PART II

POLICIES AND PROCEDURES
for
CHILDREN'S INTERVENTION SCHOOL SERVICES
(CISS)



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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PART II - POLICIES AND PROCEDURES
FOR
CHILDREN'S INTERVENTION SCHOOL SERVICES-

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INTRODUCTION

This manual describes the Medicaid Children's Intervention School Services (CISS) Program, services reimbursed under the program, provider qualifications, Medicaid-eligible student qualifications and general and specific service requirements. The purpose of this Manual is to provide information regarding the Federal and State Medicaid requirements for claiming Medicaid for children with an Individualized Education Program (IEP) under the CISS program.

There are 180 Local Education Agencies (LEAs) in Georgia. Each LEA is responsible for ensuring that students with disabilities receive the health care necessary to allow them to obtain a free appropriate education.

The phrase 'Written Service Plan' has been removed from this manual in January 2015 and replaced with the phrase 'Plan of Care' or 'Care Plan'.

CHAPTER 600

SPECIAL CONDITIONS OF PARTICIPATION

601. General Information

Medicaid, in the State of Georgia, is administered by the Georgia Department of Community Health, Division of Medical Assistance Plans. Policies and procedures are developed within Federal and State guidelines.

601.1 Purpose: The purpose of the Medicaid Children's Intervention School Services (CISS) Program is to provide reimbursement for medically-necessary services that are received in schools and provided by or arranged by an LEA for Medicaid-eligible students with an Individualized Education Program (IEP).

The Children's Intervention School Services (CISS) program includes covered rehabilitative services provided by or through the Georgia State Department of Education (DOE) or a Local Education Agency (LEA) to children with or suspected of having disabilities, who attend public school in Georgia, recommended by a physician or other licensed practitioners of the healing arts to EPSDT eligible special education students (from ages 3-20). These services are provided pursuant to an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

601.2 Medicaid Policy Manual: This manual is intended for use by LEA providers who are enrolled in the CISS program. Specific policies for each CISS service reimbursed by Medicaid are contained in service specific sections in Chapter 900 of this manual.

601.3 The LEA must enroll as the provider for all schools in their system and must choose one of the following options:

Option 1: The LEA employs health professionals such as therapists and nurses and has direct supervision and control over those professionals' activities. The arrangement between the LEA and its providers governs how and by whom Medicaid is billed for services and to whom payment may be made. Where the LEA employs the staff that provides the health services, the LEA can enter into a provider agreement with the Medicaid program and receive Medicaid payments for the covered services provided.

Option 2: The LEA contracts with health practitioners or clinics to furnish services.

Federal Medicaid requirements permit Medicaid providers to voluntarily reassign their right to payment to a governmental entity. Consequently, the LEA and the provider must work out an agreement under which the provider reassigns payment to the LEA; the LEA may both bill and receive payment directly from the State Medicaid agency. Under these circumstances, the provider must be separately qualified and meet all State licensing requirements for their discipline. In addition, assignment to the LEA must be accomplished in a way that satisfies all applicable Federal requirements. The LEA is responsible for billing third party payers and Medicaid on behalf of the licensed providers.

Option 3: The LEA uses a combination of employed health professionals and contracted health professionals to furnish services. In general, where an LEA provides a service through employed staff and contracts with additional health professionals to supplement the care and services being provided by its own employees, the LEA can still qualify as the provider and receive payment from the Medicaid agency for the services being provided by both the employed and contracted health staff. A key element in making the determination that the LEA is the provider is that the LEA itself provides the service through its own employees and includes certain contracted health professionals only to supplement that which it is already providing. For example, the LEA may employ one physical therapist and contract with other physical therapists to supplement the services provided. The LEA is responsible for billing third party payers and Medicaid on behalf of the licensed providers. In addition, the LEA and the provider must work out an agreement under which contracted providers agree to allow the LEA to bill Medicaid.

Option 4: This model is similar to Option 3, in which the LEA uses a mix of employed and contracted providers. This model is used where the LEA provides some services directly, but wishes to contract out entire service types without directly employing even a single practitioner in a service category. The LEA may establish itself as an organized health care delivery system under which it provides at least one service directly, such as physical therapy, but provides additional services solely under contract. Under this model, payment must be made to the LEA on behalf of those contracted providers who have voluntarily agreed to enter into this arrangement with the LEA. The LEA may use one or a combination of these options to bill for health care services for Medicaid-eligible students. If an LEA chooses to enroll as a Medicaid provider for any of the services included in this manual, it must be reimbursed under the policies for the CISS Program.

601.4 The CISS Program offers coverage for medically necessary restorative or rehabilitative services to eligible recipients in public schools. **Services must be determined to be medically necessary and be recommended and documented as appropriate interventions by a physician.**

A multidisciplinary team meeting must be held to develop the IEP. This meeting confirms the collaboration of the appropriate professionals to identify and meet the needs of the student with disabilities, and to determine the strategies and activities necessary to achieve the documented outcomes. (Refer to Section 801.1 for the applicable federal law governing authorization for each therapy type – Audiology, Counseling, Nursing, Nutrition, Occupational Therapy, Physical Therapy, and Speech Language Pathology).

601.5 The CISS program is comprised of seven (7) intervention services which include: Audiology; Counseling provided by licensed Clinical Social Workers; Nursing; Nutrition provided by licensed Dietitians; Occupational Therapy; Physical Therapy; and Speech Therapy. Qualified providers must be currently licensed in the State of Georgia as Audiologists, Clinical Social Workers, Registered Nurses, Dietitians, Occupational Therapists, Occupational Therapist Assistants, Physical Therapists, Physical Therapist Assistants, Speech Language Pathologists, or Master's prepared Speech Language Pathologists certified by the State Department of Education and employed by an LEA.

602. Enrollment

In order to receive Medicaid reimbursement under the CISS program, the LEA must enroll as a provider and must agree to the statements below. Provider enrollment contact information and Georgia Health Partnership (GHP) information can be found in Appendix C.

602.1 The Memorandum of Understanding between DCH and the LEA must be signed by the LEA's superintendent or other designated official and received by the Division prior to the LEA billing Medicaid for school-based services. Failure to do so may result in the recoupment of funds.

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All required enrollment documents must be uploaded with the provider application in the Medicaid web portal. **Effective October 1, 2022, the Memorandum of Understanding must be emailed** to Tamara Wilson at twilson@dch.ga.gov.

> Note: See Appendix A for the Memorandum of Understanding that each LEA must sign.

602.2 The LEA must employ or contract with health care staff who meet the Medicaid provider qualifications to provide the specific services for which the LEA will bill Medicaid. The LEA must sign an agreement with Medicaid certifying that all of its health care staff meet the Medicaid provider qualifications. Note: See the service specific sections in Chapter

900 in this manual for the individual provider qualifications for specific services.

602.3 The LEA must maintain documentation that the continuing education requirements have been met for each practitioner.

602.4 The LEA is not required to assign the Department of Education as the payee on the "Power of Attorney for Payee" and Electronic Funds Transfer (EFT) forms in order to participate. The LEA may receive payments directly via EFT only.

602.5 LEAs may enroll in the Health Check Program (COS 600) to serve as telemedicine originating sites only. The originating site is the actual location at which an eligible Medicaid member is receiving services via the telecommunications system. In order to enroll as a Health Check provider, the LEA will be required to submit a signed copy of the Attestation Form "For the Provision of Telehealth Services by Georgia's Local Education Agencies (LEAs)" which indicates that the LEA will comply with the telemedicine requirements as established in the current DCH Georgia Medicaid Telemedicine Handbook. The Attestation Form is located on the MMIS web portal under the "Provider Information, Forms, Enrollment" tab. Please complete the form and fax it with the coversheet located under the "Provider Information, Forms" tab to Gainwell Technologies Provider Enrollment at 1-866-483-1044. See section 603.20 for claiming information.

603. Conditions of Participation

In addition to the General Conditions of Participation in the Medicaid program as outlined in Section 106 of the Part I Policies and Procedures for Medicaid and PeachCare for Kids®, LEAs enrolled in the CISS program must meet the following conditions:

603.1 Maintain a copy of their practitioners' professional licenses or certifications and continuing education credits on file on site for audit purposes.

603.2 Adhere to the service limitations stipulated in the written Individualized Education Program (IEP).

603.3 Maintain a copy of the written IEP in the child's confidential file or record.

603.4 Assure that there is no duplication of service(s) by the LEA's providers or duplication between the LEA's providers and the community providers enrolled in the Children's Intervention Services program.

603.5 Notify the fiscal agent's Provider Enrollment Unit in writing or via the GHP website (refer to Appendix C) should any change in enrollment status occur, such as new address and/or telephone number, additional practice locations, change in payee, or voluntary termination from the program. Each notice of change must include the date on which the change is to become effective.

603.6 Submit the signed Memorandum of Understanding (See Appendix A).

603.7 Submit claims using the procedure code(s) and the appropriate modifier(s) which best describes the level and complexity of the service rendered (See Chapter 900).

603.8 Maintain and provide access to records which fully disclose the medical necessity for treatment and the extent of services provided to Medicaid recipients. These records must be available to the Division and its agents and to other state/federal agencies when requested.

603.9 Maintain member confidentiality at all times.

603.10 Maintain written documentation of all services provided to recipients for a minimum of five (5) years after the date of service.

603.11 Maintain on site all medical and fiscal records pertaining to Medicaid recipients for a period of five (5) years. These records must be made available to the Division or its agents when requested.

603.12 All LEA practitioners are required to maintain in their records, verification that they have obtained a minimum of one third of their required professional State Licensing Board Continuing Education Units (CEU's) in pediatrics every two years. Registered nurses must obtain and submit verification of ten (10) clock hours or one CEU in pediatrics every two years. The certified speech language pathologist must meet the equivalent continuing education requirements as the licensed speech language pathologist.

603.13 Maintain and submit all records and reports required by the LEA to ensure compliance with the IEP.

603.14 Provide school health services as listed in the IEP.

603.15 Medicaid is the payor of first resort for IEP related health services.

Note: The Regional Educational Service Agency (**RESA)** cannot be enrolled in Medicaid as a provider and **cannot** bill for health related services as the LEA in the CISS program.

603.16 Providers **should not** bill for services provided prior to the date that medical necessity was determined and documented. This documentation must include a physician's signature and signature date on the Letter of Medical Necessity or Plan of Care and either signed and dated document must be included in the child's IEP. Any change in the child's needs detected by the CISS provider must be documented in the Letter of Medical Necessity or Plan of Care and submitted to the child's PCP for review. If a child has been formally discharged from any Medicaid health related services and requires a restart of service(s) a new medical necessity document is required.

603.17 In order to bill Medicaid under the CISS program, the LEA's health care staff must be fully or partially state funded. They cannot be 100% federally funded.

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603.18 LEAs participating in the Georgia Administrative Claiming for Education (ACE) program must submit CISS Program claims for the direct services provided within the school setting in order to submit ACE claims. For quarterly ACE payments to occur, corresponding CISS claims must be received by DCH during the same quarter and cover service delivery within the same quarter that the ACE claim covers. For example, if the LEA submits claims for the delivery of OT and PT services under the CISS program during the January through March quarter, they will be eligible to submit an ACE claim for relevant administrative activities that occurred during that same January through March quarter. If no CISS claim is submitted for the quarter, the LEA is not eligible to submit an ACE claim for that quarter.

603.19 LEAs participating in the CISS program or the CISS and ACE programs must adhere to the requirements outlined in the LEA's MOU with DCH. Failure to adhere to these requirements may: limit the LEA's ability to submit an ACE claim; result in a recoupment of funds under the CISS program; or result in suspension from participation in the ACE or CISS programs. Non-compliant LEAs will also be subject to the remedial actions identified in the MOU (found in Appendix A).

603.20 Effective April 1, 2016, LEAs are allowed to enroll in the Health Check Program (COS 600) to serve as telemedicine originating sites only. As a Health Check provider, the LEA serving as a telemedicine originating site will be allowed to bill only the telemedicine originating site facility fee

(procedure code Q3014). The LEA should report procedure code Q3014 along with the EP and GT modifiers, Place of Service (POS) 03, and the appropriate ICD-10 diagnosis code(s). The diagnosis code(s) should be the same diagnosis code(s) listed on the distant site (rendering) provider's claim. The rendering provider serving as the telemedicine distant site should report the evaluation and management (E/M) office visit code (992xx) along with the GT modifier (including any other applicable modifiers), the appropriate POS, and the ICD-10 diagnosis code(s). LEAs are reimbursed for procedure code Q3014 under the Health Check Program (COS 600). It is the responsibility of the LEA to contact the provider who rendered the distant site service to determine if the E/M visit was billed.

604. Cost Settlement Process

Effective October 1, 2010, all LEAs participating in the CISS program must participate in an annual Cost Report and Cost Settlement process. In addition, participating LEAs must participate in CISS Cost Report and Cost Settlement process training conducted by DCH or its vendor to become well versed in these processes. Additional questions following training must be directed to DCH staff and/or the DCH contracted vendor managing the CISS Cost Report and Cost Settlement processes.

604.1 The Certification of Public Expenditures (CPE) form allows each LEA to certify their incurred total computable expenditures (funded from state/local funds) that are eligible for Federal matching funds for Medicaid school based health services delivery. By signing the CPE form, the LEA's superintendent, CEO, or CFO is certifying that they incurred allowable expenditures during the period identified on the form that were funded from state/local funds in an amount equal to or greater than the total Medicaid CISS interim payment received for the same period.

604.2 The annual CPE form contains the Total Expenditures, Total Medicaid Expenditures, Medicaid Interim payments, and Medicaid Cost Settlement amounts. The LEA must identify the local account code(s) from which the expenditures identified were drawn. By signing the annual CPE form, the LEA official is certifying the public expenditures identified that were used to match the federal funds under the Medicaid program.

604.3 On an annual basis, the initial CISS cost settlement notifications are sent to the LEAs. The LEA will be allowed time to review the cost settlement notification and request an administrative review should questions arise regarding the cost settlement amount. Providers also have appeal rights. Please refer to the Part I Policies and Procedures for Medicaid/PeachCare for Kids for additional information on the administrative review and the appeals processes. Following the review period, the LEA will be sent a

final cost settlement notification along with a request for the annual CISS CPE form to be certified in the financial information system designated for this program and process.

605. General Service Requirements

605.1 **Medically necessary, medical necessity or medically necessary and appropriate** means medical services or equipment based upon generally accepted medical practices in light of conditions at the time of treatment which are: appropriate and consistent with the diagnosis of the treating physician and the omission of which could adversely affect the eligible member's medical condition; compatible with the standards of acceptable medical practice in the United States; provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; not provided solely for the convenience of the member or the convenience of the health care provider or hospital; not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage; and there must be no other effective and more conservative or substantially less costly treatment, service and setting available.

605.2 Place of service: For Medicaid purposes, services may be provided at the school or in a community setting if services rendered are listed on the IEP from a school or in the Medicaid-eligible student's home if the student is classified as homebound and still requires the services in his or her IEP.

606. Parental/Guardian Consent

606.1 LEAs must obtain written permission/consent from the parent/guardian of the Medicaid-eligible student prior to billing Medicaid. Appendix B contains a suggested sample consent form. The parental/guardian's written permission/consent needs to be obtained only once. Parents/guardians must inform the LEA, in writing, if they no longer wish to allow Medicaid to be billed. The LEA must inform the parents/guardians of the procedure to withdraw consent. If the IEP is utilized as the consent form, the exact wording in Appendix B must be included on the IEP form and parental/guardian consent obtained. If the IEP option is chosen for parental consent to bill Medicaid, then parental consent must be obtained annually.

606.2 The consent form must be fully explained to the parent/guardian. Parents/guardians should be informed that Medicaid eligible children, who also have private insurance, are eligible to receive Medicaid covered services provided and billed by the LEA. Medical necessity and the child's IEP determine the services to be provided by the LEA. The LEA may remind the parents/guardians that Medicaid is the payor of first resort for IEP related health services.

Parents should also be informed that Medicaid eligible children may receive services through the Children's Intervention Services (CIS) program while receiving services through the CISS program if both programs are required to meet the child's medical needs. This information is to be explained at the time the LEA obtains parental/guardian consent.

606.3 This signed consent form must be retained in the Medicaid-eligible student's record.

607. Documentation Requirements

Each rendering provider delivering CISS services must maintain legible, accurate and complete charts and records in order to support and justify the services provided. Charting means a method of documenting the rendering provider's encounter with a member and the essential medical information about a member obtained during the encounter. Charting includes the signature of the rendering provider and the signature date. Electronic and fax signatures are acceptable under documentation requirements only if these documents are legible. When a fax document or signature is included in the medical record, the document with the original signature must be retrievable from the original source. Records of service must be entered in chronological order by the practitioner who rendered the service.

In accordance with Centers for Medicare and Medicaid Services (CMS) requirements, each LEA must keep organized and confidential records that detail member information regarding all specific services provided for each member and retain those records in a centralized designated area for review.

Required Documentation

Documentation is needed to support an audit trail and the medical necessity of the service. The basic minimum elements to be documented are: date of service; name of member; person providing the service (manuscript); signature (electronic signature is acceptable) of person providing the service; time of visit; units of service; and medical justification of the service. Initial justification of medical necessity for any Medicaid paid service to be provided must include, at a minimum: an initial evaluation; a plan of care to include a summary of the services to be provided; and the goal(s) for treatment. These services must be recommended and documented as appropriate interventions by the child's primary care practitioner (PCP) or other prescribing practitioner at the request of the PCP. The documentation of medical necessity, as previously described, must be

included in the child's IEP. Just as the IEP must be updated on an annual basis, so must documentation of medical necessity.

Note: When Medicaid eligible school-aged children are deemed to need medically necessary services in both the school and community settings, CIS and CISS providers must collaborate and share the medical necessity documentation to ensure the services will not be duplicative in these settings. Duplicated services are defined as medically necessary therapy services that: provide the same general areas of treatment, treatment goals, or ranges of specific treatment or processing codes, notwithstanding a difference in the setting, intensity, or modalities of skilled services and; address the same types and degrees of disability as other concurrently provided services (via other community, school or hospital-based providers).

A PCP's prescription for services alone, does not serve as documentation of medical necessity. As previously stated, the PCP must prepare a Letter of Medical Necessity, sign and date it or review the treating provider's Plan of Care, included in the treatment section of the child's IEP, sign and date it in order to document medical necessity for the CISS service (audiology, counseling, nursing, nutrition, occupational therapy, physical therapy, or speech therapy) to be rendered to the member and reimbursed by Medicaid or PeachCare for Kids. The LMN or POC must identify the rehabilitation potential, set realistic goals and outline when and how progress will be measured. At the time the LEA obtains the PCP's signature on the medical necessity documentation, The LEA should also obtain the PCP's NPI number for Medicaid billing purposes. All claims submitted by the LEA must contain the NPI number of the PCP ordering or prescribing the CISS service.

The signed and dated Letter of Medical Necessity or Plan of Care must also contain, at a minimum, and as applicable for the type of service to be provided: the member's full name, Medicaid number, date of birth, type of modalities and procedures, effective dates and frequency of visits, estimated duration, location of services, diagnosis/ or condition requiring treatment, functional goals and recovery potential, current level of function, child's progress to date and goals to be achieved as well. With the exception of group speech therapy services, all CISS-related services are provided to the child on an individual basis and billed as such by the LEA. Effective April 1, 2013, when the child's PCP determines that group speech therapy is medically necessary, the PCP must specifically document this service type in the Letter of Medical Necessity or Plan of Care.

For CISS services rendered during the 2011-2012 school year, the LEAs may utilize documents allowed prior to the establishment of the October 2011 requirements as documentation of medical necessity. If this documentation is in place and supports CISS service delivery for the entire school year, no additional medical necessity documentation will be required for CISS service delivery and Medicaid billing during the 2011-2012 school year. If the documentation expired prior to the end of the 2011 – 2012 school year, the LEA needed to comply with the requirements set forth in the then current CISS manuals for all services rendered and for Medicaid billing. If no medical necessity documentation was in

place as of October 2011, the LEA must comply with the policies outlined in the October 2011 CISS Manual.

For group speech therapy services rendered during the 2012-2013 school year, the LEA may utilize documents allowed prior to the establishment of the April 1, 2013 requirements as documentation of medical necessity if this documentation was in place and supported group speech therapy service delivery for the entire school year. If the documentation expired prior to the end of the 2012-2013 school year, the LEA needed to comply with the CISS Policies and Procedure pertinent to the time period in question.

The above requirements apply to all CISS providers regardless of the setting in which the service is rendered.

Documentation of school-based medical services presents further unique challenges for the following reasons: (1) one service type – speech therapy - may be provided within a group setting or on an individual basis; (2) speech therapy services specifically may be provided in a classroom setting where a provider is serving/attending one or more children at the same time, or in a separate, distinct room/part of the school; and (3) some CISS services may be provided by the same provider to the same child at different times during the day. Thus, in addition to meeting the basic minimum documentation requirements discussed in the paragraphs above, the school-based provider must also document: whether the service is group or individual; the number of children in the group (Speech Therapy is the only service that can bill for group therapy); the setting (classroom or distinct treatment area); and cumulative time of services if the service is provided several times during the same day.

If group speech therapy is provided, this should be noted in the provider's documentation for each child receiving services in the group. For Speech Language Pathologists conducting inclusion services for children with an IEP) in a classroom setting or who provide a service several times during the course of a single school day, the documentation should reflect the inclusion services and the duration of services noted in the chart should accurately reflect how much time the provider spent with the child during the day. Such documentation ensures that an adequate audit trail exists and that Medicaid claims are accurate.

The student's IEP, which is generally only revised once a year, does not serve as documentation sufficient to: demonstrate that a service was actually provided; justify its ongoing medical need (unless it is updated whenever medical necessity changes, reviewed and signed by the child's PCP); or develop a Medicaid claim. The IEP identifies what services are to be provided and at what frequency. It does not document the provision of these services.

607.1 Student Records

In order to support the Medicaid claim, each LEA should prepare and preserve the following information in the suggested format for each claim for Medicaid reimbursement.

REQUIRED INFORMATION	DOCUMENTATION FORMAT
A. Date and location of service	Treatment Record or Provider Logbook
B. Student's name and date of birth	IEP, Treatment Record
C. Medical Condition, Diagnosis, Medical Necessity, Rehabilitation Potential, Goals	IEP, Letter of Medical Necessity, Plan of Care signed by the physician and rendering provider
D. Type of Service	IEP, Treatment Record
E. Who provided the service and their qualifications	Treatment Record or Provider Logbook
F. Length of time the service was performed for each encounter, specific location of where service was provided	Treatment Record, Provider logbook
G. Progress in treatment toward stated objective(s)	Standard progress grading period (not to exceed 9 weeks)
H. Test and results	IEP, Treatment Record

Note: Practitioners/Clinicians are encouraged to keep their own records of each encounter, including the treatment or therapy methods used, progress achieved, and any additional notes required by the needs of the student. The format of these personal notes/records will not be mandated, but should be retained for future review by State or Federal Medicaid reviewers.

If checklists or other charts are used, they must contain, at a minimum, the information listed in Section 607 above and a narrative note summarizing the treatment done at least once during the standard progress grading period. Modifications/recommendations for additional treatments, procedures or consultations should be addressed in the narrative note.

ADDITIONAL REQUIREMENTS

Annual reports that document the IEP services and the progress of the child should be shared with the parents so they can share these with the member's Primary Care Provider.

Note: The annual report is a summary that documents the student's progress or lack of progress and plan of treatment or other recommendation(s).

Records must be available to the Division of Medical Assistance Plans and its agents and to the U. S. Department of Health & Human Services, Centers for Medicare and Medicaid Services, upon request.

Lack of appropriate medical justification may be grounds for denial, reduction or recoupment of reimbursement.

608. Medical Services Under the Individuals with Disabilities Education Act (IDEA)

Medical Services under the Individuals with Disabilities Education Act (IDEA) (Medicaid and School Health: A Technical Assistance Guide, HCFA, 1997)

IDEA, formerly called the Education of the Handicapped Act, authorized Federal funding to states for programs that impact Medicaid payment for services provided in schools. This permits Medicaid payment for medical services provided to children under IDEA through a child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

Part B of IDEA was designed to ensure that children with special education needs receive a free appropriate public education. As LEAs are aware, under Part B of IDEA, LEAs must prepare an IEP that specifies all special education and "related services" needed by each child. Medicaid reimbursement may be requested for some of the "health related services" required by Part B of IDEA in an IEP that are provided to Medicaid eligible children. Most services included in an IFSP are reimbursed by the Children's Intervention Services (CIS) program, not the CISS program.

In addition, if medical evaluations or assessments are conducted to determine a child's health-related needs for purposes of the IEP/IFSP, payment for some or all of the costs may be available under Medicaid. However, if the evaluations or assessments are for educational purposes only, Medicaid reimbursement is not available.

In summary, the policy of the Centers for Medicare and Medicaid Services (CMS) is that health related services included in a child's IEP or IFSP can be covered under Medicaid as long as:

1. the services are medically necessary and coverable under Medicaid, i.e. physical therapy, occupational therapy, etc.

2. all other Federal and state regulations are followed, including those for provider qualifications, comparability of services and the amount, duration and scope provisions; and

3. the services are included in the state's Medicaid plan.

Effective March 18, 2013, IDEA 2004 Regulations Section 300.154 (d) (2) (iv) (Federal regulations published by the U.S. Department of Education):

The Department of Education clarifies the parental consent a public agency must obtain prior to accessing a child's or parent's public benefits or insurance for the first time. §300.154(d) (2) (iv)

The Department of Education requires "that the public agency provide written notification to the child's parents both prior to accessing a child's or parent's public benefits or insurance for the first time, and annually thereafter." §300.154(d) (2) (v)

FREE CARE RULE

In light of the Departmental Appeals Board (DAB) Decision No. 1924 (2004) ruling, CMS withdrew its prior guidance on the "free care" policy as expressed in the School-Based Administrative Claiming Guide and other CMS guidance in December 2014. Under the new guidance, Medicaid reimbursement is available for covered services under the approved state plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large.

Third Party Liability Exceptions to the Free Care Rule

The Medicaid statute contains an exception at section 1903(c) of the Act, which requires that Medicaid serve as the primary payer to schools and providers of services in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) under the IDEA. Likewise, IDEA sections 612(e) and 640(c), codified in 20 U.S.C. 1412(e) and 1440(c), provide that nothing in the IDEA permits a state to reduce medical or other assistance available, or to alter eligibility, under Titles V (relating to maternal and child health) and XIX of the Social Security Act (relating to Medicaid for infants and toddlers with disabilities and to the provision of a free appropriate public education to children with disabilities) in the state.

PART II CHAPTER 700

SPECIAL ELIGIBILITY CONDITIONS

Children's Intervention School Services (CISS) are provided to Medicaid-eligible recipients ages three through twenty (20) years with physical disabilities or a developmental delay, who have been recommended for rehabilitative or restorative intervention services by the child's primary care practitioner (PCP) or other prescribing practitioner at the request of the PCP, within the scope of his or her practice under State Law, and who are included in the following categories:

1. Students with specified disabilities, as defined in Georgia's Special Education Rules and are eligible under the Individuals with Disabilities Education Act (IDEA Part B), and have an authorized Individualized Education Program (IEP).

   (A) (i.) IN GENERAL-The term "child with a disability" means a child (i) with mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance (hereinafter referred to as "emotional disturbance"), orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities; and

   (ii) who, by reason thereof, needs special education and related services.

To be qualified under the Medicaid Children's Intervention School Services Program described in this manual, a Medicaid-eligible student must meet the following criteria:

A. Be Medicaid-eligible on the date of service

B. Be under 21 years of age

C. Be considered disabled under LEA definitions

D. Have Medicaid reimbursable services documented in the Letter of Medical Necessity or Plan of Care and included in his or her IEP.

2. Eligible students may receive medically necessary services through the CISS program and the Children's Intervention Services (CIS) program simultaneously when the services have been deemed medically necessary and not duplicative. See Section 606.2)

CHAPTER 800

INDIVIDUALIZED EDUCATION PROGRAMS AND Non-IEP WRITTEN REFERRALS

801. Individualized Education Programs

801.1 Individualized Education Programs – IEP

The Letter of Medical Necessity or the Plan of Care included in the Medicaid-eligible student's IEP, which is generally revised annually, must identify the rehabilitation potential, set realistic goals and measure progress. The plan must contain the type of modalities and procedures, frequency of visits, estimated duration, diagnosis, functional goals and recovery potential.

An IEP is required for recipients with specified disabilities, as defined in Georgia's Special Education Rules. It is developed by the school, the child's teacher, parent and the appropriate licensed practitioner(s). It details the specific health-related services required in order to assist the student with a disability to benefit from his/her special education, along with the amount, frequency, duration and method of delivering the services.

Therapy Services Identified in Federal Regulations

Physical Therapy – Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law, and provided to a member by a qualified physical therapist. (42 CFR 440.110)

Occupational Therapy – Services prescribed by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, and provided to a member by a qualified occupational therapist. (42 CFR 440.110)

Services for Individuals with Speech, Hearing, and Language Disorders Diagnostic, screening, preventive, or corrective services provided by or under direction of a speech pathologist or audiologists, for which a member is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law.(42 CFR 440.110)

Other CISS Therapy Services not mentioned in 42 CFR 440.110

Counseling, Nursing, and Nutrition- Medical care or any other type remedial care provided by licensed practitioners means any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law.

Note: Reimbursement for health related services provided by a CISS provider **is allowed** after the appropriate prescribing practitioner has determined the medical necessity for the service and documents such. Prescribing Practitioner is defined as a licensed primary care practitioner (PCP)/or other prescribing practitioner at the request of the PCP.

802. PCP's Written Referral for Non-IEP Services

Audiologists may provide non-IEP identified medically necessary services to children with an IEP. These services include testing a child for suspected hearing loss. A PCP's written referral to the audiologist following the child's face-to-face visit with the PCP will serve as the medical necessity document for the evaluation of a child for suspected hearing loss.

803. Prior Approval is not required for the CISS program.

CHAPTER 900
SCOPE OF SERVICES

901. General Services

In addition to the services listed in this section, an LEA must meet the CISS Program's general Medicaid record keeping requirements and understand the process of submission and resubmission of claims listed in Part I Policies and Procedures for Medicaid/PeachCare for Kids and Part II Policies and Procedures for the Children's Intervention School Services Program.

902. Audiology

This section describes Audiology services under the Medicaid CISS Program, the provider qualifications, and the covered services.

902.1 Audiology Services identify children with hearing loss, determine the range, nature and degree of hearing loss, and include the referral for medical or other professional attention for restoration or rehabilitation due to hearing disorders.

902.2 Audiologist Provider Qualifications:

Audiological services must be provided by a professional who holds a valid Georgia license as an audiologist.

902.3 Covered Services:

- Auditory acuity (including pure tone air and bone conduction), speech detection, and speech reception threshold
- Auditory discrimination in quiet and noise
- Impedance audiometry, including tympanometry and acoustic reflex
- Central auditory function
- Testing to determine the child's need for individual amplification
- Auditory training
- Speech reading
- Augmentative communication

903. Counseling Services

This section describes Counseling services under the Medicaid CISS Program, the provider qualifications, and the covered services.

903.1 Counseling Services involve assisting children and/or their parents in understanding the nature of their illness or disability, special needs of the child, and the child's development.

903.2 Clinical Social Worker Provider Qualifications:

Counseling must be provided by a professional who holds a valid Georgia license as a clinical social worker.

903.3 Covered Services:

- Assessment of the family resources, including the social and emotional impact of the child's physical disability or developmental delay on the child and family, and its affect on the child's response to treatment and adjustment to medical care.

- Provision of counseling services to resolve social and emotional barriers to effective treatment of the child's physical disability or developmental delay.

904. Nursing Services

This section describes Nursing services under the Medicaid CISS Program, the provider qualifications, and the covered services.

904.1 Nursing services include the administration of physician ordered medications and treatments to any children with medical problems who require these services during the school day. Safe, efficient and effective nursing care delivery, and appropriate monitoring of the child in school for ongoing problems related to the treatment or medication administered is expected. In addition, teaching the child, teacher or other caretaker nursing self-care related to the medication or treatment administration may be billed.

A flow sheet or equivalent documentation may be used by the registered nurse for daily medication administration. The documentation must show the nurse's full name and title. The nurse's initials must be written or typed after each medication given. Note: The initial entry on each page should have the nurse's full name, credentials and initials. With all subsequent entries the nurse may use initials only. Electronic or pen in hand signatures are also acceptable. A narrative note summarizing the medication administered should be completed monthly or when a new medication is administered. (This note may document progress or lack of progress to goal, side effects of medication, medication monitoring notes or exacerbation of symptoms, physical condition, etc.).

The IEP must clearly state the need for nursing services to receive reimbursement.

904.2 Nursing Provider Qualifications:

Nursing services must be provided by a professional who holds a valid Georgia license as a registered professional nurse.

904.3 Covered Services:

- Skilled, intermittent nursing care (e.g., suctioning, dressing changes, and catheterization)
- Administration of medication during the school day as prescribed by the child's physician
- Administration of treatment regimens during the school day as prescribed by the child's physician
- Assessment of the capabilities of the child, his family, and other caretakers to carry out nursing care, medication administration or monitoring, and specific physician ordered treatments
- Teaching nursing self-care to the child and family or caretaker.

905. Nutrition

This section describes Nutrition services under the Medicaid CISS Program, the provider qualifications and the covered services.

905.1 Nutrition Services include the management and counseling for students on special diets for genetic metabolic disorders, prolonged illness, deficiency disorders or other complicated medical problems. Nutritional support through assessment and monitoring of the nutritional status, and teaching related to the dietary regimen.

905.2 Dietitian Provider Qualifications:

Nutrition services must be provided by a professional who holds a valid Georgia license as a dietitian.

905.3 Covered Services:

- Nutritional history
- Dietary intake
- Anthropometric measurements
- Evaluation of laboratory work
- Evaluation of feeding behavior and environment
- Biochemical and clinical variables
- Food habits and preferences

906. Occupational Therapy

This section describes Occupational Therapy services under the Medicaid CISS Program, the provider qualifications and the covered services.

906.1 Occupational Therapy Services include assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation, improving ability to perform tasks for independent

functioning when functions are lost or impaired; and preventing through early intervention, initial or further impairment or loss of function.

- The therapist can bill for time spent in "hands on" activities with the student. This includes time spent assisting the student to use adaptive equipment and assistive technology. Time spent in training teachers or aides to work with the student (unless the therapist is working directly with the student during the training time), and time spent on actually manipulating or modifying the adaptive equipment is not billable.

906.2 Occupational Therapist Provider Qualifications:

Occupational therapy services must be provided by a professional who holds a valid Georgia license as an occupational therapist or as an occupational therapist assistant.

Note: Services rendered by Occupational Therapy Assistants (OTAs) can be billed to Medicaid through the CISS program. The OTA must be working under the supervision of a State of Georgia licensed Occupational Therapist (OT). The OTA is permitted to provide services based on the medical necessity documentation from the student's PCP or other qualified healthcare professional. All documentation and continuing education requirements applied to other CISS service providers will apply to the OTAs. (§ 43-28-3.7)

Supervision Defined:

> Supervision shall mean personal involvement of the licensed occupational therapist in the supervisee's professional experience which includes evaluation of his or her performance. Further, supervision shall mean personal supervision with weekly verbal contact and consultation, monthly review of patient care documentation, and specific delineation of tasks and responsibilities by the licensed occupational therapist and shall include the responsibility for personally reviewing and interpreting the results of any habilitative or rehabilitative procedures conducted by the supervisee. It is the responsibility of the licensed occupational therapist to ensure that the supervisee does not perform duties for which he or she is not trained. (§ 671-2-02)

906.3 Covered Services:

- Activities of daily living;
- Sensory or perceptual motor development and integration;
- Neuromuscular and musculo-skeletal status (muscle strength and tone, reflex, joint range of motion, postural control, endurance);
- Gross and fine motor development;
- Feeding or oral motor function;
- Adaptive equipment assessment;
- Adaptive behavior and play development;

- Prosthetic or orthotic training;
- Fabrication or observation of orthotic devices;
- Neuromotor or neurodevelopmental assessment;
- Gait, balance and coordination skills; and
- Postural control.

907. Physical Therapy

This section describes Physical Therapy services under the Medicaid CISS Program, the provider qualifications, and the covered services.

907.1 Physical Therapy Services involve assessing, preventing or alleviating movement dysfunction and related functional problems, obtaining, interpreting and integrating information relative to the student.

- The therapist can bill for time spent in "hands on" activities with the student. This includes time spent assisting the student to use adaptive equipment and assistive technology. Time spent in training teachers or aides to work with the student (unless the therapist is working directly with the student during the training time) is not billable.

907.2 Physical Therapist Provider Qualifications:

Physical therapy services must be provided by a professional who holds a valid Georgia license as a physical therapist or as a physical therapist assistant.

Note: Services rendered by Physical Therapy Assistants (PTAs) can be billed to Medicaid through the CISS program. The PTA must be working under the supervision of a State of Georgia licensed Physical Therapist (PT). The PTA is permitted to provide services based on the medical necessity documentation from the student's PCP or other qualified healthcare professional. All documentation and continuing education requirements applied to other CISS service providers will apply to the PTAs.

Supervision Defined:

Supervision shall mean personal involvement of the licensed physical therapist in the supervisee's professional experience which includes evaluation of his or her performance. Further, supervision shall mean personal supervision with weekly verbal contact and consultation, monthly review of patient care documentation, and specific delineation of tasks and responsibilities by the licensed physical therapist and shall include the responsibility for personally reviewing and interpreting the results of any habilitative or rehabilitative procedures conducted by the supervisee. It is the responsibility of the licensed physical therapist to ensure that the supervisee does not perform duties for which he or she is not trained.

907.3 Covered Services:

- Neuromotor or neurodevelopmental assessment
- Musculo-skeletal status (including muscle strength and tone posture, joint range of motion)
- Gait, balance and coordination skills
- Postural control
- Cardio-pulmonary function
- Activities of daily living
- Sensory motor and related central nervous system function
- Oral motor assessment
- Adaptive equipment assessment
- Gross and fine motor development
- Observation and fabrication of orthotic devices
- Prosthetic training

908. Speech Therapy

This section describes Speech Therapy services under the Medicaid CISS Program, the provider qualifications and the covered services.

908.1 Speech Language Pathology Services involve the identification of children with speech and/or language disorders, diagnosis and appraisal of specific speech and/or language disorders, referral for medical and other professional attention necessary for the rehabilitation of speech and/or language disorders, provision of speech or language services for the prevention of communicative disorders. The speech language pathologist must bill for time spent in hands on activities or via telehealth services with the student. This includes time spent assisting the student with learning to use adaptive equipment and assistive technology.

908.2 Speech Language Pathologist Provider Qualifications:

Speech-language therapy services must be provided by a professional who holds a valid Georgia license as a speech-language pathologist; or the professional meets one of the State of Georgia Department of Education's requirements for Speech Language Pathologist that align with the Georgia Professional Standards Commission. According to the Georgia Professional Standards Commission the requirements are as follows:

- Completion of a state approved certification preparation program in Speech and Language Pathology at the Masters Degree level (level 5) or higher; or
- Completion of a masters degree or higher program approved by the American Speech Language and Hearing Association (ASHA); or
- Submission of a valid ASHA Certification of Clinical Competence in Speech and Language Pathology (CCC-SLP)

This information can be found at http://www.gapsc.com/Rules/Current/Certification/505-2-.206.pdf.

908.3 Covered Services:

- Expressive language
- Receptive language
- Auditory processing, discrimination, perception and memory
- Vocal quality
- Resonance patterns
- Phonological
- Pragmatic language
- Rhythm or fluency
- Feeding and swallowing assessment
- Articulation Therapy

PART II - CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001. REIMBURSEMENT METHODOLOGY

The Division will pay the lesser of the lowest price regularly and routinely offered to any segment of the general public for the same service or items on the same date(s) of service, the lowest price charged to other third party payers, or "effective with dates of service July 1, 2003, the statewide maximum allowable reimbursement which is 84.645% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2000 for Region IV (Atlanta). All procedure codes recognized and adopted after the 2000 RBRVS are subject to the statewide maximum allowable reimbursement - 84.645% of the Region IV Medicare RBRVS in effect at the time the procedure code was adopted. As of October 1, 2010, these reimbursements are considered as Interim Payments. LEAs must participate in an annual cost settlement process for the CISS program. Cost settlement documents must be submitted to DCH and/or its agent as of September 15 of each Calendar Year unless otherwise specified by DCH. Reimbursement rates adjusted as of October 1, 2011.

Note: When billing procedure codes, 1 unit equals a minimum of 15 minutes unless otherwise specified. Please refer to CMS for the codes that may not be billed in combination per NCCI edits and the medically unlikely edits (MUEs). These codes and MUEs may change each quarter. An LEA who wishes to appeal a claim that denied for an NCCI edit or the MUE units must follow the appeals process outlined in the Part I Policies and Procedures for Medicaid/PeachCare for Kids. The National Provider Identifier (NPI) number of the child's PCP is required on all CISS claims submitted to DCH. As of April 1, 2015, the descriptions for the HIPAA Compliant CPT Codes have been removed from this manual. Please consult the latest version of the Current Procedural Terminology for the procedure code descriptions.

1. Audiology Services

Procedure codes to be billed when providing Audiology Services:

HIPAA Compliant CPT Code	1st modifier	2nd modifier	Maximum Allowable
92507	UC	TM	$62.53
92550		TM	$13.81
92552		TM	$15.63
92555		TM	$13.38
92557		TM	$42.04

HIPAA Compliant CPT Code	1st modifier	2nd modifier	Maximum Allowable
92567	UC	TM	$18.46
92568		TM	$13.38
92579		TM	$25.19
92582		TM	$25.19
92587		TM	$52.51
92588		TM	$70.52
92601	UC	TM	$116.23
92602	UC	TM	$81.09
92603	UC	TM	$76.74
92604	UC	TM	$51.30

2. **Counseling Services**

Procedure codes to be billed by licensed clinical social workers when providing Counseling Services:

Rev. 01/20

HIPAA Compliant CPT Code	1st modifier	2nd modifier	Maximum Allowable
96156		TM	$84.57
96158		TM	$57.70
96159		TM	$20.15
96164		TM	$8.55
96165		TM	$3.97
96167		TM	$61.98
96168		TM	$21.98

3. Nursing Services

Procedure Codes to be billed when providing Nursing Services:

HIPAA Compliant CPT Code	1st modifier	2nd modifier	Maximum Allowable
T1502	TD	TM	$5.78/unit
T1002		TM	$5.78/unit
T1003		TM	$5.78/unit

4. Nutrition Services

Procedure Codes to be billed when providing nutrition services:

Rev. 07/22

HIPAA Compliant CPT Code	1st modifier	2nd modifier	Maximum Allowable
97802		TM	$28.09
97803	TS	TM	$23.94
97804		TM	$13.00

5. Occupational Therapy Services

Procedure Codes to be billed when providing Occupational Therapy Services:

	HIPAA Compliant CPT Code	1st modifier	2nd modifier	Maximum Allowable
Rev. 01/24	96112	GO	TM	$110.42
	96113	GO	TM	$50.48
	97165	GO	TM	$67.21
	97166	GO	TM	$67.21
	97167	GO	TM	$67.21
	97168	GO	TM	$44.40
	97113	GO	TM	$22.32
Rev. 01/20	97129	GO	TM	$20.76
Rev. 01/20	97130	GO	TM	$19.84
	97140	GO	TM	$ 22.97
	97530	GO	TM	$19.76

HIPAA Compliant CPT Code	1st modifier	2nd modifier	Maximum Allowable
97533	GO	TM	$24.46
97535		TM	$21.67
97537		TM	$21.37
97542	GO	TM	$14.82
97750	GO	TM	$22.31
97760		TM	$27.38
97761	GO	TM	$24.98

HIPAA Compliant CPT Code	1st modifier	2nd modifier	Maximum Allowable
97763	GO	TM	$41.69

Rev. 01/18

6. Physical Therapy Services

Procedure Codes to be billed when providing Physical Therapy Services:

HIPAA Compliant CPT Code	1st modifier	2nd modifier	Maximum Allowable
96112	GP	TM	$110.42
96113	GP	TM	$50.48
97161	GP	TM	$69.34
97162	GP	TM	$69.34
97163	GP	TM	$69.34
97164	GP	TM	$47.14
97022		TM	$12.97
97024		TM	$9.22
97032		TM	$14.50
97035		TM	$10.69
97110		TM	$20.07

Rev.0124

HIPAA Compliant CPT Code	1st modifier	2nd modifier	Maximum Allowable
97112		TM	$21.03
97113	GP	TM	$22.32
97116		TM	$18.85
97124		TM	$17.29
97140	GP	TM	$22.97
97530	GP	TM	$19.76
97542	GP	TM	$14.82
97750	GP	TM	$22.31
97761	GP	TM	$24.98
97763	GP	TM	$41.69

Rev. 01/18

Note:

- The reimbursement for covered codes includes all services and supplies.
- Services and supplies cannot be billed separately from the physical therapy visit code.

7. Speech-Language Pathology Services

Therapy services by a speech language pathologist should be billed using the following codes. No payment will be made for a treatment code on the same day as an evaluation.

The reimbursement for covered codes includes all services and items, including any equipment and supplies furnished. Services and supplies cannot be billed separately from the speech therapy code.

HIPAA Compliant CPT Code	1st modifier	2nd modifier	Maximum Allowable
92507	GN	TM	$62.53

92508		TM	$26.35
92521		TM	$97.14
92522		TM	$78.86
92523		TM	$163.81
92524		TM	$82.12
92526		TM	$44.66
92567	GN	TM	$18.46
92597		TM	$85.57
92601	GN	TM	$116.23
92602	GN	TM	$81.09
92603	GN	TM	$76.74
92604	GN	TM	$51.30
92607	TM	U1	$109.28

	92609	TM	U1	$54.75
	92610		TM	$117.54
	96105		TM	$62.10
	96110		TM	$11.77
Rev. 01/19 01/24	96112	GN	TM	$110.42
Rev. 01/19 01/24	96113	GN	TM	$50.48
Rev. 01/20	97129	GN	TM	$20.76
Rev. 01/20	97130	GN	TM	$19.84
	97533	GN	TM	$24.46

Group Speech Therapy 92508 TM - limited to 2 to 5 students per group and each session must last a minimum of 30 minutes. Group Speech Therapy should be identified in the IEP but must be included in the POC/LMN signed by the child's primary care physician. LEAs are responsible for implementing these changes on and after April 1, 2013. Section 607 of this manual provides additional clarity regarding this new policy. It adds that for group speech therapy services rendered during the 2012-2013 school year, the LEA may utilize documents allowed prior to the establishment of these new policy requirements as documentation of medical necessity if this documentation was in place and supported group speech therapy service delivery for the entire school year. If current documentation expires prior to the end of the 2012-2013 school year or does not specifically support group speech therapy, the LEA must obtain and retain in their files, the signed POC/LMN authorizing group speech therapy services. The LEA may continue to bill for documented medically necessary speech-therapy services while this POC/LMN is being obtained.

Note: Procedure code 92506 has been discontinued effective 12/31/13.

Note: Providers cannot use code 92609 unless the child has had an evaluation for a speech-generating device.

Note: The U1 modifier must be added to procedure codes 92607 and 92609 to indicate the services are related to a mobile SGD (92607) and the use of the mobile SGD with (AAC) software/application (92609).

Please refer to CMS for the codes that may not be billed in combination per NCCI Edits. These codes may change each quarter. A provider who wishes to appeal a claim that denied for an NCCI edit must follow the appeals process and submit form 520A, along with clinical documentation, to the Georgia Medical Care Foundation (GMCF) for review.

> Any two or more therapist cannot bill Medicaid for health related services rendered to a student at the same time on the same date of service. For example, an Occupational Therapist and a Physical Therapist serve a student at the same time to help with positioning and therapeutic procedures. Both therapists can not bill Medicaid for health related services provided at the same time for the same child.

Effective 1/1/15, claims will suspend to GMCF to be manually priced at half the rate for reduced services when the 52 modifier (along with the HA modifier) is placed on the claim for procedure code 92523.

Note: Procedure codes 97001-97004 will be discontinued effective 12/31/16.

Note: As of 1/1/17, final rates for codes 97161 – 97168 have not been received from CMS. Rates will be updated upon receipt from CMS.

Effective April 1, 2017, the Department of Community Health (DCH) will allow some speech therapy services to be rendered via telehealth. The allowed procedure codes are 92507, 92521, 92522, 92523, and 92524. Each billed procedure code must be submitted

with the usual program modifier(s). Additionally, the GT modifier and place of service code 02 must be added to the allowed procedure codes to indicate the services are related to telehealth services.

Effective 7/1/2017, the new physical and occupational therapy evaluation codes require a specific modifier to identify the type of therapy. Procedure codes 97161-97164 must be accompanied by the GP modifier and procedure codes 97165-97168 must be accompanied by the GO modifier in addition to the usual program modifier.

Effective October 1, 2017, procedure code 92508 will also be allowed to be rendered via telehealth. The billed procedure code must be submitted with the usual program modifier(s). Additionally, the GT modifier and place of service code 02 must be added to the allowed procedure codes to indicate the services are related to telehealth services.

Rev. 01/18 Note: Procedure codes 97532 and 97762 have been discontinued effective 12/31/17. Procedure code 97532 has been replaced with 97127. Procedure code 97762 has been replaced with 97763.

Rev. 10/18 Effective 10/1/18, the Department of Community Health (DCH) will allow some audiology services to be rendered via telehealth. The allowed procedure codes are 92567, 92568, 92587, and 92588. Each billed procedure code must be submitted with the usual program modifier(s). Additionally, the GT modifier and place of service code 02 must be added to the allowed procedure codes to indicate the services are related to telehealth services.

Rev. 1/19 Effective 1/1/19, procedure code 92550 will be open for reimbursement. The procedure codes must be submitted with the usual program modifier(s). Standards of practice dictates that audiologists should bill procedure code 92550 if performing both 92567 & 92568 on the same day. If not, providers should bill the respective code for the service performed.

Rev. 1/20 Note: Procedure codes 96150 and 96151 have been discontinued effective 12/31/19.

Rev. 1/20 Note: Procedure code 97127 has been discontinued effective 12/31/19. Procedure code 97127 has been replaced with 97129 and 97130.

Rev. 4/20 In response to COVID-19 and the public health emergency declaration, the Department of Community Health (DCH) will allow therapy services to be rendered via telehealth. Each billed procedure code must be submitted with the usual program modifier(s). Place of service code 02 must be submitted on the claim to indicate the services are delivered through telehealth.

APPENDIX A
MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding is between the Georgia Department of Community Health (DCH) and the Georgia Local Education Agency (LEA).

The Medicare Catastrophic Coverage Act of 1988 contains provisions permitting Medicaid reimbursement to be available to qualified providers for certain health related services provided to Medicaid-eligible children in special education. The Act became effective in January 1989. As a result, Local Education Agencies have been able to present claims to Medicaid for covered medical, health and health-related services.

Local Education Agencies provide the payments for school-based health services rendered to Medicaid-eligible children through the use of existing state and local education allocations. LEAs submit claims to DCH in order to receive the federal share of those payments. To the extent LEAs already provide these services, no new state or local funding is required to receive the additional federal funding.

Purpose: The purpose of this memorandum is to outline the roles and responsibilities of: the Local Education Agencies (LEA) in their pursuit of Medicaid reimbursement for school-based health services; the DCH Division of Medicaid in its administration of the Medicaid program pursuant to the State Plan for Medicaid; and Public Consulting Group (PCG) and DCH in their implementation of the requirements of this program**.** PCG and DCH will work together on the Administrative Claiming for Education (ACE) and the Children's Intervention School Services (CISS) Cost Settlement processes.

Roles and Responsibilities

The LEA agrees that:

1. It will only bill for Medicaid reimbursable services delineated in the policy and procedures manual for the Children's Intervention School Services (CISS) Program and provided by health care providers who meet DCH requirements;
2. The Individualized Education Program (IEP) for eligible clients aged 3 to 20, as specified under IDEA, will not serve as the basis for the provision of services that, if covered, are appropriate for payment under Title XIX and are in accordance with the applicable state and federal requirements for each documented service unless it includes a Letter of Medical Necessity or Plan of Care that has been signed and dated by the child's primary care provider;
3. A signed and dated Letter of Medical Necessity (LMN) or Plan of Care (POC) is **required** for the provision of services that, if covered, are appropriate for payment under Title XIX and are in accordance with the applicable state and federal requirements for each documented service if a Treatment Plan, signed and dated by the primary care provider, is not included in the IEP;
4. The DCH requirements must be met at the time services are rendered to a Medicaid-eligible child who meets the criteria set forth in the Individuals with Disabilities Education Act (IDEA);

5. It will only file administrative claims for those eligible activities that are related to, or in support of, services that are included in the State's Title XIX Medicaid State Plan and in accordance with the Centers for Medicare and Medicaid Services (CMS) approved administrative claiming protocol for Georgia Local Education Agencies;
6. If the LEA is not participating or chooses not to bill Medicaid for school based health services rendered to Medicaid eligible children, those school based health services cannot be reimbursed and the administrative expenditures related to those service are also not reimbursable. As an example, Speech Language Pathology services are provided in the LEA, but the school provider decides not to bill Medicaid for those services. As a result, the Speech Language Pathologist(s) cannot be included on the Administrative Claiming for Education Staff Pool List;
7. It will maintain the necessary documentation required for school based health-related services/activities as defined by DCH policy manuals and procedures, and agreements;
8. It will provide DCH with the information necessary to request federal funds;
9. It will maintain the confidentiality of members' records and eligibility information received from DCH and its agents and will use that information only in the administration and coordination of health-related services/activities pursuant to DCH policy manuals, procedures and agreements;
10. It will provide to DCH on an annual basis, a complete list of total students with an IEP receiving direct medical services in the LEA in order to obtain the IEP Ratio;
11. It will provide to DCH on an annual basis through the Certification of Public Expenditures form, certification that it has sufficient state/local funds available to cover the total computable costs (state and federal share) for service delivery. This certification will allow DCH to draw down any and all federal revenue reimbursement for health related services in the Children's Intervention School Services program;
12. It will provide to DCH on a quarterly basis through the Certification of Public Expenditures form, certification that it has sufficient state/local funds available to cover the total computable costs (state and federal share) for the ACE program. This certification will allow DCH to draw down any and all federal revenue reimbursement for health-related services and activities in the Administrative Claiming for Education (ACE) program;
13. It will submit to an audit of all records related to the claims for which it receives Medicaid reimbursement at intervals deemed appropriate by DCH;
14. It will reimburse DCH for disallowances identified through audits, with interest if applicable, as defined in the DCH policy manuals and DCH will remit a portion to the Centers for Medicaid and Medicare Services (CMS);
15. It will consult with DCH on issues arising out of this agreement;
16. It will conduct all functions recognizing the authority of DCH in the administration of state plan issues;
17. It will share policy updates with its health care providers to ensure they are aware of the policies and procedures;
18. It agrees that DCH will assist the LEA in submitting and/or reconciling Medicaid claims and obtaining technical assistance in securing reimbursement for eligible services provided to eligible children;
19. It is fiscally liable for reimbursing DCH for disallowed claims;
20. It has the legal obligation to provide access to records to appropriate state and federal agencies (including but not limited to DCH, CMS, Office of Inspector General (OIG), and General Accounting Office (GAO);

21. It will comply with all federal and state laws, regulations, and guidelines regarding Medicaid reimbursement;
22. In order to bill Medicaid under the CISS and ACE programs, the LEA's health care staff must be fully or partially state funded. They cannot be 100% federally funded.
23. It will submit all required documentation and respond to questions sent by DCH or DCH's contractor via email, fax, or mail by the due date.

DCH agrees that:

1. A PCP signed and dated Letter of Medical Necessity (LMN) or Plan of Care (POC) **is acceptable documentation** for the provision of services that, if covered, are appropriate for payment under Title XIX and are in accordance with the applicable state and federal requirements for each documented service **if** a Treatment Plan, signed and dated by the student's primary care provider, is not included in the IEP;
2. Other Medicaid covered services may be provided by the LEA in accordance with DCH policy and procedures;
3. It will provide policy and procedures and technical assistance to the LEA;
4. It will provide the LEA with regular program updates;
5. It will process all Medicaid CISS claims and make payments directly to the participating LEA for Medicaid;
6. It will process all approved Administrative Claiming for Education claims and make quarterly Administrative Claiming for Education payments to the participating LEA after withholding eight percent (8%) of the total claimable amount as an administrative fee;
7. It will remit a portion of the funds to CMS for disallowances identified through audits, with interest if applicable, from the LEA;
8. It will assist the LEA to become enrolled as a Medicaid provider;
9. It agrees to provide oversight for all services and activities reimbursed to the LEA, including but not limited to desk and on-site audits;
11. It will review, revise, finalize, submit and resolve federal school-based reimbursement issues as they relate to all claims and payments;
12. It will assist in the development of uniform procedures, protocols, and standard statistical methodologies for the CISS program;
13. It or its contractor will calculate the number of Medicaid eligible students with an IEP and direct medical service from claims and eligibility data from the Medicaid Management Information System (MMIS).
14. It will work with the Georgia Department of Education (DOE) to obtain the student data from the October and March student count collection processes and match those data with the Medicaid eligibility data, based on the DOE collection date, to determine the ACE Medicaid Eligibility Rate.
15. It will develop and implement its quality control and assurance components, establish that the LEAs are complying with all CMS and state requirements and regulations and report outcomes for final review;
16. The DCH Accounting Unit will also maintain records identifying the source of funds used for the State match in order to validate the certification of funds process and ensure that an adequate amount of State and local funds are expended to obtain federal match.

C. Notices

The LEA agrees that the DCH Provider Policies and Procedures manuals and other DCH policy informational materials, such as Banner Page Messages and Provider letters/bulletins, will be the official transmittals from DCH to inform it of Medicaid services and record keeping policies.

D. Remedial Actions

The Parties agree that DCH may pursue remedial action if the LEA fails to meet the ACE and CISS programs' requirements or fails to correct problems identified during audits. Examples of actions that will cause implementation of sanctions include, but are not limited to:

- Repeated and/or uncorrected errors in financial reporting, including failure to use the financial reporting worksheets provided by DCH or its vendor
- Failure to cooperate with state, federal, or the DCH vendor's staff during reviews or other requests for information
- Failure to maintain adequate documentation
- Failure to provide accurate and timely information to DCH or its vendor as required

Remedial action may include the suspension of payments to the LEA for ACE and CISS claims, more frequent auditing of the LEA's records by DCH, and the recoupment of funds from the LEA. Once an LEA has been notified of the need for remedial action, the LEA will be given thirty (30) days to submit a corrective action plan to the state, and the state will have an additional thirty (30) days to approve or amend the corrective action plan.

The LEA agrees that DCH's acceptance of the plan will not: (1) excuse the LEA's prior substandard performance or (2) relieve the LEA of its obligation to comply with the terms of this Agreement.

E. Term & Termination

This Agreement shall become effective on the date that it is executed by DCH and shall automatically renew annually unless otherwise terminated as provided for in this Agreement. After that time, this Memorandum of Understanding will remain in effect until either party terminates the agreement with 30 days written notice.

F. Parties Bound

This Agreement is binding upon all employees, agents and third-party vendors of DCH and the LEA and will bind the respective heirs, executors, administrators, legal representatives, successors and assigns of each party.

G. Entire Agreement

This Memorandum of Understanding constitutes the entire agreement between the Parties with respect to the subject matter hereof and supersedes all prior negotiations, representations, or contracts. No written or oral agreements, representatives, statements, negotiations, understandings, or discussions that are not set out, referenced, or specifically incorporated in this Contract shall in any way be binding or of effect between the Parties.

IN WITNESS WHEREOF, the undersigned duly authorized officers or agents of each party have hereunto affixed their signatures on the day and year indicated below.

Signature of Local Education Official:

_____

Typed Name: _____

County Name and Code: _____ Date: _____

Signature of Department of Community Health:

_____

Typed Name: _____Date: _____

(Sample Form)

APPENDIX B

Special Education Department
Parental/Guardian
Medicaid or PeachCare for Kids® Consent Form

Student Name:_____ Date of Birth_____
(Last, First)

Identification Number:_____ Social Security Number:_____

Street Address:
_____

City _____ State_____Zip_____

DR. NAME (student's physician):_____
DR. PHONE NUMBER: _____
DR. ADDRESS:_____CITY:_____

Your Local Education Agency (LEA) is providing health-related services that are medically necessary for your child. These services are identified in his/her Individualized Education Program (IEP), the Letter of Medical Necessity (LMN), or the Plan of Care (POC) that your child's doctor signed. The Medicaid or PeachCare for Kids® program is required to cover the cost of certain services.

Your LEA cannot bill Medicaid or PeachCare for Kids® without your consent. If you will allow your LEA to bill Medicaid or PeachCare for Kids® for these medically necessary services, please check the "YES" Box and sign below.

To comply with the requirements of the Family Educational Rights and Privacy Act (20 U.S.C. §1232g and 34 CFR §99.30), I further consent to the release of my child's education records that contain information about the health-related services provided at school and billed to the Georgia Department of Community Health (DCH). I understand these records may be used, as necessary, to make sure the health services received at school are not an exact copy of health services provided by other healthcare providers. I also understand these records will allow DCH (or its agents) to perform reviews of the Medicaid payments made to the school. I understand that I may request a copy of the records disclosed pursuant to this consent.

☐ **YES** I authorize my LEA to bill Medicaid or PeachCare for Kids® for the health-related services listed in my child's IEP, the Plan of Care, or the Letter of Medical Necessity.

☐ **NO** I do not want Medicaid or PeachCare for Kids® billed for the health-related services my child is receiving.

Parent/Guardian Name (Please print):
_____

Parent/Guardian Signature:_____

Date:_____

It is my responsibility as a parent to notify the LEA's Special Education Department in writing if I ever decide to withdraw this consent allowing the LEA to seek reimbursement from Medicaid or PeachCare for Kids®. I understand this consent is for the school lifetime of my child.

If you have any questions, please call: PERSONALIZE THIS SECTION FOR YOUR SCHOOL SYSTEM.

APPENDIX C

GEORGIA HEALTH PARTNERSHIP (GHP)

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

Provider Correspondence

P.O. Box 105200
Tucker, Georgia 30085-5200

Provider Inquiry Number:
800 766-4456 (Toll free)

Electronic Data Interchange (EDI)
877 261-8785

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

APPENDIX D
Office of Child Health District Coordinators
Updated January 2024

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
1-1 ROME Northwest Health District	Bartow Gordon Catoosa Haralson Chattooga Paulding Dade Polk Floyd Walker	**Tamela Baker** 1309 Redmond Road, NW Rome, GA 30165 (706) 802-5076 FAX (706) 802-5071 Referrals 706-802-5072 Tamela.Baker@dph.ga.gov	**Stacy Henderson** 1309 Redmond Road, NW Rome, GA 30165 (706)802-5626 FAX (706) 802-5309 Stacy.Henderson@dph.ga.gov	**Brittany Hatcher** 1309 Redmond Road, NW Rome, GA 30165 (706) 802-5312 FAX (706) 802-5309 Brittany.Hatcher@dph.ga.gov
1-2 Dalton North Georgia Health District	Cherokee Murray Fannin Pickens Gilmer Whitfield	**Lois Blockley** 1710 Whitehouse Ct. Dalton, Georgia 30720(888) 276-1558 Toll Free 706-529-5763 Ext. 1431 888-276-1558 FAX (706) 529-5794 Lois.Blockley@dph.ga.gov	**Holli Collier** 1710 Whitehouse Ct. Dalton, GA 30720-8402 (706) 529-5763 Ext. 1409 FAX (706) 529-5767 Holli.Collier@dph.ga.gov	**Susan Sims** 1710 Whitehouse Ct. Dalton, GA 30720 706-529-5763 Ext. 1420 FAX (706) 529-5798 susan.sims@dph.ga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
2 Gainesville North Health District	Banks Lumpkin Dawson Rabun Forsyth Stephens Franklin Towns Habersham Union Hall White Hart	**Shari Whiting** 440 Prior Street SE Gainesville, GA 30501 (770) 535-5963 FAX (770) 538-2784 Shari.Whiting@dph.ga.gov	**Angela Gilstrap** 440 Prior Street, SE Gainesville, GA 30501 (770) 538-2788 FAX (770) 531-6341 Angie.Gilstrap@dph.ga.gov	**Tonya Newsom, MBA, MA, LPC, CPCS** 440 Prior Street SE Gainesville, GA 30501 (770) 538-2778 FAX (770) 538-2784 Tonya.Newsom@dph.ga.gov
3-1 Cobb Health District	Cobb Douglas	**Yvette Garrett** Cobb County Board of Health 1738 County Services Parkway, Bldg B Marietta, GA 30008 (770) 319-4717 Fax: (770) 514-2803 YvetteGarrett@dph.ga.gov	**Sherri Garry** 1738 County Services Parkway, Bldg B Marietta, GA 30008 (770) 319-4719 ext 2121 Fax: (770) 514-2803 Sherri.Garry@dph.ga.gov	**Amanda Holley, MPH, BSN, RN** 1738 County Services Parkway, Bldg B Marietta, GA 30008 (770) 514-2404 FAX (678) 354-0751 Amanda.Holley@dph.ga.gov
3-2 Fulton Health District	Fulton	**Fanthnecia "Nisey" Dunbar** 2805 Metropolitan Parkway Atlanta, Georgia 30315 (770) 520-7289 or 404-612-8770 FAX (770) 264-7554 Fanthnecia.Dunbar@dph.ga.gov	**Wendolyn Miller** 2805 Metropolitan Pkwy Atlanta, GA 30315 (404) 612-1496 FAX (770) 264-7554 Wendolyn.Miller@fultoncountyga.gov	**Cynthia Corsino, MPH** 2805 Metropolitan Pkwy, SW Atlanta, GA 30315 (770)520-7285 FAX (770)264-7554 cynthia.corsino@fultoncountyga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
3-3 Clayton County Health District	Clayton	**Sandra Pye, RN (Interim)** 1117 Battlecreek Rd Jonesboro, Georgia 30236 (678) 610-7259 FAX (678) 610-7781 Sandra.Pye@dph.ga.gov	**Yolanda Willis** 1117 Battlecreek Rd Jonesboro, Georgia 30236 (678) 610-7417 FAX 770-610-7781 Yolanda.Willis@dph.ga.gov	**Andrew Gaines** 1117 Battlecreek Rd Jonesboro, GA 30236 (678)610-7299 FAX 678-472-2244 Andrew.Gaines@dph.ga.gov
3-4 Gwinnett East Metro Health District	Gwinnett Rockdale Newton	**Laura Moncada** **Easter Seals N. Georgia** 4335 Steve Reynolds Blvd Norcross, GA 30093 770-822-9115 ext 105 FAX 770-822-9457 lmoncada@esng.org	**VACANT** 2570 Riverside Pkwy P.O. Box 897 770-339-9078 FAX (770) 237-5309	**Kelly Griffith, M. ED** East Metro Health District 2570 Riverside Pkwy P.O. Box 897 Lawrenceville, GA 30046 **Referral Line** **678-339-4264** FAX (866) 680-1530 kelly.griffith@gnrhealth.com
3-5 DeKalb Health District	DeKalb	**(Ellie) Beronica Gonsalves** DeKalb Board of Health 440 Winn Way Decatur, Georgia 30031-0987 (404) 294-3722 Referral: (404) 508-7981 FAX (404) 294-6316 Ellie.Gonsalves@dph.ga.gov	**Patrice Cannon** 440 Winn Way Decatur, GA 30031-0987 (404) 508-7762 FAX (404) 294-6316 Patrice.Cannon@dph.ga.gov	**Aletha Dixon** 440 Winn Way Atlanta, GA 30317 (404) 294-3814 Referral: (404) 508-7981 FAX (404) 294-6316 Aletha.Dixon@dph.ga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
4 LaGrange Health District	Butts Lamar Carroll Meriwether Coweta Pike Fayette Spalding Heard Troup Henry Upson	**Tracy Bain** 301 Main Street LaGrange, GA 30240 706-298-7750 FAX (706) 845-4351 Tracy.Bain@dph.ga.gov	**Wendy Wilson** 301 Main Street LaGrange, GA 30240 (706) 298-7753 FAX (706) 845-4351 Wendy.Wilson@dph.ga.gov	**Tracy Bain** 301 Main Street LaGrange, GA 30240 (706) 298-7750 FAX (706) 845-4351 tracy.bain@dph.ga.gov
5-1 Dublin South Central Health District	Bleckley Pulaski Dodge Telfair Johnson Treutlen Laurens Wheeler Montgomery Wilcox	**Debra Pileggi** 1110 Hillcrest Pkwy, Suite B Dublin, GA 31021 478-275-6841 FAX (478) 274-7893 Debra.Pileggi@dph.ga.gov	**Hannah Hicks** 1110 Hillcrest Pkwy, Suite B Dublin, GA 31021 (478)275-5119 FAX (478) 274-5117 Hannah.Hicks@dph.ga.gov	**Tamiko Coley** 1110 Hillcrest Pkwy, Suite B Dublin, GA 31021 (478) 274-7717 FAX (478) 275-7893 Tamiko.Coley@dph.ga.gov
5-2 Macon North Central Health District	Baldwin Monroe Bibb Peach Crawford Putnam Hancock Twiggs Houston Washington Jasper Wilkinson Jones	**Lisa Wiles** 201 Second St. Suite 1100 Macon, Georgia 31201 (478) 745-9200 FAX (478) 745-9040 Lisa.Wiles@dph.ga.gov	**Tekeisha Jenkins, RN** 201 Second St., Suite 1100 Macon, GA 31201 (478) 538—0802 FAX (478) 751-6429 Tekeisha.Jenkins@dph.ga.gov	**Belinda Hunt, LPN** 201 Second St., Suite 1100 Macon, GA 31201 (478) 751-6359 FAX (478) 751-6429 Belinda.Hunt@dph.ga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
6 Augusta East Central Health District	Burke Columbia McDuffie Emanuel Richmond Glascock Screven Jefferson Taliaferro Jenkins Warren Lincoln Wilkes	**Javonna Williams** 1916 North Leg Road Augusta, GA 30909-4437 (706) 667-4273 FAX (706) 667-4278 Javonna.Williams@dph.ga.gov	**Jan Walker, RN** 1916 North Leg Road Augusta , GA 30909-4402 (706) 667-4606 FAX (706) 667-4555 Jan.Walker@dph.ga.gov	**Jan Walker, RN** 1916 North Leg Road Augusta , GA 30909-4402 (706)667-4606 FAX (706)667-4555 Jan.Walker@dph.ga.gov
7 Columbus West Central Health District	Chattahoochee Quitman Clay Randolph Crisp Schely Dooly Stewart Harris Sumter Macon Talbot Marion Taylor Muscogee Webster	**Kiara Loud** 5601 Veterans Pkwy Columbus, GA 31904 (706) 321-6362 FAX (706) 327-1355 Kiara.Loud@phd.ga.gov	**LaShondria Jones** 5601 Veterans Pkwy Columbus, GA 31904 (706) 321-6324 Lashondria.Jones@dph.ga.gov	**Shiketheia Simmons, RN** 5601 Veterans Pkwy Columbus, GA 31904 706.307-6365 FAX 706.327.1355 Shiketheia.Simmons@dph.ga.gov
8-1 Valdosta South Health District	Ben Hill Irwin Berrien Lanier Brooks Lowndes Cook Tift Echols Turner	**Jessie Judkins** 206 S. Patterson St 3rd Floor PO Box 1027 Valdosta, GA 31603-1027 (229) 259-5138 FAX (229) 245-6561 Jessie.Judkins@dph.ga.gov	**Kirbi Spires BSN, RNC-OB, C-EFM** 206 South Patterson Street (P. O. Box 1027) Valdosta, Georgia 31603-1027 (229) 245-4310 Fax: (229) 245-4317 Kirbi.Spires@dph.ga.gov	**Reomona Thomas, MSN, RN** 206 S. Patterson St 3rd Floor PO Box 1027 Valdosta, GA 31603-1027 (229) 293-6286 FAX (229) 293-6292 Reomona.Thomas@dph.ga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
8-2 Albany Southwest Health District	Baker Calhoun Colquitt Decatur Dougherty Early Grady Lee Miller Mitchell Seminole Terrell Thomas Worth	**Sharonda Davis** 1306 South Slappy Boulevard Suite A – Colony Square South Albany, GA 31701 (229) 229-4447 FAX (229)420-1156 Sharonda.Barlow@dph.ga.gov	**Quinteria Murray** 1306 South Slappy Blvd. Albany, GA 31701 (229) 299-4447 Ext. 6703 FAX (229) 353-3201 Quinteria.Murray@dph.ga.gov	**Mattie Woodson, BSN, RN** 1306 South Slappy Blvd. Suite A – Colony Square South Albany, GA 31701 229-299-4447 or 886-987-0204 FAX (229) 430-1379 Mattie.Woodson@dph.ga.gov
9-1 Savannah/Bruns wick Coastal Health District	Bryan Camden Chatham Effingham Glynn Liberty Long McIntosh	**Stefanie Clardy** 420 Mall Blvd Savannah, GA 31406 (912)644-5806 Referral Line : 912-644-5804 FAX (912) 349-2326 Stefanie.Clardy@dph.ga.gov	**Christina Sanchez, ASN, RN** 420 Mall Blvd Savannah, GA 31406 (912) 644-5812 FAX (912) 349-2326 Christina.Sanchez@dph.ga.gov	**Christina Sanchez, ASN, RN** 420 Mall Blvd, Suite G Savannah, GA 31406 (912) 644-5208 FAX (912) 349-2326 Christina.Sanchez@dph.ga.gov
9-2 Waycross Southeast	Appling Atkinson Bacon Brantley Bulloch Candler Coffee Evans Jeff Davis Pierce Tattnall Toombs		**Jill Aldridge** 1123 Church Street, Annex B Waycross, GA 31501 (912)-285-6304 FAX (912)287-6644 Jill.Aldridge@dph.ga.gov	**Julie Prestenbach, RN** 1123 Church Street, Annex B Waycross, GA 31501 (912) 284-2920 FAX (912)338-5914 Julie.Prestenbach@dph.ga.gov
	Charlton Clinch Ware Wayne			

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
10 Athens Northeast Health District	Barrow Madison Clarke Morgan Elbert Oconee Greene Oglethorpe Jackson Walton	**Robin Schafer, LMSW, CLC** 740 Prince Ave., Building 15 Athens, GA 30606 (706) 227-7191 FAX (706) 227-7184 Robin.Schafer@dph.ga.gov	**Caylie Mahaffey** 740 Prince Ave., Building 15 Athens, GA 30606 (706) 389-6923 ext. 2706 FAX (706) 552-4536 Caylie.Mahaffey@dph.ga.gov	**Robin Schafer, LMSW, CLC** 740 Prince Ave., Building 15 Athens, GA 30606 (706)227-7191 FAX (706) 227-7184 Robin.Schafer@dph.ga.gov

State Staff Contacts

Last Name	First Name	Telephone Number	Email Address	Title	Location
MCH Child Health Services					
Welborn	Kathy	404-651-7442	Kathy.welborn@dph.ga.gov	Coordinator, Children 1st	11-485
Clark	Pamela	404-657-3153	Pamela.Clark@dph.ga.gov	Clinical Coordinator, NBS	11-484
Culpepper	Brandt	404-651-5482	Brandt.Culpepper@dph.ga.gov	Team Lead, EDHI	11-477
Harris	Jaquay	404-657-3173	Jaquay.Harris@dph.ga.gov	Data Entry Specialist, NBS	11-475
Souza	Keilana	470-388-4902	Keilana.Souza@dph.ga.gov	Program Coordinator, Children 1st	11-486
Turner	Tina	470-462-7434	Tina.Turner1@dph.ga.gov	Deputy Director, Child Health Services	
VACANT				Team Lead, NBS	11-476
Williams	Raven		Raven.Williams@dph.ga.gov	Program Coordinator, NBS	11-493
Abeyta	Karin		Karin.Abeyta@dph.ga.gov	Program Coordinator, EDHI	11-483
MCH Children & Youth With Special Healthcare Needs					
Peart	Sharifa	404-657-2861	Sharifa.Peart@dph.ga.gov	Program Director, CYSHCN/CMS	11-462
Rainey	Quondalynn	404-657-2874	Quondalynn.Rainey@dph.ga.gov	Program Coordinator, CMS	11-473
Givens	Kira		Kira.Givens@dph.ga.gov	Youth Engagement Program Coordinator, CDC PHAP Associate CMS	
Conner	Jackie	404-463-0812	Jackie.Conner@dph.ga.gov	Child Health EPI I	
Snarey	Elizabeth	404-651-5995	Elizabeth.Snarey@dph.ga.gov	Family Support Coordinator, BCW/CMS	11-458
VACANT				Clinical Coordinator, CMS	11-463
Griswell	Synita	404-232-1630	Synita.Griswell@dph.ga.gov	Program Manager, Autism & Developmental Disabilities	11-472
VACANT				Program Coordinator, Autism & Developmental Disabilities	
MCH Early Intervention					
Byrd	Kevin	404-673-0703	Kevin.Byrd@dph.ga.gov	Deputy Director/Part C Coordinator, Early	11-456

				Intervention	
Glecia	Carter		Glecia.Carter@dph.ga.gov	(Metro) Regional Coordinator Team Lead, BCW	11-457
Jenni	Nowicki	404-651-5494	Jenni.Nowicki@dph.ga.gov	(North) Regional Coordinator Team Lead, BCW	
Artis	Krystal	678-708-5838	Judy.Threlkeld@dph.ga.gov	(South) Regional Coordinator, BCW	
Dian	Facey	404-985-2281	Dian.Facey@dph.ga.gov	Provider Relations Specialist, Early Intervention	
Mesha	Robinson		Mesha.Robinson@dph.ga.gov	Training and Support Coordinator, Early Interventions	
VACANT				Part C Data Manager/Evaluator	11-205
Reynolds	LaToya	404-657-5622	Latoya.Reynolds@dph.ga.gov	Administrative Coordinator/SICC Coordinator, BCW	11-455

APPENDIX E

Other Related Medicaid Programs Which Provide Services to Children

A. Durable Medical Equipment includes reimbursement for the purchase or rental of certain medical equipment and accessories and the purchase of certain medical supplies for a member's use in a non-institutional setting. It includes such items as prescribed hospital beds, wheelchairs, oxygen equipment, ventilators, and ambulation devices such as crutches and walkers. The equipment must be used by the member in their residence or that of a relative and must have been prescribed by a physician. The equipment remains the property of the state throughout its useful life.

B. Early Intervention Service Coordination (Case Management) is an active, on-going process consisting of specific activities which are aimed at assisting parents in gaining access to the early intervention services designed to meet the developmental needs of each eligible child from birth up to age three (3) and the needs of the family related to enhancing the child's development.

C. Emergency Ambulance Services are for the emergency transportation of those eligible recipients whose lives or immediate health are in danger and who require the supplies, equipment or personnel provided in an emergency vehicle.

D. Health Check Services (EPSDT) is a program of comprehensive health screening, diagnosis referral and treatment services provided under the Medicaid program to eligible children under twenty-one (21) years of age. Treatment for abnormalities detected through such screening includes any needed medical services, dental services, prescription lenses and frames, and hearing aids.

E. Non-Emergency Medical Transportation Services and related expenses such as meals and lodging are reimbursed to providers who transport recipients in order to obtain medical treatment or examination under non-emergency circumstances.

F. Orthotics and Prosthetics include devices such as artificial limbs, hearing aids, braces, etc. which assist or replace physical impairments. For Medicaid patients under twenty-one (21) years of age, hearing aid coverage determinations are made on a case-by-case basis through the prior approval process.

G. Physician Services are those services provided by or under the immediate supervision of an enrolled individual licensed under Georgia law to practice medicine or osteopathy.

H. Psychology Services include diagnosis and evaluation, and individual and group therapy services that must be provided by enrolled licensed psychologists. Psychology services are available only to Medicaid recipients under twenty-one (21) years of age.

I. Vision Care Services are those refractive or medical services provided by enrolled licensed optometrists, licensed dispensing opticians or ophthalmologists within their scope of practice as set out in the applicable to recipients under twenty-one (21) years of age for refraction. Diagnosis and treatment services are available for recipients under the age of twenty-one (21).

APPENDIX F

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

How do I get NEMT services?

If you are a qualifying Medicaid recipient and have no other means of transportation for your medical care or services covered by Medicaid, you may contact a transportation broker for transport to and from your appointment. The member must contact the Broker to request NEMT services at least three (3) business days prior to a non-urgent, scheduled appointment. The three (3) day advance scheduling includes the day of the call but not the day of the appointment. Advance scheduling will be mandatory for all NEMT services except urgent care and follow-up appointments when the timeframe does not allow advance scheduling. Urgent care or same day reservations may require verification from your direct provider of service confirming you must be seen that day. Each broker has a toll-free telephone number to schedule transportation services, and available weekdays (Monday-Friday) from 7 a.m. to 6 p.m.

All counties in Georgia are grouped into five regions for NEMT services. A NEMT Broker covers each region. If you need NEMT services, **you must contact the NEMT Broker serving the county you live in** to ask for Non-Emergency Medical Transportation. Contact Southeastrans for Atlanta and North Regions and ModivCare, formerly LogistiCare, for Central, East and Southwest See the chart below to determine which broker serves your county and call the broker's telephone number for that region.

What if I have problems with a NEMT provider or broker?

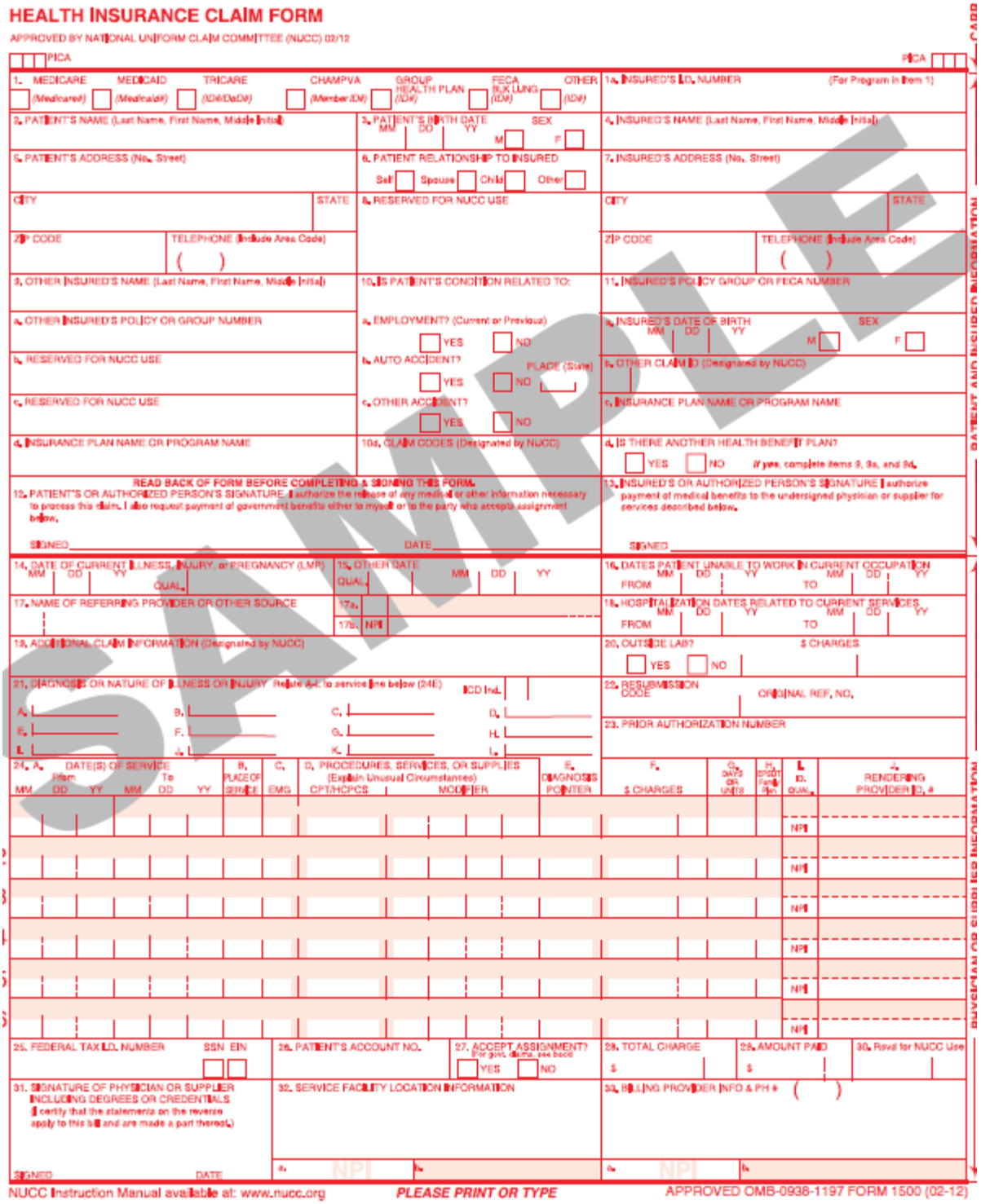
The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. If you have a question, comment, or complaint about a NEMT provider or broker that has not been resolved with the broker, you may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

NEMT REGIONS & COUNTIES SERVED

Region	NEMT Broker & Phone Number	Counties Served
North	**Verida** ***(formerly 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** ***(formerly Southeastrans)*** 404-209-4000 *Note: For Georgia Families 360°* 1-866-991-6701	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

APPENDIX G

New CMS-1500 Claim Form



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 MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

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. #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										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)

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/HP:** 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/HP: 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).

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/HP:** 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/HP:** 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 values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. **(Do not bill ICD 10 code sets before 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. F **FOR DCH/HP**: 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)."

APPENDIX H

Children's Intervention School Services Program Staff

Tamara Wilson
Compliance Specialist 3
Division of Medical Assistance Plans
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APPENDIX J

Ordering, Prescribing, and Referring (OPR) Update

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.

APPENDIX K

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/GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com

Registering immunizations with GRITS:

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

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

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

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

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

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

Participating in a Georgia Families' health plan:

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

Billing the health plans for services provided:

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

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

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

Credentialing

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

Credentialing and recredentialing services 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 L



Information for Providers Serving Medicaid Members
in the Georgia Families 360°SM Program

Georgia Families 360°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°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°SM Every member in Georgia Families 360° 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 will be 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 will 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 M
Expanded Nursing Services

Introduction

The Department of Community Health (DCH) has expanded the scope of nursing services provided to eligible Medicaid and PeachCare for Kids members through its Children's Intervention School Services (CISS) program. The expansion will allow additional claiming for Medicaid-enrolled children from the general student population for medically necessary services. The expansion is limited to nursing services only. The goal of the nursing expansion is to increase access to health care for children and enhance care coordination.

Nursing Services

DCH will reimburse Local Education Agencies (LEAs) for medically necessary nursing services provided to children with an Individualized Education Program (IEP), as well as currently enrolled Medicaid and PeachCare for Kids members who do not have an IEP. For children not served under an IEP, nursing services must be those services documented in the student's Care Plan based on a written order by the child's primary care practitioner (PCP) or other prescribing practitioner at the request of the PCP, within the scope of his or her practice under State Law. The term Care Plan is defined as an Individualized Health Plan (IHP), diabetes plan, or other standard document that identifies the student's medical need. Collaboration between the school and the community healthcare providers is necessary to coordinate treatment and to prevent duplication of services.

Covered nursing services may include, but are not limited to:

- Enteral (tube) feedings
- Medication administration
- Breathing treatments
- Diabetes management
- Health counseling and health education as ordered by the child's PCP or other prescribing practitioner
- Routine health screenings in collaboration with public health departments, pediatric practices, FQHCs or other entities participating in the Health Check Program
    - Example: hearing, vision, scoliosis, and dental screens

In order to receive reimbursement, the LEA must be an enrolled Medicaid provider. Enrollment in both the CISS and ACE programs is mandatory to receive reimbursement for direct nursing services rendered to eligible non-IEP Medicaid and PeachCare for Kids members. The LEA must submit a letter to the DCH attesting enrollment in both programs. See sample attestation form attached.

Interim Billing & Service Documentation

Medicaid reimbursement requires that all claims include a clinically appropriate ICD-10 diagnosis consistent with the treatment or service provided. All claims must be submitted with an ICD-10 code provided by a medical practitioner licensed to diagnose. The LEA is responsible for submitting interim claims on a timely basis. Interim claims must be submitted within six months from the date of service via the Georgia Medicaid Management Information System (GAMMIS). When billing procedure codes, 1 unit equals 15 minutes unless otherwise specified. Billable procedure codes are listed below and in Chapter 1000 – Basis of Reimbursement of this manual.

T1002 – RN services
T1003 - LPN services
T1502 – Medication Administration

Rounding Rules

Units	Number of Minutes
1 unit:	≥ 8 minutes through 22 minutes
2 units:	≥ 23 minutes through 37 minutes
3 units:	≥ 38 minutes through 52 minutes
4 units:	≥ 53 minutes through 67 minutes
5 units:	≥ 68 minutes through 82 minutes
6 units:	≥ 83 minutes through 97 minutes
7 units:	≥ 98 minutes through 112 minutes
8 units:	≥ 113 minutes through 127 minutes

All nursing services must be documented in accordance with standard clinical practices. Each encounter must include the basic minimum elements: member's name, member's date of birth, date of service, duration of service, name and signature of person providing the service, medical justification of the service, and any additional notes required by the needs of the student. The LEA must retain this information in the child's confidential file or record.

Provider Qualifications

Nursing services must be provided by registered nurses (RNs) or licensed practical nurses (LPNs). LPNs must deliver nursing services under the supervision of a physician practicing medicine, a dentist practicing dentistry, a podiatrist practicing podiatry, or a registered nurse practicing nursing in accordance with applicable provisions of law. O.C.G.A. Title 43 Chapter 26 Article 2. Licensed practitioners must provide services within their scope of practice and must comply with all supervision requirements of the practitioners' licensing body.

Parental Consent

LEAs must obtain written permission/consent from the parent/guardian of the Medicaid-eligible student (with or without an IEP) prior to billing Medicaid. Appendix B contains a suggested sample consent form. The parental/ guardian's written permission/consent needs to be obtained annually. Parents/guardians must inform the LEA, in writing, if they no longer wish to allow Medicaid to be billed. The LEA must inform the parents/guardians of the procedure to withdraw consent. If the IEP is utilized as the consent form, the exact wording in Appendix B must be included on the IEP form and parental/guardian consent obtained. If the IEP option is chosen for parental consent to bill Medicaid, then parental consent must be obtained annually.

Medicaid Eligibility Verification

Student Medicaid eligibility information can be obtained by logging into the Georgia Medicaid Management Information System (GAMMIS) portal. The member Eligibility Verification Request panel allows providers and billing agents to request individual student eligibility information for Georgia Medicaid members.

Department of Community Health

Attestation for Children's Intervention School Services (CISS) for Expanded Nursing Services

To be completed by the *designated Local Education Official*

Name of LEA _____ Provider ID# _____

The Georgia Department of Community Health (DCH) has expanded the scope of nursing services provided to eligible Medicaid and PeachCare for Kids members through its Children's Intervention School Services (CISS) program. The expansion will allow additional claiming for Medicaid-enrolled children from the general student population for medically necessary services. The expansion is limited to nursing services only. The goal of the nursing expansion is to increase access to health care for children and enhance care coordination. In order to provide the expanded nursing services to enrolled Medicaid members and receive reimbursement, providers must complete and submit this "*Attestation for Children's Intervention School Services (CISS) for Expanded Nursing Services."*

I hereby attest to the following:

- I am a LEA and enrolled in both the CISS and ACE programs and wish to participate in the expansion.
- I have completed the Free Care Nursing Services Webinar.

By signing this attestation, I acknowledge that I am qualified to render the expanded nursing services and that I have reviewed the terms and conditions outlined in the Part II, Policies and Procedures manual for CISS. I agree to stay abreast of Policies and Procedures related to the program(s) in which I am enrolled.

Printed Name of Signer _____ Signature _____ Date _____

NOTE: Upon completion of this form, please forward to the school nursing mailbox at ciss.schoolnursingservices@dch.ga.gov