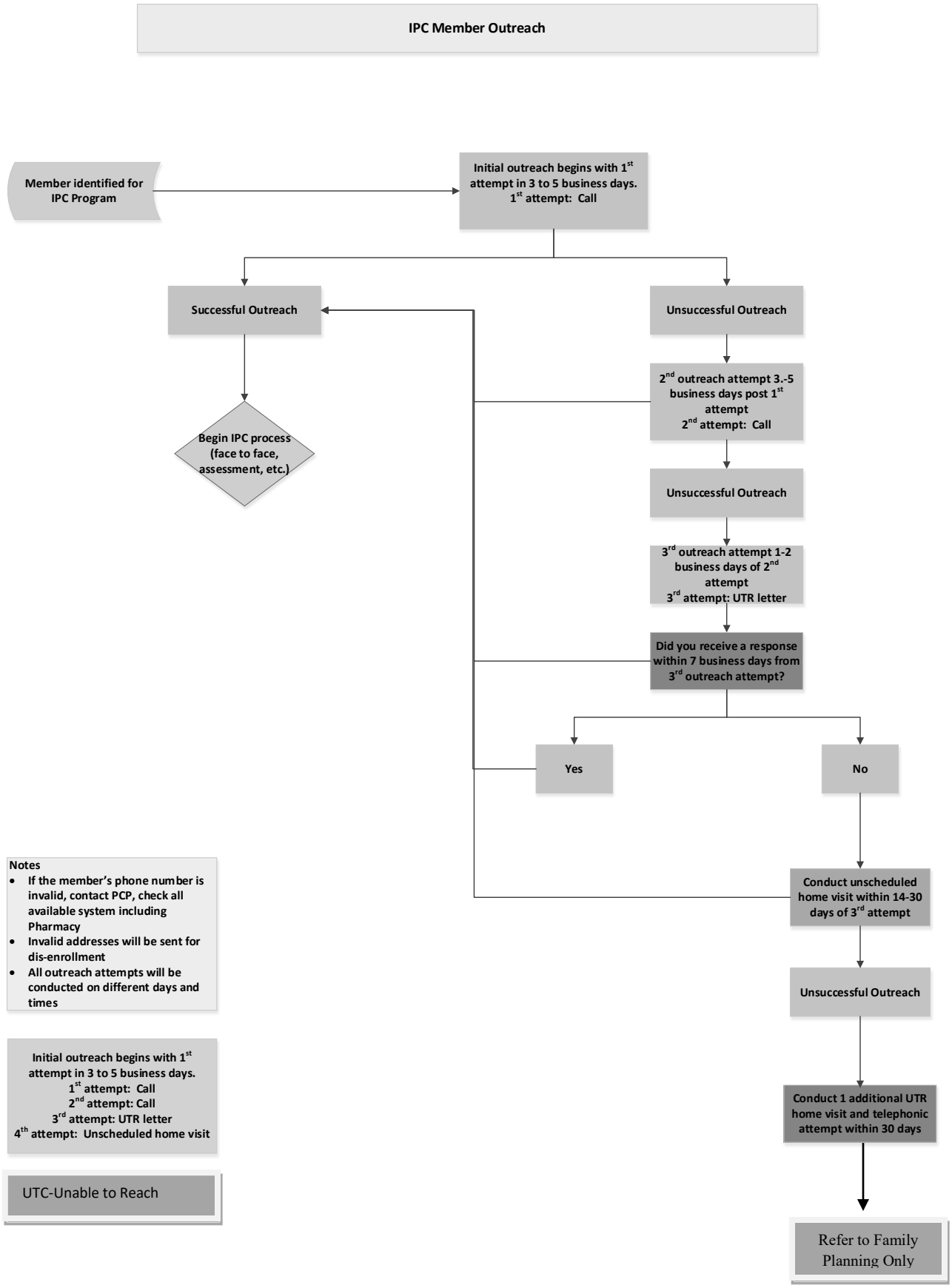
Women enrolled in the IPC component will also have access to non-emergency medical transportation (see Appendix F for details).

Resource Mother Outreach Component:

- Women served under the IPC component of the P4HB program and women enrolled in other Medicaid programs who have delivered a VLBW baby on or after January 1, 2011, will have access to case management including a Resource Mother (RM). The CMOs will employ or contract with Resource Mothers to provide this service.

- The Resource Mother will carry out the following responsibilities with each P4HB participant on her case load:

- Complete P4HB enrollee intake based on interviews with the P4HB enrollee, her family, significant other and appropriate community agencies.
- Demonstrate skillful use of observation and assessment tools to evaluate the P4HB enrollee's needs.
- Monitor the P4HB participant's progress towards treatment goals.
- Meet with the P4HB participant via phone or in person to increase the participant's adoption of healthy behaviors, including healthy eating choices and smoking cessation.
- Support P4HB participant's compliance with primary care medical appointments including assistance with non-emergency transportation arrangements; serve as the liaison between the P4HB participant and their family members, significant other, nurses, physicians, and organizational components to facilitate communication, linkage and continuity of service.
- Consult with physicians, nurses, social workers, and case managers about problems identified and assist in the development of an appropriate action plan.
- Document compliance with appointments and enrollment and participation in planned services and benefits in the P4HB participant's case management record and/or required P4HB Program forms.
- Prepare and disseminate pertinent reports for/to supervisors, colleagues and other appropriate individuals. Maintain program statistics for purposes of evaluation and research.
- Submit all data, forms and documentation per P4HB program guidelines.
- Provide short-term case management and referral services to the P4HB participant with an emergency situation.
- Support the P4HB participant's compliance with medications to treat chronic health conditions including assisting her with obtaining needed medications and reinforcing the need for medication compliance;
- Assist the P4HB participant with the coordination of social services support for family and life issues; implement and organize the delivery of specific social services within the community and maintain an updated resource file.
- Assist the P4HB participant in locating and utilizing community resources including legal, medical, financial assistance, and other referral services; assist with linking her to community resources such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- Provide emotional support for the P4HB participant following substance abuse treatment;
- Provide mentoring for the P4HB participant;
- Assist the P4HB participant to obtain regular preventive health visits and appropriate immunizations for their child;
- Provide the P4HB participant with the peer and emotional support needed to meet the health demands of her VLBW infant;
- Encourage the P4HB participant to implement the parenting and child safety concepts taught during classes she will be encouraged to attend.


IPC Member Outreach
Member identified for IPC Program
Initial outreach begins with 1st attempt in 3 to 5 business days.
1st attempt: Call
Successful Outreach
Unsuccessful Outreach
Begin IPC process (face to face, assessment, etc.)
2nd outreach attempt 3.-5 business days post 1st attempt
2nd attempt: Call
Unsuccessful Outreach
3rd outreach attempt 1-2 business days of 2nd attempt
3rd attempt: UTR letter
Did you receive a response within 7 business days from 3rd outreach attempt?
Yes
No
Conduct unscheduled home visit within 14-30 days of 3rd attempt
Unsuccessful Outreach
Conduct 1 additional UTR home visit and telephonic attempt within 30 days
Refer to Family Planning Only
Notes
If the member's phone number is invalid, contact PCP, check all available system including Pharmacy
Invalid addresses will be sent for dis-enrollment
All outreach attempts will be conducted on different days and times
Initial outreach begins with 1st attempt in 3 to 5 business days.
1st attempt: Call
2nd attempt: Call
3rd attempt: UTR letter
4th attempt: Unscheduled home visit
UTC-Unable to Reach

P4HB Disenrollment:

Women who no longer meet the eligibility criteria outlined for the P4HB program will be disenrolled from the P4HB program: These include women who:

- Become pregnant
- Receive a sterilization procedure and complete all necessary follow-up
- Move out of the state
- Become incarcerated
- Change income status
- Become unable to become pregnant
- Women who have aged out

Rev. 10/12

Women who participate in the IPC component will be disenrolled after two (2) years of participation. They may transition to the Family Planning only component if deemed eligible following their IPC participation.

Redeterminations:

Redeterminations of eligibility for the P4HB program are conducted every 12 months.

What verification is required?

- Physician's Statement for P4HB Inter-Pregnancy Care and Resource Mother
- Hospital Confirmation of Birth Record that includes birth weight
- Care Management Organizations (CMO) Report

Planning for Healthy Babies (P4HB) and other COA

Rev. 01/17

When a member is actively receiving P4HB benefits and full Medicaid benefits are added (if the member becomes pregnant), she can apply for Presumptive Eligibility (PE) Pregnant Women Medical Assistance. P4HB services will be terminated the same day of her pregnancy eligibility to prevent dually eligible. *The RSM Pregnant Woman will supersede any Planning for Healthy Babies segment and the P4HB segment will be terminated.*

P4HB service claims should be filed with the members' Managed Care Healthy Babies (MCHB) plan. MCHB is the program reference that appears for P4HB members only. Fee for Service Medicaid claims must be filed with Fee for Service (FFS)/Gainwell Technologies, not with the MCHB plan.

Enrollment to IPC-180 and RM-181 &182 limited to 24 months

Rev. 01/18

Women applying for IPC 180 and RM 182 & 183 must have delivered a very low birth weight (VLBW) baby. Even if the member delivers multiple births on the same day or a different day, the birth of the last child delivered is used to count toward the 24 months. Therefore, the member will be disenrolled after 24 months of participation with an eligibility re-determination after 12 months. After her 24 months have ended, the IPC women may be eligible for FP only

services as long as she meets the eligibility criteria. The RM mother will be eligible for FP services if she has an active Parent Caretaker or ABD/SSI case in Gateway.

Prior to Exhausting the 24 Months

If an IPC 180 or RM 183 member leaves the program prior to exhausting their 24 months of services; she can reenter the program and reclaim the remaining months. If she delivers and reports another VLBW baby within her remaining 24 months, the clock will reset in Gateway, even if she did not complete her 24 months in a previous case. Any remaining months will be voided after verification of new reported VLBW baby and a new 24 months restarts. An IPC 180 and RM 182 & 183 member cannot exceed 24 months at any given period.

If a provider is having problems with claims or service issues, please contact the Gainwell Technologies Provider Contact Center and/or the Provider Representatives at 800-766-4456.

PLANNING FOR HEALTHY BABIES (P4HB)
AID CATEGORIES AND ELIGIBILITY CRITERIA

180 AID CATEGORY INTER-PREGNANCY CARE

- APPLICATION REQUIRED
- NET ELIGIBLE
- IPC FORM COMPLETED BY PROVIDER OR HOSPITAL CONFIRMATION OF BIRTH RECORD THAT INCLUDES BIRTH WEIGHT REQUIRED
- BIOLOGICAL WOMAN BETWEEN 18-44 YEARS OF AGE
- NOT PREGNANT BUT FERTILE
- INCOME NOT TO EXCEED 211% OF THE FEDERAL POVERTY LEVEL
- GEORGIA RESIDENT THAT IS EITHER A U.S. CITIZEN or LAWFULLY ADMITTED IMMIGRANT (5 YEAR REQUIREMENT)
- NOT RECEIVING MEDICAID, MEDICARE OR PRIVATE INSURANCE
- DELIVERED A VERY LOW BIRTH WEIGHT BABY (3LBS. 5 OZ. OR LESS) WITHIN THREE YEARS OF THE APPLICATION DATE
- CMO SELECTION REQUIRED

181 AID CATEGORY FAMILY PLANNING

- APPLICATION REQUIRED
- NOT NET ELIGIBLE
- BIOLOGICAL WOMAN BETWEEN 18-44 YEARS OF AGE
- NOT PREGNANT BUT FERTILE
- INCOME NOT TO EXCEED 211% OF THE FEDERAL POVERTY LEVEL
- GEORGIA RESIDENT THAT IS EITHER A U.S. CITIZEN or LAWFULLY ADMITTED IMMIGRANT (5 YEAR REQUIREMENT)
- NOT RECEIVING MEDICAID, MEDICARE OR PRIVATE INSURANCE
- CMO SELECTION REQUIRED

182 AID CATEGORY FAMILY MEDICAID RESOURCE MOTHER

- NO APPLICATION- RM FORM COMPLETED BY PROVIDER OR HOSPITAL CONFIRMATION OF BIRTH RECORD THAT INCLUDES BIRTH WEIGHT REQUIRED
- RECEIVING MEDICAID
- NET ELIGIBLE
- NOT PREGNANT BUT FERTILE
- DELIVERED A VERY LOW BIRTH WEIGHT BABY (3LBS. 5 OZ. OR LESS) WITHIN THREE YEARS OF THE APPLICATION DATE
- CONTINUE TO USE CURRENT CMO

183 AID CATEGORY ABD/SSI RESOURCE MOTHER

- NO APPLICATION- RM FORM COMPLETED BY PROVIDER OR HOSPITAL CONFIRMATION OF BIRTH RECORD THAT INCLUDES BIRTH WEIGHT REQUIRED
- RECEIVING MEDICAID
- NET ELIGIBLE
- NOT PREGNANT BUT FERTILE
- DELIVERED A VERY LOW BIRTH WEIGHT BABY (3LBS. 5 OZ. OR LESS) WITHIN THREE YEARS OF THE APPLICATION DATE
- CMO SELECTION REQUIRED

426 West 12th Street, Alma, GA 31510
PHONE 1-877-427-3224
FAX 912-632-0389 WEB www.gateway.ga.gov

APPENDIX I

P4HB PROVIDER INQUIRY NUMBERS:

877-P4H-B101 or 877-744-2101

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Planning for Healthy Babies

Amerigroup Community Care	**Care Source**	**Peach State Health Plan**
800-600-4441	888-901-0014	800-704-1484
www.myamerigroup.com	www.caresource.com	**www.pshpgeorgia.com**

The web contact address is:

www.dch.georgia.gov/planning-healthy-babies

APPENDIX J

ICD-10 OVERVIEW

Rev. 11/15

Please refer to Appendix J of the Part I Policies And Procedures For Medicaid/PeachCare For Kids manual for detailed information pertaining to ICD-10.

Rev. 10/15

APPENDIX K
Information for Providers Serving Medicaid Members
in the Georgia Families 360⁰ SM Program

Georgia Families 360⁰ SM, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

DCH, Amerigroup, and partner agencies -- the Department of Human Services (DHS) and DHS' Division of Family and Children Services (DFCS), the Department of Juvenile Justice (DJJ) and the Department of Behavioral Health and Developmental Disabilities (DBHDD), as well as the Children's and Families Task Force continue their collaborative efforts to successfully rollout this new program.

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 360⁰SM 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 360⁰ SM Every member in Georgia Families 360⁰ 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