PART II

POLICIES AND PROCEDURES
for
DIAGNOSTIC SCREENING AND PREVENTIVE SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: January 1, 2024

Policy Revisions Record

Part II Policies and Procedures Manual for DIAGNOSTIC SCREENING AND PREVENTIVE SERVICES 2021

Revision Date	Section	Revision Description	Revision Type A= Added D = Deleted M = Modified	Citation (Revision required by Regulation, Legislation, etc.)
01/01/2024		No update for this quarter		

PART II - POLICIES AND PROCEDURES FOR DIAGNOSTIC, SCREENING AND PREVENTIVE SERVICES (DSPS)

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PART II - CHAPTER 600

SPECIAL CONDITIONS OF PARTICIPATION

601. In addition to the general conditions of participation identified in Part I, Section 106, providers enrolled in the Diagnostic, Screening and Preventive Services (DSPS) program must meet the following special conditions:

601.1 The provider agrees to bill only for those diagnostic, screening and treatment services provided personally and directly by licensed practitioners of the healing arts within the scope of their licensure under state law.

601.2 The provider agrees to provide diagnostic, screening and treatment services at an office, clinic, school-based clinic, home, or other similar physical facility within the boundaries of the State of Georgia. The only exception to this condition is the provision of environmental lead investigations, which must be provided at the member's primary place of residence within the boundaries of the State of Georgia. At a minimum, the Diagnostic, Screening and Preventive Services provider must provide the following services:

a) Antepartum and postpartum care;
b) Newborn follow-up services;
c) Immunizations for adults;
d) Diagnosis and treatment of sexually transmitted diseases;
e) Hepatitis B management;
f) Hypertension diagnosis and treatment;
g) Follow-up and management of tuberculosis; and
h) Nutritional counseling;
i) Case management services
j) Children 1st services
k) High-risk infant follow-up

Note: Case management services are only reimbursable for Women's Health Medicaid, Children's Medical Services and High-Risk Infant Follow-Up (Medicaid and Peach Care) eligible.

The services listed above must be provided directly by the enrolled provider. Enrolled providers may not subcontract for the delivery of services.

601.3 The provider agrees to bill the Division the usual and customary fee for each procedure performed. "Usual and customary" is defined as the fee charged to private-paying patients for the same procedure during the same period of time.

601.4 The provider agrees to maintain records on both Medicaid-eligible and private-paying patients for a minimum of five (5) years. The provider further agrees to furnish the Division, its authorized representatives, or contractual agents, with such information as the Division may request from time-to-time, including information on fees.

601.5 The provider agrees not to bill for any services performed by an independent laboratory or x-ray facility or other health care provider.

601.6 The provider agrees to cooperate with the appropriate guidelines of other Medicaid programs adjunctive to DSPS, such as non-emergency transportation, ambulance, durable medical equipment, orthotics and prosthetics, pharmacy and physician services, family planning and Health Check (EPSDT).

601.7 The provider agrees to notify the Division's Provider Enrollment Unit in writing should any change in enrollment status occur such as: new address and/or telephone number; additional DSPS locations; change in payee; and voluntary termination from the program. Each notice of change must include the date on which the change(s) is to become effective.

601.8 The provider agrees to bill the Division the procedure code(s) which best describes the level and complexity of the service rendered and not to bill under separate procedure codes for services which are included under a single procedure code.

601.9 The provider agrees to maintain such records as are necessary to demonstrate program compliance and to submit or make such records available upon request for a minimum of five (5) years from the date(s) the service(s) is provided.

601.10 Enrolled Diagnostic, Screening and Preventive Services providers also must be a provider of Health Check (EPSDT), family planning, pregnancy related and perinatal case management services.

601.11 The provider agrees to submit cost and information reports in accordance with the policies and procedures of the Division of Medical Assistance and the Division of Public Health of the

Department of Human Resources for the determination of reimbursement rates for covered services.

601.12 The provider agrees to maintain patient confidentiality at all times.

601.13 The provider agrees to assure that there is no duplication of services, i.e., members receive only one type of case management service.

602. Collaboration Between Providers Must Take Place In Order To Avoid Duplication Of Services

Certain members may be eligible for other types of case management services. DCH will reimburse only one provider agency for case management services.

602.1 Children 1st and Case Management

Definitions:

Children 1st is a statewide system for assessing health and socio-environmental risk factors in children from birth to age five (5). It provides a single point of entry to identify risk factors and offer linkages to services to promote early childhood development and improved health for children at risk.

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

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

Providers of Children 1st and case management services must:

1. Have the capacity to provide the full range of services as described in Part I, Section 106.1-106.29, 113.1-113.9, and Chapter 600, sections 601.1-601.13.

2. Have full-time trained staff who meet the following qualifications:

   A nurse, social worker or nutritionist licensed in Georgia with a minimum of one year of experience working in the delivery of services to children with special health care needs and/or women's health; and

   A professional (Bachelor, Masters level) or paraprofessional with one year of human service delivery experience in health and human services. Such staff supports Children 1st or case management services and performs under the supervision of a licensed nurse, social worker, or nutritionist.

3. Have demonstrated ability to provide and coordinate services to specific population and program category through family assessments, home visits, referrals, and case management.

PART II - CHAPTER 700

SPECIAL ELIGIBILITY CONDITIONS

There are no special eligibility conditions which members must meet in order to receive diagnostic, screening and preventive services other than those stipulated in Section 113 of Part 1.

PART II - CHAPTER 800

PRIOR APPROVAL

Prior Approval

The services covered in this Policy Manual do not require approval by the Division prior to their provision. However, the Division may require prior approval of all, or certain procedures rendered by all or certain providers based on the findings or recommendations of the Division, its authorized agents or the Department of Health and Human Services. In such instances, the Division will serve written notice to the provider of this requirement.

PART II - CHAPTER 900

SCOPE OF SERVICES

901. General

The Diagnostic, Screening and Preventive Services (DSPS) program provides reimbursement for a broad range of diagnostic, screening and preventive services, subject to the reimbursement limitations established in this manual.

902. Covered Services

902.1 General

The procedure codes listed in Appendix B of this manual constitute the services covered under the DSPS program. Other program services covered by the Division, such as Health Check (EPSDT) and Family Planning, are not included. Referrals should be made for Family Planning, Health Check, and WIC services. Nutritional counseling for adults not eligible for WIC services is covered under the DSPS program when provided by a licensed dietician.

902.2 Children 1st and Case Management Services

Children 1st and case management services for Medicaid Peach Care eligible members are covered under the DSPS program when provided by a licensed nurse, social worker or nutritionist.

For detailed description, see Appendix A for Case Management Services and Appendix I for Children 1st Services.

903. Service Limitations

The services in this Section are covered with limitations. If a provider has special medical justification for exceeding a service limitation, the medical justification should be well documented and made available to the Division upon request. Such documentation may be requested in a prepayment or post payment review. Lack of appropriate medical justification may be grounds for denial, reduction or recoupment of reimbursement.

903.1 Injectable Drugs

Procedure codes and descriptions for injectable drugs (other than allergy injections) are listed in the Division's Schedule of Maximum Allowable Providers` Administered Drug List, which may be obtained from the Division's web site.

903.2 Laboratory Services

A) In order to bill the Division for laboratory services, the provider's laboratory must meet the criteria established in the 1988 Clinical Laboratory Improvement Act (CLIA 88). In addition, the laboratory must meet current OSHA standards.

A copy of the laboratory's most recent certification must be submitted to the Division.

B) Independent laboratories are enrolled separately in the Medicaid program and must bill the Division directly for their services. When a DSPS provider collects specimens and forwards them to an independent or public laboratory, the DSPS provider may not bill the Division for the collection and handling of the specimen(s) as reimbursement for collection and handling is included in the Evaluation and Management (E/M) code billed.

C) The Division will not reimburse DSPS providers for laboratory procedures performed by independent, State or public laboratories. DSPS providers must furnish the independent or public laboratory with the member's name and Medicaid number and identify test procedures to be performed. The following procedures are to be sent to the State Laboratory System:

1. Newborn Neonatal Metabolic screening tests;

2. Hemoglobin testing for sickle cell detection (Homocystine, Galactose, Phenylalanine, Thyroxine, Tyrosine and Mucopolysaccharides);

3. Hemoglobin Electrophoretic Separation (HES) includes SS, SC, SE, S Beta Thalassemia, SO and SD;

4. Hemoglobin solubility test for members over six (6) months of age with HES results that indicate sickle cell anemia or trait;

5. Syphilis Serology

   a) VDRL, RPR; and
   b) Precipitation or floculation and Fluorescent Teponema Antibodies (FTA);

6. Tuberculosis Testing
   a) Tubercle culture;
   b) Definitive identification;

7. Salmonella and Shigella Testing; and

The State Laboratory addresses and telephone numbers are listed below:

1. **Decatur Central Public Health Laboratory**
Georgia Department of Public Health
Laboratory Services & Supply
1749 Clairmont Road
Decatur, Georgia 30033-4050
(404) 327-7920 FAX (404) 327-7922

2. **Waycross Public Health Laboratory**

Georgia Department of Public Health
Laboratory Services & Supply
1751 Gus Karle Parkway
Waycross, Georgia 31503
(912) 338-7050 FAX (912) 338-7061

GA Dept. of Human Resources
1101 Church Street
Waycross, Georgia 31501-3525
(912) 285-6000

Specimen outfits for testing to be done in the Regional Laboratories are available at the above addresses with the exception of Atlanta Central Laboratory. Specimen outfits for Atlanta Central must be obtained from:

Laboratory Services and Supply
1749 Clairmont Road
Decatur, Georgia 30033-4050

903.3 Newborn Services

Preventive health screening of eligible children performed after the newborn examination is covered under the Health Check and Pregnancy Related Services programs only.

The Division has set up a procedure whereby Medicaid-participating hospitals and birthing centers can directly report to Medicaid the birth of a child born to a Medicaid-eligible woman.

Diagnostic, Screening and Preventive Services (DSPS) providers are encouraged to refer pregnant women to DFCS for eligibility determination for the mother and the unborn child and to contact the hospital for Medicaid numbers on newborns.

Please see Part I, Section 113.1 for information regarding Medicaid eligibility for newborns. See Appendix F for the Newborn Eligibility Form.

903.4 Obstetrical Services

A) Initial Visit and Prenatal Profile

The Division provides reimbursement for the initial visit to determine pregnancy separately from any other obstetrical care. If a specimen for pregnancy testing is collected for referral to an independent laboratory, a collection and handling fee is not billable separately under CPT code 99000. Reimbursement for collection and handling is included in the E/M code billed. Charges for the clinic visit should be billed immediately after the contact. The initial visit must be billed as a family planning service using diagnosis code "FP."

B) Antepartum and Postpartum Care--Partial Obstetrical Care Due to Involvement of More Than One Provider During Pregnancy

Rev. 04/14

Note: Procedure Code 59420 for antepartum care was deleted from the 1993 CPT code book; therefore, when billing for services which usually fall under antepartum care only, you must bill the appropriate evaluation and management procedure code per encounter. The visits for antepartum care must be billed with a diagnosis code in the ICD -10 CM range of **O02.81** through **O92.70**, as antepartum visits are not subject to the ten-office visit limitation.

1. If the same provider began routine antepartum care in the first trimester of pregnancy (on or before 13 weeks gestation) and continued to deliver routine prenatal care through no less than 32 weeks of gestation (by date and/or ultrasound) and did not deliver the child, the provider must bill the appropriate evaluation and management code for ANTEPARTUM CARE.

2. If the same provider began routine antepartum care later than the first trimester and/or did not continue to deliver routine prenatal care (as outlined above) through the 32nd week of gestation, the provider must bill each prenatal visit with an E/M procedure code.

   Routine prenatal care visits should be coded at the appropriate E/M code level, depending on the services rendered.

3. If a member begins prenatal care late (greater than 28 weeks gestation by dates and/or ultrasound), the provider must bill subsequent prenatal visits under the appropriate E/M Code. The provider may also bill for POSTPARTUM CARE, depending on the services rendered.

C) Pregnancy Testing

Effective with date of service October 1, 1994, pregnancy testing became a covered service under the DSPS Program. When billing for this procedure, you must use procedure code 81025. If the pregnancy test is directly related to the patient's contraceptive method, it must be billed under the Family Planning Program. For billing instructions under the Family Planning Program, reference the Policies and Procedures for Family Planning Services manual.

903.5 Clinic Visits

Only one clinic visit per date of service is reimbursable regardless of extenuating circumstances.

Rev. 01/18 903.6 Radiological Services

Radiological services covered for DSPS provided are listed in Appendix B of this manual.

When billing for multiple identical radiology services performed on the same date of service, charges must be placed on only one line of the claim form. For example, three single view frontal chest x-rays performed on the same date of service would be billed as one unit of procedure code 71047.

903.7 Immunizations

Diagnostic, Screening and Preventive Services (DSPS) providers may bill under code 99211 for a clinic visit associated with the administration of covered immunizations given to members over 21 years of age.

903.8 Nutritional Counseling

Rev.07/21

A. The Division will reimburse Providers for new patient nutritional assessment, established patient nutritional counseling and nutritional group counseling visits (refer to Appendix B for the appropriate procedure codes).

- Nutritional counseling (individual or group) can be billed as a single service if it was the only service provided that day.

- Nutritional counseling (individual or group) rendered in combination with other clinic services on a particular day should not be billed separately.

-

- Nutritional counseling for WIC-eligible members must be beyond the first two (2) nutrition education contacts.

- Nutritional group counseling classes must be specific to member's nutrition-related medical condition and diagnosis.

Coverage and Limitations

B.
- A total of twelve sessions of nutritional counseling services are allowed per member per calendar year.
- Only one nutritional counseling session may be billed per day.
- The new patient nutritional assessment session, procedure code 99203, is limited to one per member, per calendar year.
- The established patient nutritional (individual or group) counseling session, procedure codes 99213, 99211 are limited to eleven per member per calendar year the first year and twelve each subsequent year.
- A Group Nutritional Counseling may replace the individual counseling visit and will be billed as 99211.

Note: Procedure Codes 99203, 99211 and 99213 are not reimbursable if done on the same date of service.

903.9 Speech, Language and Hearing Services

A. The Division provides reimbursement for speech, language and hearing services for members less than twenty-one years of age when rendered by licensed audiologists or licensed speech therapists. Please see Appendix C of this manual for appropriate procedure codes.

Coverage and Limitations

B. Speech, language and hearing services are limited to eligible Medicaid members under twenty-one years of age.

Procedure code 96105, assessment of higher cerebral functions, is limited to one per member per calendar year (see Appendix C for additional speech, language and hearing service procedure codes).

903.10 Environmental lead investigations are limited to members between the ages of six months and seventy-two months who meet the blood lead level requirements described in Appendix E of this manual.

903.11 Special Services

Diagnostic, Screening and Preventive Services (DSPS) providers may offer additional services that are beyond the scope of services described in Section 901 of this manual.

Providers must seek separate and individual enrollment from the Provider Enrollment Unit for each type of service rendered, including:

A) Health Check;
B) Dental Services;
C) Mental Health Clinic Services;
D) Vision Care Services;
E) Family Planning Services;
F) Nurse Midwifery Services;
G) Nurse Practitioner Services;
H) Pregnancy Related Services;
I) Perinatal Case Management;
J) Pharmacy; and
K) Physician Services.

The above services are governed by policies and procedures specific to each program. Policies and procedures for DSPS do not apply to these services and billing would be according to program policies and procedures for each program identified above.

903.12 Case Management Services

A licensed nurse, social worker or nutritionist may bill for case management services (refer to Appendix A for appropriate procedure codes).

Levels of acuity for case management interrelated activities are based on the assumption that members will require care coordination of varying levels of intensity depending upon the complexity of medical condition, psycho-social needs, economic and environmental factors.

The case manager will conduct and document a program specific Needs Assessment.

Care Plan based on the Needs Assessment will assign level of intervention. The Level of Service (Intervention) must not exceed the Level of Need.

All levels of case management services include counseling and/or coordination of care with other providers or agencies consistent with the nature of the problems and the individual and family needs.

Autism Screening:

903.13

CPT 96110 - DEVELOPMENTAL SCREENING is required at ages 18 months and 24 months or any time parents raise a concern: The screening should be performed with an autism-specific screening tool. The Modified Checklist for Autism in Toddlers (MCHAT) is the recommended tool and downloadable at https://m-chat.org. The M-CHAT is a validated developmental screening tool for toddlers between 16 and 30 months of age and should not be used for children younger than 16 months of age. The M-CHAT is designed to identify children who may benefit from a more thorough developmental and autism evaluation The M-CHAT can be administered and scored as part of the preventive health visit, and also can be used by specialists or other professionals to screen for developmental delay and autism. The M-CHAT on-line version features the latest scoring system, Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F), making the results more sensitive in detecting developmental concerns.

Documentation:

Evidence of the screening. Documentation in the medical record must include a note indicating the date on which the screening was performed; a copy of the screening tool used; and documented evidence of a screening result or screening score. If indicated, document the follow-up assessment, therapeutic interventions used, referrals made, and treatments received.

903.14 Children 1st Services

Refer to Appendix I for appropriate procedure codes and reimbursement guidelines.

903.15 High Risk Infant Follow up Services

See Appendix A for details.

903.16 Dental Services in Public Health Clinic

See Part II Policies and Procedures for Dental Services manual Section 910, Pages IX-35.

904. Non-Covered Services

The following services or procedures are non-covered by the Division under the DSPS program. This list is representative of non-covered services or procedures and is not meant to be exhaustive.

A) Nursing home visits;

B) Day care center visits;

C) Hospital visits;

D) Family planning services;

E) Radiological procedures performed by a portable x-ray service;

F) Drugs used or dispensed in the clinic except those injectables authorized by the Division;

G) Health Check screening services;

H) Laboratory services;

I) Experimental services;

J) Educational supplies, medical testimony, special reports, travel by the nurse, no-show or canceled appointments, additional allowances for services provided after clinic hours or between 10:00 pm and 8:00 am or on weekends and holidays;

K) Services or procedures performed without regard to the policies contained in this manual;

L) Services performed outside of protocol or licensure of the specific practitioner;

M) The first two nutrition education contacts for WIC-eligible members;

N) Speech, language and hearing services for members 21 years of age and older; and

O) The initial basic audiometry screening. (Initial screening must be done under Health Check.)

P) Investigational items and experimental services, drugs or procedures or those not recognized by the Federal Drug Administration, the United States Public Health Service, Medicare and the Division's contracted peer review organization as universally accepted treatment, including but not limited to, positron emission tomography, dual photon absorptiometry, etc.

Q) Lead investigations done at sites other than the child's primary place of residence.

R) Consultation Services.

905. Health Check referrals are not required for members under 21 years of age.

CHAPTER 1000

BASIS FOR REIMBURSEMENT

Reimbursement Methodology

The Division will pay the lower of the physician's lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date(s) of service, the lowest price charged to other third-party payers, or the statewide maximum allowable reimbursement amount allowed for the procedure code reflecting the service rendered. Effective with dates of service October 1, 2003, the statewide maximum allowable reimbursement is 84.645% of the 2000 Resource Based Relative Value Scale (RBRVS) as specified by Medicare for Georgia Area 1 (Atlanta). All procedure codes recognized and adopted after the 2000 RBRVS are subject to the same level of reimbursement.

Services provided by a physician's assistant will be limited to no more than 90% of the maximum allowable amount paid to a physician.

Reimbursement for services will be contingent on the DSPS provider's enrollment in the program, the patient's eligibility at the time services are rendered, and compliance with any other applicable policies and/or procedures.

1002. Billing Instructions and Forms

The appropriate claim form for reimbursement is the Physician/Other Services Invoice (CMS-1500). DSPS providers should complete this form and forward it to the Division's fiscal agent. The Place of Service codes for services provided at the clinic is "71". Detailed instructions for completion of the CMS-1500 are contained in Appendix O.

1003. National Correct Cording Initiative (NCCI)

The Centers for Medicare and Medicaid Services (CMS) has directed all State Medicaid agencies to implement the National Correct Coding Initiative (NCCI) as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010.

Georgia Medicaid uses NCCI standard payment methodologies. NCCI Procedure to Procedure edits prevent inappropriate payment of services

that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUEs) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

For additional questions regarding the NCCI or MUE regulations, please see the CMS website: http://www.cms.gov/.

1004. General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

Rev 04/14

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

For the NEW CMS-1500 claim form:
Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

For claims entered via the web:
Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:
The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

The following resources are available for more information:

- Access the department's DCH-i newsletter and FAQs at http://dch.georgia.gov/publications

- Search to see if a provider is enrolled at

  https://www.mmis.georgia.gov/portal/default.aspx

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

- Access a provider listing at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Notices/tabId/53/Default.aspx

  Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

APPENDIX A

CASE MANAGEMENT SERVICES

Effective with date of service on or after October 1, 2002, the following procedure codes for case management services will be covered for Women's Health Medicaid, Children's Medical Services and "1st Care Services (Medicaid and Peach Care) eligible members. Program areas will determine appropriate assessment tools and levels of care for case management services. Cost will be evaluated and reimbursement adjusted to reflect cost.

	99211	99341	99347
99202	99212	99342	99348
99203	99213		99349
99204	99214	99344	99350
99205	99215	99345	

Medicaid Reimbursement Guidelines

1. Case management services must be completed prior to billing.
2. The Annual or Comprehensive Assessment can be billed only once per family per calendar year.
3. The dates of service for the follow-up visits must be after the date of the Annual or Comprehensive Assessment.
4. Level I, Case Management Services are limited to a maximum of ten (10) 99211/minimal visits, ten (10) 99202/99212 problem-focused follow-up visits, and one (1) 99347/home visit per year.
5. Level II, Case Management Services are limited to a maximum of ten (10) 99211/minimal visits, ten (10) 99203/99213 expanded-problem focused follow-up visits, and one (1) 99348/home visit per year.
6. Level III, Case Management Services are limited to a maximum of ten (10) 99211/minimal visits, ten (10) 99204/99214 detailed follow-up visits, and one (1) 99349/home visit per year.
7 Level IV, Case Management Services are limited to a maximum of ten (10) 99211/minimal visits, ten (10) 99205/99215 comprehensive follow-up visits, and two (2) home visits per year. The Home Visits will be at the 99349 level at a minimum. If indicated, a 99350 Home Visit may be charged after October 1, 2002.

APPENDIX B

DIAGNOSTIC, SCREENING AND PREVENTIVE SERVICES (DSPS) PROCEDURE COVERED CODES

10060	73092	82947	90636	92587	96159	99385
10120	73110	82948	90651	92588	96164	99386
10160	73130	82962	90654	92650	96165	99387
11102	73140	85013	90656	92651	96167	99395
11103	73501	85018	90662	92652	96168	99396
11104	73502	85025	90670	92653	96573	99397
11105	73503	86328	90671	93005	96574	99401
11106	73521	86480	90672	93010	97151	99406
11107	73522	86580	90674	93041	97152	99407
29700	73523	86769	90675	93050	97153	99408
29705	73551	86794	90677	93264	97154	99409
29710	73552	87070	90682	93792	97155	99415
29720	73560	87081	90686	93793	97156	99416
30300	73592	87164	90687	93986	97157	99421
46900	73610	87205	90688	94010	97158	99422
54050	73650	87210	90694	94150	97535	99451
56501	73660	87220	90707	94617	97750	99452
57061	74018	87426	90713	94618	97763	99458
57150	74019	87428	90714	94664	99050	99473
57452	74021	87662	90715	95004	99051	99474
57454	74712	87634	90716	95017	99202	99491
59430	74713	87635	90732	95018	99203	G2023
65205	76805	87636	90733	95249	99204	G2024
69209	76810	87637	90734	95836	99205	Q2036
70350	76815	87804	90736	96105	99211	Q2037
70360	76816	87811	90739	96110	99212	Q2038
71045	77073	87913	90746	96112	99213	Q3014
71046	78265	90375	90748	96113	99214	U0001
71047	78266	90377	90750	96121	99215	U0003
71048	78830	90378	90756	96127	99341	U0004
72081	78831	90611	90759	96133	99342	0202U
72082	78832	90619	92537	96136	99344	0240U
72083	78835	90620	92538	96138	99345	0241U
72084	81000	90621	92557	96139	99347	
73020	81002	90622	92567	96146	99348	
73070	81025	90627	92568	96156	99349	
73090	82270	90632	92582	96158	99350	

Preventive Service Visits

99385 – New Patient, 18-39 years

99386 – New Patient, 40-64 years

99387 – New Patient, 65 years and older

99395 – Established Patient, 18-39 years

99396 – Established Patient, 40-64 years

99397 – Established Patient, 65 years and older

Nutritional Assessment and Counseling

99203 – New Patient

99211 - Group Nutritional Counseling

99213 - Established Patient

Environmental Lead Investigation

T1028 – Initial Lead Investigation

T1028– Post Hazard Abatement - Modifier U-1

Note: Continue to use procedure code Y5400 –Initial Lead Investigation and Y5401-Post Hazard Abatement until date of service December 31, 2003. Effective October 1, 2004 date of service you MUST use the aforementioned codes next to Rev. 1/04 above this note box.

APPENDIX C

COPAYMENTS FOR CERTAIN SERVICES

Effective with dates of service October 1, 2005, the Division is implementing a tiered member co-payment scale as described in 42CFR447.54 on all evaluation and management procedure codes (99202 - 99499) including the ophthalmologic services procedure codes (92002 - 92014) used by physicians or physicians' assistants.

The tiered co-payment amounts are as follows:

State's payment for the service	Maximum co-payment chargeable to recipient
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

The co-payment will be deducted from each evaluation and management procedure code billed unless the member is included in one of the exempted groups below.

The co-payment does not apply to the following members:

- Pregnant women
- Nursing facility residents
- Hospice care members
- Members under 21
- Women diagnosed with breast or cervical cancer and receiving Medicaid under the Women's Health Medicaid Program, aid categories 245 and 800, only.

Rev 10/13

The co-payment does not apply to the following services:

- Emergency services
- Family Planning services
- Waiver Services
- Dialysis Services

The provider may not deny services to any eligible Medicaid member because of the member's inability to pay the co-payment.

The provider should check the Eligibility Certification (Medicaid card) each month in order to identify those individuals who may be responsible for the co-payment. The Eligibility Certification has been modified to include a co-payment column adjacent to the date-of-birth section. When "yes" appears in this column for a specified member, the member may be subject to the co-payment.

The Division may not be able to identify all members who are exempt from the co-payment. Therefore, providers should identify the members by entering the following indicators in field 24(I) of CMS 1500 claim form:

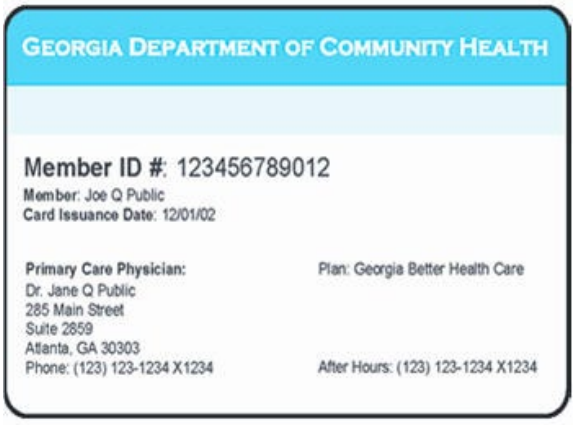
P = Pregnant
S = Nursing facility members
H = Hospice
E = Emergency services

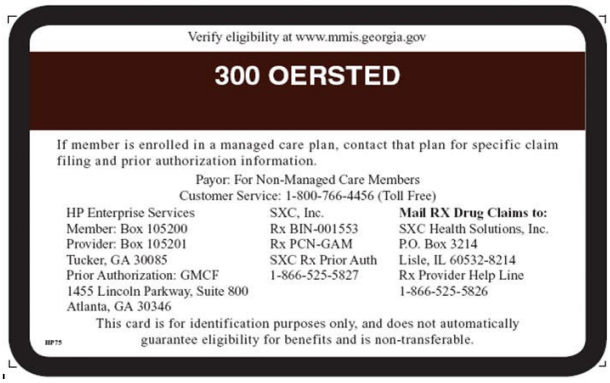
Gainwell Technologies will automatically deduct the co-payment amount from the provider's payment for claims processed with dates of service October 1, 1994, and after. Do not deduct the co-payment from your submitted charges. The application of the co-payment will be identified on the remittance advice. A new explanation of benefit (EOB) code will indicate payment has been reduced due to the application of co-payment.

Pharmacy Services, please refer to Pharmacy Service Manual for current policy and copayment requirements.

APPENDIX D

Medicaid Member Identification Card Sample





APPENDIX E

ENVIRONMENTAL LEAD INVESTIGATIONS

Rev 10/15

Effective with date of service October 1, 1994, the following procedure codes for environmental lead investigations will be covered for children six months to seventy-two months of age. These codes are limited to one each per member per lifetime. They are covered only for the member's primary place of residence. Prior approval or other consideration for lead investigations done at locations other than the child's primary residence is not available.

T1028 - Initial lead investigation $229.60 – Y5400
T1028 - Post hazard abatement (Modifier U-1) $197.34 - Y5401

LEAD INVESTIGATIONS

MEDICAID REIMBURSEMENT GUIDELINES

1. This service must be provided in conjunction with a blood lead screening program for Medicaid eligible children.

2. A thorough environmental lead investigation should be conducted within specified time frames for:

All children ages six months to seventy-two months whose blood lead level, as confirmed by either two consecutive lab-analyzed capillary or one venous blood, equal to or greater than 3.5 micrograms per deciliter of blood.

3. An environmental lead inspection must consist of:

On-site inspections of potential sources of exposure;

Testing of paint using a lead-in-paint analyzer and/or the physical collection of dust, soil, water and paint samples for laboratory analysis;

Analysis and interpretation of data;

APPENDIX F

NEWBORN MEDICAID CERTIFICATION
(TEMPORARY)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Division of Public Health

Please mail completed form to

GHP
P.O. Box 105209
Tucker, GA. 30085-5209

NEWBORN MEDICAID ID NUMBER
Certifying provider must contact GHP to obtain a newborn I.D.

NEWBORN'S NAME — *First* | *MI* | *Last* | *Suffix*

DATE OF BIRTH

SEX Male ☐ Female ☐

Mother's Medicaid ID No.

Mother's Social Security No.

Is the mother a U.S. Citizen? YES ☐ NO ☐

MOTHERS NAME — *First Name* | *MI* | *Last*

MAILING ADDRESS — *Number and street* | *City* | *State* | *Zip* | *County* | *Telephone Number*

Date of Request

Parent/Relative Signature

COMPLETED BY — *Please Print*

TITLE — *Please Print*

PROVIDER NAME — *Please Print*

TELEPHONE

PROVIDER SIGNATURE

By signing, I certify to the best of my knowledge that the information above is verified and accurate

DATE COMPLETED

PROVIDER NO.

Please contact GHP to verify the mother's Medicaid eligibility for the month of the newborn's birth, and to obtain the newborn's Medicaid I.D. number.

DMA-550 REV. (07/10)

INSTRUCTIONS TO CLIENTS	INSTRUCTION TO PROVIDERS
This certification can be used to receive medical assistance services for only those persons listed on the reverse side. This certification must be presented to the provider each time medical assistance is requested for any person on the certification. You are responsible for this certification, do not let anyone borrow it. Unlawful use of this certification will result in prosecution. If you lose it, contact your caseworker. If you have other insurance coverage, you must notify the provider when seeking medical assistance. All out-of-state services must be prior approved to ensure payment. For information call: 1-800-766-4456 Hours: 8:00 a.m. – 7:00 p.m. ET. Monday thru Friday Please have your Medicaid client ID number ready when you call.	Medical assistance services are to be provided in accordance with the Department's medical assistance plan up to and including the last day specified on the reverse side. Certification must be requested each time a service is requested. Always check for other proof of identity. Enter the medical assistance claim from the complete case number as shown for the person receiving the service. Contact the Department of Medical Assistance on questions regarding client eligibility. Clients under the age of 21 are exempt from co-payment requirements. Clients of Medicaid in Georgia are not required to pay any portion of those medical bills that are required to be paid by Medicaid. If you have medical bills that should have been paid by Medicaid, please call 1-800-766-4456. You may also write to the Department at: Department of Medical Assistance Member Inquiry Unit 19th Floor 2 Martin Luther King Jr. Dr. SE East Tower Atlanta, Georgia 30334 The Department will inform you within 30 days of receipt of your telephone call or letter of your responsibilities, if any, for payment of the bill.

APPENDIX G

GEORGIA HEALTH PARTNERSHIP (GHP)

Electronic Data Interchange (EDI)

1-877-261-8785

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

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

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

APPENDIX H

STATEMENT OF PARTICIPATION

The new Statement of Participation
is available in the Provider Enrollment Application Package via the web.

Phone your request to:

1 (800) 766-4456

APPENDIX I

CHILDREN 1ST FAMILY ASSESSMENT AND REFERRAL SERVICES

Effective with date of service on or after October 1, 2002, the following procedure codes for the Children 1st Family Assessment and referral services will be covered for Medicaid and Peach Care eligible members. Cost will be evaluated and reimbursement adjusted to reflect cost.

99341	99347		99211
99342	99348	99202	99212
	99349	99203	99213
99344	99345	99350	99214

Medicaid Reimbursement Guidelines

Rev 01/15

1. Children 1st Family Assessment Home Visit is limited to a maximum of one (1) per family unit, per calendar year. If provided to a new client, codes 99341, 99342, 99344 or 99345 are used. If provided to an established client, codes 99347, 99348, 99349 or 99350 are used.

2. Children 1st Family Assessment clinic Visit is limited to a maximum of one (1) per family unit, per calendar year. If provided to a new client, codes 99202 or 99203 are used. If provided to an established client, codes 99213 or 99214 are used.

3. Children 1st Optional Follow Up Visit, if indicated, is limited to a maximum of one (1) per family unit, per calendar year. If provided in the home, codes 99347, 99348, 99349 or 99350 are used. If provided in the clinic, codes 99213 or 99214 are used.

4. Follow-Up /Referral services are limited to a maximum of three (3), contacts per family unit, per calendar year and may be direct or indirect. 99211 is coded when service provider is licensed or non-licensed. 99212 is coded when service provider is licensed.

Billing Note: When billing Children 1st assessment and referral services for Medicaid and Peach Care eligible members, use diagnosis code ICD-10-CM R68.89. Children 1st assessment and referral services must be billed under the Diagnostic, Screening and Preventive Services program only.

APPENDIX J

Rev 7/2021

Georgia Families

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

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

The three licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	CareSource 1-855-202-1058 www.caresource.com

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

Eligibility Categories for Georgia Families:

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

Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

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

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

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

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

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

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

Included Categories of Eligibility (COE):

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

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

Excluded Categories of Eligibility (COE):

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

220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind

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

917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

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

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

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

Registering immunizations with GRITS:

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

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

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

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

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

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

Participating in a Georgia Families' health plan:

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

Billing the health plans for services provided:

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

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

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

Credentialing

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

Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- Saves time
- Increases efficiency
- Eliminates duplication of data needed for multiple CMOs
- Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

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

Billing the health plans for services provided:

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

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

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

Receiving payment:

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

Health plans payment of clean claims:

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

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

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.

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

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

PHARMACY

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

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

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

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

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

If a patient does not have an identification card:

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

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

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

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

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

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

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

Who to call to request a PA:

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

APPENDIX K



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

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

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

Georgia Families 360^{0} SM Every member in Georgia Families 360^{0} is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov

APPENDIX L

Case Management Hierarchy

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

It is the responsibility of the case manager to ensure that the member is not receiving case management services from any other agency. The case manager must obtain from the member information regarding any and all other services that he/she may be receiving prior to enrolling the member in a case management program. If the case manager should learn that the member is enrolled in another case management program, the case manager is advised not to render any case management services until it is verified that his/her case management services are primary. This may require termination of the member from another case management provider before case management from the new provider can be billed. It is the case manager's responsibility to advise the member of the various case management choices available to the member and to allow the member to make an affirmative choice among them.
DCH will reimburse only one provider agency for case management services. The Department has established the case management hierarchy below to define which case management is primary and will be reimbursed the case management provider highest on the hierarchy will be reimbursed if 2 case management providers should submit claims for the same month of service.

COS 830 - (Case Management Organization - CMO) and
COS 851 - (SOURCE Case Management)
COS 100 - (MR Case Management Support) Only participants enrolled in COS 680 or 681
COS 764 - (Child Protective Services Targeted Case Management)
COS 800 - (Early Intervention Case Management)
COS 765 - (Adult Protective Services Targeted Case Management)
COS 760 - (Children At Risk Targeted Case Management)
COS 762 - (Adults with AIDS Targeted Case Management)
COS 763 - (At Risk of Incarceration Targeted Case Management)
COS 100 - (Case Management Support) Only MRDD participants on the Short-term planning list.
COS 960 - (Children Intervention School Service)
COS 790 - (Rehab Services/DSPS)

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

APPENDIX M

Non-Emergency Medical Transportation

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

How do I get NEMT services?
If you are a qualifying Medicaid recipient and have no other means of transportation for your medical care or services covered by Medicaid, you may contact a transportation broker for transport to and from your appointment. The member must contact the Broker to request NEMT services at least three (3) business days prior to a non-urgent, scheduled appointment. The three (3) advance scheduling includes the day of the but not the 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 sane 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.

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.

Region	Broker / Phone number	Counties served
North	**Verida** (Formerly Southeastern) 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	Verida (Formerly Southeastern) 404-209-4000 *Note: For Georgia Families 360* 1-866-991-6701	Fulton, DeKalb, and Gwinnett

Central	**ModivCare** (Formerly LogistiCare) Toll free 1-866-224-7981	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 N

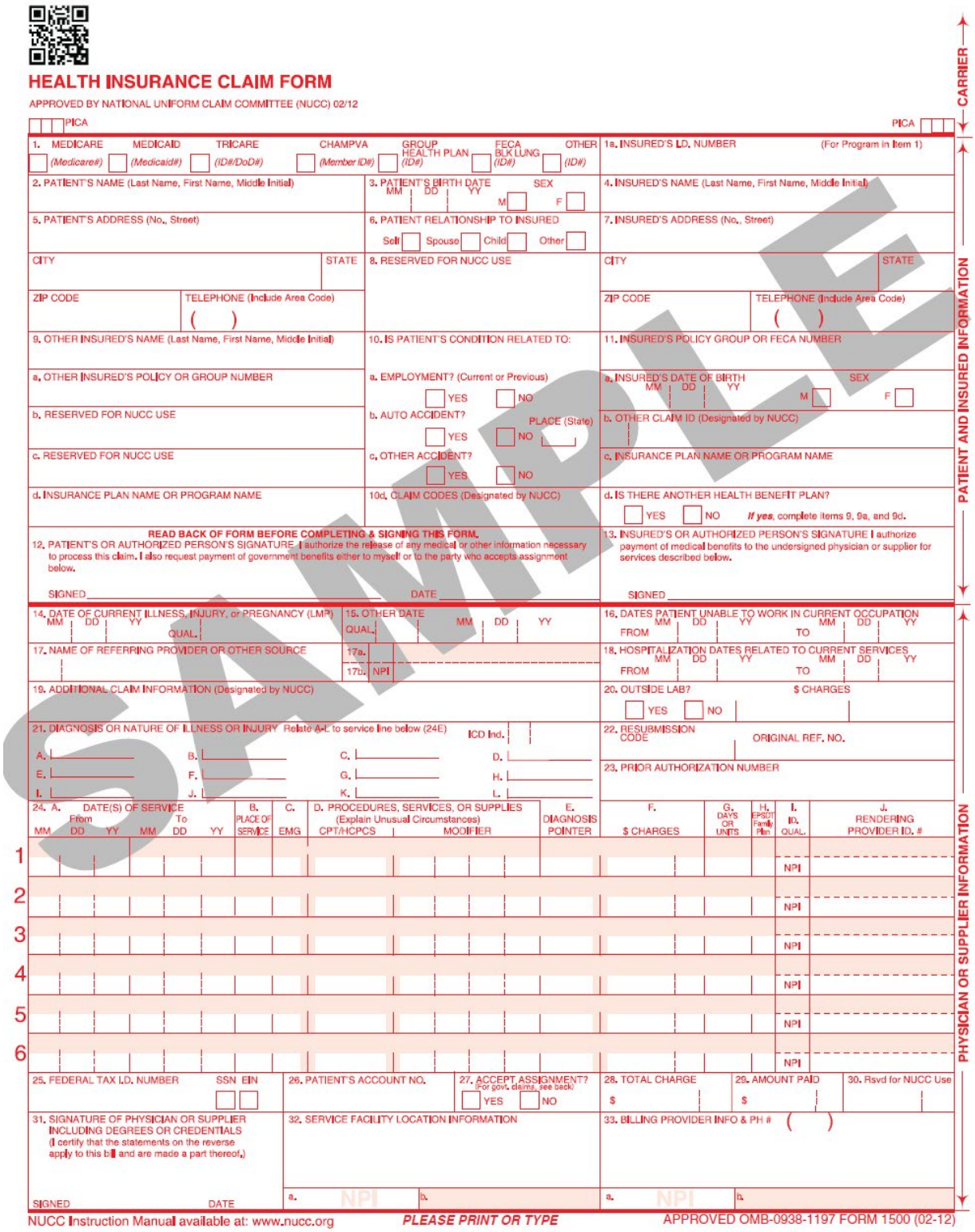
Peach Care for Kids® Co-payments: For children ages 6 and over, the following co-payments apply for each CMO:

Category of Service	Co-Payment
Ambulatory Surgical Centers / Birthing	$3.00
Durable Medical Equipment	$2.00
Federally Qualified Health Centers	$2.00
Free Standing Rural Health Clinic	$2.00
Home Health Services	$3.00
Hospital-based Rural Health Center	$2.00
Inpatient Hospital Services	$12.50
Oral Maxillofacial Surgery	Cost-Based
Orthotics and Prosthetics	$3.00
Outpatient Hospital Services	$3.00
Pharmacy - Preferred Drugs	$0.50
Pharmacy - Non-Preferred Drugs	Cost-Based
Physician Assistant Services	Cost-Based
Physician Services	Cost-Based
Podiatry	Cost-Based
Vision Care	Cost-Based

Cost-Based Co-Payment Schedule	
Cost of Service	
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

*There are no co-payments for children below the age of 6 years old, for children in Foster Care, or for children who are American Indians or Alaska Natives.

APPENDIX O



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. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

SAMPLE

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

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/Gainwell Technologies:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?)
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)." Removed the arrow and text in the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier." **FOR DCH/Gainwell Technologies: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date)**.
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471

	(Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/Gainwell Technologies:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/Gainwell Technologies:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values ICD -10 diagnoses (CM) codes =
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. **FOR DCH/Gainwell Technologies**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

APPENDIX P

Rev 01/18

HEALTH CHECK AND ADULT PREVENTIVE VISIT

The mission of the Department of Community Health (Department) goal is to improve the health outcomes of our enrolled Medicaid members by allowing them to establish a medical home and receive preventive health services.

Health Check

The Health Check program is Georgia Medicaid's well-child or preventive health care program for children birth to twenty-one (21) years of age. It is the early and periodic screening, (EPS) component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT is the result of a 1967 Amendment of Title XIX of the Social Security Act, which directed attention to the importance of preventive health services for children. The Medicaid manual for the Health Check program covers the screening (EPS) policies and procedures for well-child check-ups. The screening consists of a comprehensive unclothed physical examination, a comprehensive health and developmental history, developmental assessment, anticipatory guidance, measurements, age-appropriate vision and hearing tests, certain laboratory procedures and lead risk assessment.

NOTE: Please refer to the Health Check Manual for children birth to twenty-one (21) years of age for specific details.

Adult Preventive Visit

Effective October 1, 2016, the Department of Community Health will implement one adult preventive visit for members 21 years of age and older. The members will have access to one preventive health visit each calendar year (CY) and 10 office visits (Evaluation and Management codes 99202 - 99215) each CY. Additional office visits (above the 10 visits) will still be available based upon documentation and supporting medical necessity that must be sent to Alliant/Georgia Medical Care Foundation (GMCF) for review. Providers may bill ONE (1) preventive health visit (993XX) for a member annually (between October and December of the CY). Providers must use one of the following ICD-10 diagnosis codes when billing the preventive health visit code: Z00.00 or Z00.01 (Encounter for adult examination). Each member is allowed 10 office visits (992XX) per CY without prior authorization.

The following preventive procedure codes and services are available for reimbursement for adult Preventive annual visit:

Adult preventive services provide reimbursement for the following preventive health services:

- 99385 or 99395 - (Adults 21 through 39 years of age).
- 99386 or 99396 - (Adults 40 through 64 years of age)
- 99387 or 99397 - (Adults 65 years and older)

Adult preventive services benefits include, but not limited to the following:

Immunization:

- Influenza vaccination *
- Pneumococcal vaccination*
- Tetanus Diphtheria (Td) *
- Zoster vaccination
- Hepatitis A & B
- Measles, mumps, rubella (MMR) *
- Meningococcal
- Varicella *
- Human papillomavirus (HPV) for Women and Men *

Screening:

- Breast cancer screening *
- Testicular and Prostate screening *
- Cervical cancer screening *
- Colorectal cancer screening *
- Cholesterol screening *
- Body Mass Index (BMI) *
- Diabetes
- Hearing Assessment
- Vision (Glaucoma)
- Lipid Disorders
- Osteoporosis
- Smoking Cessation

* Adult Preventive HEDIS measures, as defined by National Committee for Quality Assurance (NCQA).

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