PART II

POLICIES AND PROCEDURES
for
THE PROVIDERS' ADMINISTERED DRUG LIST



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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Revision Date	Section	Revision Description	Revision Type: A= Added D=Deleted M=Modified
10-1-2021	Appendix A	Quarterly Pricing Updates	M
10-1-2021	Appendix A	90619 - Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use (Menquadfi) – *Priced at WAC and not ASP*	M
10-1-2021	Appendix A	**90653** - Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use (Fluad) – *No active NDCs available at this time for 2021 Season. – Code is inactive*	M
10-1-2021	Appendix A	**J0698** - Cefotaxime Sodium, 1 g (Cefotaxime Sodium) – *Price changed from ASP to WAC*	M
10-1-2021	Appendix A	**J074**1 - Cabotegravir and Rilpivirine, 2mg/3mg (Cabenuva) – *New Product – Status is Preferred and requires PA*	A
10-1-2021	Appendix A	**J0795** - Corticorelin Ovine Triflutate, 1 microgram (Acthrel) – *All NDCs are inactive - Terminated*	M
10-1-2021	Appendix A	**J1305** - Evinacumab-dgnb, 5mg (Evkeeza) – *New Product – Status is Non-Preferred and requires PA*	A
10-1-2021	Appendix A	**J1437** - Ferric Derisomaltose, 10 mg (Monoferric) – *Price changed from WAC to ASP*	M
10-1-2021	Appendix A	**J1561** - Immune Globulin IV, (Human) nonlyophilized liquid 500mg (Gamunex C) - *Change status from Preferred to Non-Preferred*	M
10-1-2021	Appendix A	**J1602** - Golimumab for Infusion 1mg (Simponi Aria) – *Max unit changed from 250 to 300*	M
10-1-2021	Appendix A	**J1627** - Granisetron, extended-release, 0.1 mg (Sustol) – *Price changed from WAC to ASP*	M
10-1-2021	Appendix A	**J1800** - Propranolol HCl 1 mg (Inderal) – *Price changed from ASP to WAC*	M
10-1-2021	Appendix A	**J3315** - Triptorelin Pamoate, 3.75 mg (Trelstar – *Status changed from Preferred to Non-Preferred*	M
10-1-2021	Appendix A	**J3316** - Triptorelin, extended-release, 3.75 mg (Triptodur) – *Status changed from Preferred to Non-Preferred*	M
10-1-2021	Appendix A	**J9202** - Goserelin Acetate Implant, per 3.6mg (Zoladex) – *Status changed from Preferred to Non-Preferred*	M
10-1-2021	Appendix A	**J9217** - Leuprolide Acetate 7.5 mg (Eligard) – *Status changed from Preferred to Non-Preferred*	M
10-1-2021	Appendix A	**J9225** - Histrelin Implant (Vantas) 50mg (Vantas Implant Kit) – *Status changed from Preferred to Non-Preferred*	M

Revision Date	Section	Revision Description	Revision Type: A= Added D=Deleted M=Modified
10-1-2021	Appendix A	**J9226 -** Histrelin Implant, 50mg (Supprelin LA) – *Status changed from Preferred to Non-Preferred*	M
10-1-2021	Appendix A	**J9315 -** Romidepsin, 1 mg (Istodax) – *Update drug name; Price changed from ASP to WAC*	M
10-1-2021	Appendix A	**Q5104 -** Infliximab-abda, Biosimilar, 10 mg (Renflexis) – *PA discontinued*	M

PREFACE

The Providers' Administered Drug List (PADL) manual contains basic information regarding Georgia's Fee for Service (FFS) Medicaid and PeachCare for Kids programs and should be used in conjunction with Policies and Procedures Manual for Medicaid and PeachCare for Kids Part I, Part II Policies and Procedures Manual for Physician Services, and other applicable program manuals. We urge you and your office staff to familiarize yourselves with the contents of this manual and refer to it when questions arise. Use of the manuals will assist in the elimination of misunderstandings concerning the coverage levels and billing procedures that can result in delays of claims processing or payments, inaccuracies and/or denials.

Rev. 01/19

This manual is reviewed and updated quarterly. Effective January 1, 2018, approved drugs listed on the PADL (Appendix A) are re-priced on a quarterly basis. Drugs that are not re-priced by the manufacturer, no longer manufactured, or obsolete, may not be re-priced or changed— refer to the PADL (Appendix A) document available under Fee Schedule at www.mmis.georgia.gov.

When quarterly updates are made, they will be included in the manual posted on the fiscal agent's, GAINWELL TECHNOLOGIES, website 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.

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FOR THE
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CHAPTER 600

SPECIAL CONDITIONS OF PARTICIPATION

601. In addition to the general conditions of participation identified in Part I, Section 105, providers must meet all the conditions as outlined in the Physician Services Program in order to use the Providers' Administered Drug List (PADL).

601.1. Each enrolled physician agrees to bill the Division for only those services which are performed by the physician or under the physician's direct supervision.

Clarified 10/14

CHAPTER 700

SPECIAL ELIGIBILITY CONDITIONS

There are no special eligibility conditions for physician diagnostic and treatment services.

CHAPTER 800

PRIOR APPROVAL

801. Services That Require Prior Approval

As a condition of reimbursement, the Division requires that certain services or procedures be approved prior to the time they are rendered. This process is called Prior Approval. It pertains to medical necessity only; the patient must be Medicaid-eligible at the time the service is rendered.

801.1 Prior Approval (PA) Process for Provider Administered Drugs

FDA approved injectable drugs listed on the Providers' Administered Drug List (PADL) do not require prior authorization unless indicated. Effective for dates of service (DOS) on and after January 1, 2006, the Department began requiring PA for specific injectable drugs administered in providers' offices, outpatient hospitals, or other applicable outpatient settings. Injectable drugs requiring prior approvals (PAs) are indicated by this PA symbol.

PA requests for injectable drugs must be submitted via the **Georgia Web Portal.** The request must include applicable clinical information along with the corresponding ICD-10 diagnosis code, beginning October 1, 2015, CPT or HCPCS code and corresponding 11-digit National Drug Code (NDC) number. Requests that are incomplete may be delayed or denied for insufficient information. Failure to obtain a PA will result in denial.

> **NOTE:** *Providers must be registered web users with active user identifications and passwords to submit requests for PA via the web.*

For additional information or questions, please visit the Georgia Web Portal at www.mmis.georgia.gov using the "Contact Us" feature.

801.2 PA Process for Prescription Drugs (Outpatient Pharmacy)

PAs for prescription drugs on the Preferred Drug List (PDL) are handled through the Outpatient Pharmacy Program and are not considered through the Providers' Administered Drug PA process. *Providers are discouraged from using written prescriptions through the outpatient pharmacy program to obtain injectable drugs for administration in the office setting.*

For detailed information pertaining to outpatient pharmacy prior approvals and related pharmacy services, refer to *Part II Policies and Procedures Manual for Pharmacy Services.* The Pharmacy Services manual is accessible online at www.mmis.georgia.gov.

Add 04/18

801.3 Non-Preferred (NP) Status

All drugs on the PADL Schedule of Maximum Allowable (**Appendix A**) in Non-Preferred (NP) status require Letters of Medical Necessity (LOMN) to obtain approval for use. The LOMN must be submitted via the **Georgia Web Portal** in similar manner to requesting prior authorization for medications. Drugs listed in Preferred (P) status do not require LOMN.

Add 01/20

801.4 PA Denial Reconsideration & Administrative Review

Requests for reconsideration of a denied PA for PADL drugs are permissible and ***may*** require

additional clinical information ***and/or a*** Letter of Medical Necessity for further review. These requests are to be submitted in writing via the Prior Authorization Medical Review Portal and received within THIRTY (30) calendar days from the date of the denial notification.

The Department's medical review contractor, Alliant Health Solutions, offers opportunities for reconsideration upon the denial of a PA. All decisions will be completed within ten (10) business days of the date of receipt, and clinical rational used to determine all outcomes will be available upon written request. A total of two (2) requests for reconsideration are generally allowed. Providers have the right to submit a final request for administrative review to Alliant via the Medical Review Portal within thirty (30) calendar days of the last denial for reconsideration.

Providers may appeal the decision of the medical review contractor when it is believed that the denial of the PA is unjustified. This is an administrative review that will be conducted by the Department of Community Health. It requires a written request that must be received within thirty (30) days from the date of the last denial. The request must include all grounds for administrative review, must be accompanied by all supporting documentation and explanation that the provider wishes the Department to consider, and may be submitted to:

The Department of Community Health
Georgia Medicaid
Director of Medical Policy and Provider Reviews Unit
2 Peachtree St. NW – 37th Floor
Atlanta, GA 30303-3159

Failure to request timely reconsideration shall constitute a waiver of any and all further appeal rights, including the right to an Administrative Review. Please refer to Part I, Chapter 500 of the Policies and Procedures for Medicaid/PeachCare for Kids Manual for additional information.

CHAPTER 900

SCOPE OF SERVICES

901. General

The Providers' Administered Drug List program describes the reimbursement process for a broad range of injectable drugs, some immunizations and vaccines are subject to specific limitations as listed in the Manual. Federal regulations allow the state agency to place appropriate limits for medical necessity and utilization control. The Medicaid Division has developed reimbursement limitations to ensure appropriate utilization of funds. These limitations consist of (a) prior approval requirements described in Chapter 800 and (b) non- covered products described in Section 1003.

Rev 01/11

The PADL is comprised of FDA approved injectable drugs that are to be purchased by Physicians or outpatient locations and that are to be administered in physicians' offices or outpatient facilities by doctors or eligible staff. The injections must be reasonable, necessary and indicated for the diagnoses or effective treatments of specific illnesses or injuries based on accepted standards of medical practice. Requests to consider coverage of additional injectable drugs or make changes to

Rev 01/17

existing drug files will be completed in the order received. The goal is to complete the review and respond to requests within 30 days of receipt of the completed form – Provider Administered Drug List Review Request Form (PRRF) Forms are to be submitted electronically to injectable.rx@dch.ga.gov by clicking **'submit'** at the top of the form. Products listed on incomplete forms will not be considered. The form is Appendix B of this manual and is also located on the website site at http://dch.georgia.gov/provider-forms.

Therapeutic injections should be utilized only if equally effective oral medications cannot be prescribed without significant risks or increased side effects. Listed below in Section 904, are specific limitations in several coverage areas. Exceptions to these limitations will be considered if the provider can document the medical necessity of an injection.

902. Coding of Claims - CPT and HCPCS Codes

The Department's procedure coding encompasses the Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. The HCPCS coding scheme for injectable drugs includes the following levels of procedure codes:

a) Level II Alphanumeric codes for covered Medicare and Medicaid services;

b) Level III Codes created by CMS or its intermediaries for services for which no Level II codes have been established. These codes begin with A, C, Q, or S.

The Department does not accept all codes from these coding schemes. Georgia Medicaid covers only the codes for injectable drugs listed in Appendix A. HCPCS codes are drug and strength specific, therefore if the HCPCS code is listed in Appendix A, the drug, regardless of brand name

Rev 07/12

is covered if it is rebateable.

The Department does not recognize unclassified HCPCS codes (J3490, J3590, J7599, J9999, etc.), not yet assigned a unique HCPCS/CPT code; except where the unclassified code has been temporarily assigned to newly approved injectable drugs; and is billed in conjunction with the corresponding NDC number.

Rev 10/14

Effective October 1, 2014, providers may bill injectable drug claims using two different NDCs with the same HCPCS code for a GA Medicaid member on the same date of service (DOS). It is important that separate lines are used with the amount of each NDC that was administered. This will no longer provoke a duplicate edit response. The combined maximum daily quantity for both NDCs may not exceed the allowed amount per HCPCS code.

Administration fees for injectable drugs are not separately reimbursable under the Physician Services program with the exception of chemotherapy administration codes 96401-96542. Acquisition of a CPT code manual can be accomplished via mail at the address listed here:

CPT
Order Department OP054193
American Medical Association
Post Office Box 10950
Chicago, IL 60610

903. Billing Methodology

Effective April 1, 2003, the Providers' Administered Drug List's (PADL) reimbursement methodology is consistent with HCPCS Level II dose and description. Local codes (X-codes) are no longer reimbursable when billing injectable drugs.

Effective January 1, 2007 and pursuant to the Congressional Budget Reconciliation Act of 2006, practitioners are required to bill/report injectable drugs administered in offices and outpatient facilities using the manufacturers' 11-digit National Drug Code (NDC) numbers[1] with the preceding N4 qualifiers and/or HCPCS/CPT codes.

Single Dose Vials

Providers may now bill for the full contents of a single dose vial (SDV) of an injectable medication so that the unused amount is also reimbursed. Billing should include the total number of units contained therein and as listed in the PADL, these are generally not billed per vial.

Add 04/17

Effective January 1, 2017, CMS required JW modifier on Medicare Part B drug or biological claims when billing for discarded amount or portion not administered to any patient from a single use vial or package. Georgia Medicaid Management Information Services (GAMMIS) will process Medicaid/Medicare crossover claims with JW modifier, but its use is not required on claims that are direct submission to GAMMIS. The Department's billing and reimbursement methodologies make provision for wastage and claims submitted directly to GAMMIS with JW modifier will deny.

Clarified 07/10

Hospitals, dialysis facilities, and Federally Qualified Health Centers (FQHC) billing injectable drugs administered in outpatient facilities must submit claims using both, the NDC numbers (FL 43) and the HCPCS/CPT codes (Fl 44) when submitting electronically or in hardcopy on the UB Claim form.

Rev. 12/09

Providers are required to bill/report the NDC number printed on the drug's package, which can also be found in the package insert, that was used for each administration and claim, or batch of claims submitted. Failure to do so may result in billing an invalid or obsolete NDC number and a subsequent denial of the claim. Claims submitted with invalid NDC numbers are not eligible for rebates and are subject to recoupment by the Department unless the provider resubmits with the NDCs that were used on the DOS, during the procedure.

Claims for injectable drugs received for processing without the NDC numbers and/or HCPCS/CPT codes or with conflicting or invalid numbers or codes will result in denials.

Add 10/14

Georgia Medicaid is required by CMS (Centers for Medicare and Medicaid Services) to obtain rebates from all manufacturers for drug products reimbursed to providers, through the Georgia Department of Community Health (Department), regardless of quantity or price. Per this requirement, any claim submitted with a drug(s) must include the specific NDC (National Drug Code) and the corresponding HCPCS (Healthcare Common Procedure Coding System) code using revenue code 636.

Currently, the Department is not able to identify claims that require rebate, as the revenue code 636 is not being used; instead, revenue code 250 is being used. Continued practice of billing revenue code 250 inappropriately may warrant retrospective reviews by the Department's Office of Inspector General, Program Integrity Unit.

The HCPCS to NDC cross walk is updated and published quarterly by the Centers for Medicare and Medicaid (CMS). The crosswalk is accessible via the CMS website and by clicking on the direct link below:
http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02_aspfiles.asp#TopOfPage
then click the year on the left side, then Quarter that is needed for the ASP NDC-HCPCS Crosswalk.

Note: Not all drugs listed on the CMS crosswalk are eligible for reimbursement by Georgia Medicaid. For specific drugs approved for reimbursement by Georgia Medicaid, refer to the list of drugs contained in this manual

1

The National Drug Code (NDC) is an 11-digit number, assigned by the manufacturer and is clearly labeled on the drug's packaging (ex. 99999-9999-99). The first five (5) digits represent the manufacturer; the second four (4) digits represent the drug's strength and dosage form; and the last two digits represent the package size and coding. NDC numbers not reported in the 11-digit format previously outlined, will require a preceding zero to be added to the missing number field: **Example 1** – NDC listed as 99999-999-99 should be billed as 99999-**0**999-99 **Example 2** – NDC listed as 9999-9999-99 should be billed as 09999-9999-99

903.1 General Claim 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.

903.2 Non-Rebateable Drugs

Effective January 14, 2008, the Department no longer provides reimbursement for non- rebateable injectable drugs administered in physicians' offices or in outpatient settings.

This action is pursuant to the Deficit Reduction Act (DRA) and in accordance with the Social Security Act—Section 1927. **[**42 U.S.C. 1396r–8**]** (a), Requirement for Rebate Agreement, which cites, "In order for payment to be available under section 1903(a) or under part B of title XVIII for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement described in subsection (b)…" Section 1903(a) is applicable to all outpatient drugs, except for certain injectable drugs where the State has authorization from the Federal government though the State Plan for medical assistance. These exceptions include but may not be limited to vaccines, injectable vitamins, etc.

Rev. 01/18

Click on this link for the list of rebateable drugs on the CMS website: https://data.medicaid.gov/Drug-Pricing-and-Payment/Drug-Products-in-the-Medicaid-Drug-Rebate-Program/v48d-4e3e/data then search by NDC. Active drugs will not show a termination date in the column named "Termination Date". A termination date is the date the drug was withdrawn from the market or the last lot expiration date.

904. Service Limitations

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

Such documentation may be requested in a pre-payment or post payment review, and lack of appropriate medical justification will be grounds for the denial, reduction or recoupment of reimbursement.

904.1 Immunizations & Vaccines

Rev 10/17

The immunizations and vaccines identified in this manual are to be submitted using valid CPT codes. These products along with administration fee are covered accordingly:

Members from birth through 18 years old
The Vaccines for Children (VFC) program provides vaccines at no cost to providers for these members. Providers will only receive reimbursement for the vaccine administration fee through the Early and Periodic Screening Diagnostic and Treatment (EPSDT) Services - Health Check Program (COS 600).

Members 19 through 20 years old
The VFC program does not provide vaccines for these members. Providers must use their stock of vaccines and the Division will reimburse providers for the vaccine product and for the administration fee through (EPSDT) Services - Health Check Program (COS 600).

Members 21 years and older
The covered vaccines are listed in this manual as well as the Physician Services Manual (COS 430).

904.2 Vitamins

a) Vitamin B-12 injections are covered only for treatment of pernicious anemia and mal-absorption syndrome.

b) Other vitamin injectables are not covered unless the provider submits documentation of medical necessity. These injections should not be billed if the patient can tolerate oral medication.

904.3 Hormones

a) Hormone injections will not be reimbursed more frequently than once monthly.

b) Reimbursement for ACTH is limited to treatment of pituitary insufficiency, ulcerative colitis or infantile spasms, unless documentation of medical necessity is submitted.

c) Gonadotropin injections for obesity are non-covered.

904.4 Experimental Drugs/Unlabeled Use

Experimental drugs or non-experimental drugs when used as an experimental treatment modality are non-covered. Drugs used for unlabeled purposes are non- covered and shall not be billed to the department.

Investigational or experimental services, drugs, or procedures not covered by Georgia Medicaid include:

- The investigational item or service, itself unless otherwise covered outside of the CLINICAL TRIAL.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct CLINICAL management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan); and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the TRIAL.

The cost, however, of routine care and services that are otherwise generally available to Medicaid members, (i.e., there exists a benefit category that is not statutorily excluded) include:

- Items or services that are typically provided absent a CLINICAL TRIAL (e.g., conventional care);
- Items or services required solely for the provision of the investigational item or service (e.g., administration of a non-covered chemotherapeutic agent), the CLINICALLY appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service-in particular, for the diagnosis or treatment of complications.

904.5 Other Limitations

Claims for the following types of injections and medications must adhere to the specific limitations as described in this policy to obtain reimbursement:

a) Antipyretic injections, except for treatment of febrile convulsions of children or malignant diseases when fever cannot be controlled by any other means, are non-covered, unless sufficient documentation of medical necessity is provided

b) Bronchodilators, antihistamine, and decongestant injectables will only be reimbursed for the initial doses when the member is in the acute stage of illness or is unable to take oral medication (e.g., asthma).

c) Steroid injections will not be reimbursed more frequently than once monthly for chronic conditions (e.g., arthritis). Up to four (4) injections per month will be reimbursable for acute conditions (e.g., asthma, Herpes Zoster).

d) Antibiotic injections warranted by diagnosis will be reimbursed for the initial injection and two (2) additional injections when given on successive days (e.g., pneumonia).

e) Analgesic injections should be billed only as the initial dosage for acute conditions (e.g., acute myocardial infarction).

CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001 Reimbursement Methodology

The reimbursement policy is for drugs to be purchased for office use and subsequently billed for payment through the Medicaid program. Providers may not bill the Department for any portion of an injectable that was not purchased for use. Providers may not bill an administration fee with the exception of VFC (see below in this section) or for chemotherapy administration. (see section 902).

Rev. 09/09

Effective September 1, 2009, the Department of Community Health amended the maximum allowable reimbursement for approved drugs on the Providers' Administered Drug List (PADL) to the lesser of:

Rev. 01/19

a) The provider's usual and customary charge

b) Average Sales Price (ASP) plus 6%

Rev. 10/17

c) Wholesale Acquisition Cost (WAC) for injectable drugs that do not have ASP pricing, until such time that ASP plus 6% pricing becomes available. Drugs on the PADL that are priced without an ASP rate are denoted by an inverted triangle **[▼].**

Only the administration fee is reimbursable for vaccines and immunizations supplied through the Vaccine for Children's (VFC) Program or the Federal Government. These products are supplied at no charge to providers.

1002 Review and Record Keeping Requirements

The Department will continuously review injectable drug claims. Periodically, a random selection sample of claims will be thoroughly reviewed. In these cases, if questionable, we will request that providers send us documentation supporting the specific services billed to the Department. Therefore, we must require that all supporting documentation, including a copy of the claim, be maintained for the length of time specified in the Part I Policies and Procedures for Medicaid/PeachCare for Kids manual.

1003 Non-Covered Injectable Drugs and Services:

Drugs and services not covered through the Physician Services Program include, but may not be limited to, those that are:

1. not DCH-approved or not currently listed on the PADL
2. not FDA approved
3. experimental or investigational
4. used for off-labeled indications
5. not rebatable—except as indicated in Section 1927. [42 U.S.C. 1396r–8] of the Social Security Act

6. dispensed by and through an outpatient pharmacy
7. self-administered, except if included on the PADL
8. obsolete or invalid, as indicated by the manufacturer's NDC number
9. Unclassified or NOC HCPCS/CPT codes used to bill injectable drugs; unless otherwise indicated for temporary use to report newly approved injectable drugs— not yet assigned a unique HCPCS number by CMS. The Unclassified HCPCS codes must be billed/reported in conjunction with the corresponding unique/valid NDC number—no exceptions.

Rev. 01/09

APPENDIX A

Schedule of Maximum Allowable

Rev. 10/17 Effective July 1, 2017, The Providers' Administered Drug List (Appendix A) is published under Fee Schedule on GAMMIS: www.mmis.georgia.gov and identified as "PADL – Appendix A - Schedule of Maximum Allowable".

The covered injectable drugs that are frequently used in Physicians' offices and other outpatient settings such as outpatient hospitals and clinics are listed in order by HCPCS/CPT codes. Additionally, each code/injectable drug shows the maximum units allowed per day as well as the maximum reimbursed per unit.

Add 04/18 A HCPCS/CPT code designated as Non-Preferred (NP) requires a Letter of Medical Necessity (LOMN). In this instance, providers must submit this specific type of documentation via the **Georgia Web Portal** in similar manner to requesting Prior Authorization for medications.

Rev. 04/19 The PADL contains drugs approved for administration only in outpatient hospitals and only in dialysis facilities. Providers contracted as Outpatient Hospitals, Category of Service (COS) 070, and Dialysis Technical Services, (COS 720), may bill for the use of these medications. The column described as "HCPCS/CPT Name, Description…" shows the drugs marked "**070**" for outpatient hospital and "**720**" for dialysis facilities. Other categories of service providers are not approved for the use of these drugs.

APPENDIX B

Providers' Administered Drug List (PADL) Review Request Form

https://dch.georgia.gov/documents/providers-administered-drug-list-padl-review-request-form

Providers' Administered Drug List (PADL) Review Request Form

The request to consider coverage of additional injectables or changes to existing injectable drugs will be completed in the order received. The goal is to complete the review and respond to requests within 30 days of receipt of the completed form. For detailed information regarding the PADL policy refer to Part II Policy and Procedure Manual for the PADL. All Medicaid policy manuals for the Georgia Department of Community Health (DCH) are accessible online at www.mmis.georgia.gov; click on the "Provider Information" tab; then the "Medicaid Provider Manuals" link.

Request Date: _____

REQUESTOR CONTACT INFORMATION

Provider Name & Number: _____ **Name of office Contact:** _____

Practice/Company Name: _____

Address: _____ **City, State Zip** _____

Phone: _____ **FAX:** _____ **Email:** _____

REQUEST

Request consideration to: ☐ Open new injectable drug ☐ Chg or add new indication(s) to already approved dru

Chemical Name: _____ **Brand Name:** _____

HCPCS/CPT Code(s): _____ **Dose/Unit:** _____

NDC(S): _____ **WAC/Unit:** _____

Does the manufacturer offer rebates on the drug at this time? ☐ **Yes** ☐ **No**

Approved Indications(s): _____ **ICD-10 Code(s)** _____

FDA Approval Date: _____ **If not FDA approved, date application submitted?** _____

Is there a specific Medicaid eligible patient pending this determination? ☐ **Yes** ☐ **No**

If yes, please indicate patient's name and Medicaid ID# _____

Briefly summarize your request in the space provided below and attach any supporting documentation you wish to be considered:

_____

Submit completed request electronically to: injectable.rx@dch.ga.gov

for receipt by:

Medical Policy Unit/PADL Review
Georgia Department of Community Health

DCH USE ONLY

PBM Consulted (Y/N)	_____	**Comments:**
Approved/Denied	_____	
Maximum Allowable	_____	
Maximum Units	_____	
PA Required (Y/N)	_____	
Effective Date	_____	
Requestor Notified (Y/N)	_____	
Date Review Completed	_____	

APPENDIX C

Georgia Families

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

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

The three licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	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 due to moral or religious objections • PCP moves, retires, etc.	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.

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

Amerigroup Community Care	CareSource	Peach State Health Plan

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

PHARMACY

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

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

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?

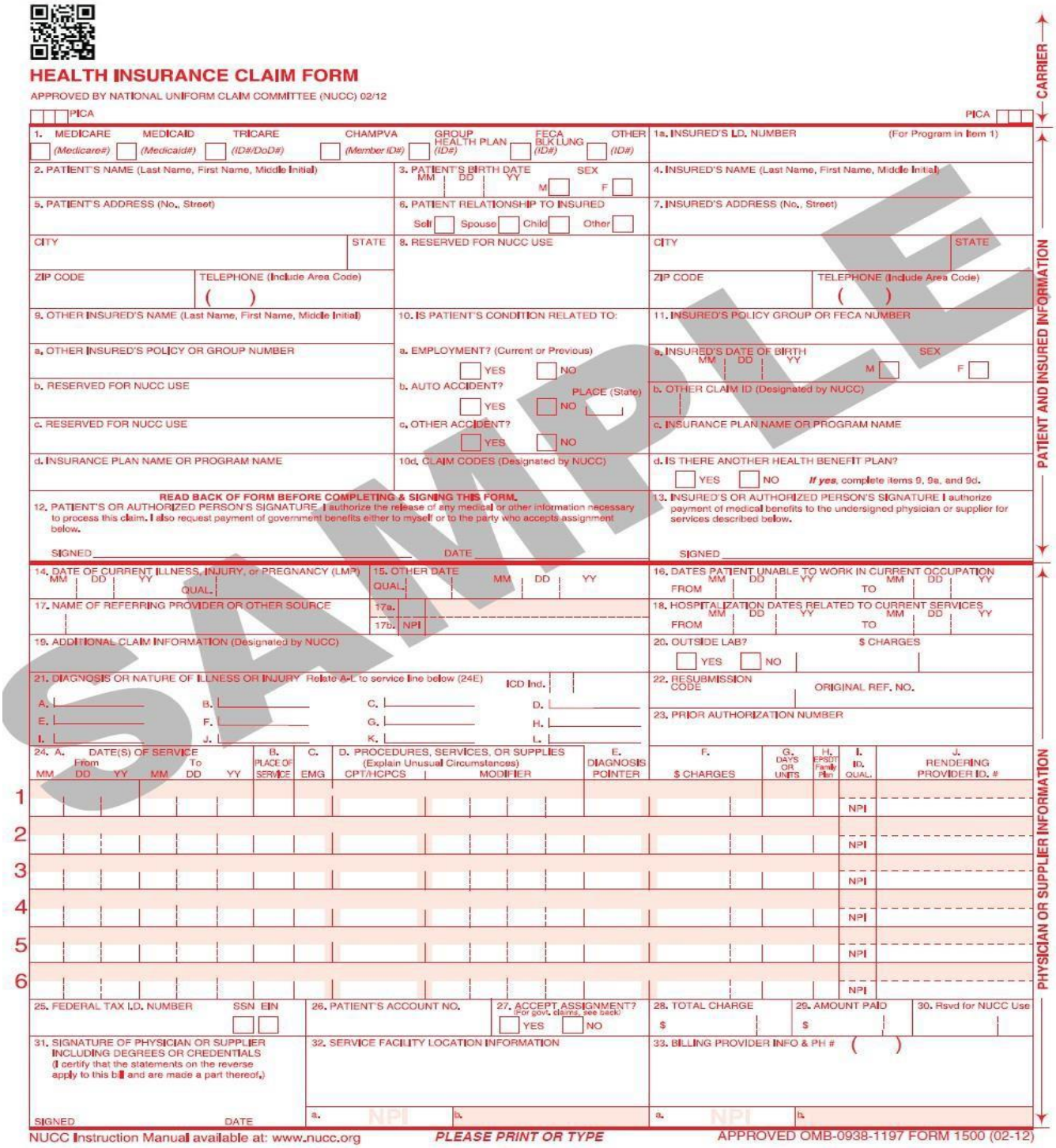
No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

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 D

NEW CMS 1500 Claim Form (version 02/12) & ZFLD Locator Instructions



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

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 YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										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 NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two- dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/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); or 453 (Estimated Delivery Date).**
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).

APPENDIX E



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

Georgia Families 360^{0} SM, the State's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

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

Georgia Families 360^{0} 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

APPENDIX F

ICD 10 Overview

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