PART II

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



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: January 1, 2025

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Policy Revision Record
[from 2024 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
10/01/2024	Appendices G and K	Removed Appendices G and K and consolidated Georgia Families and NEMT into Appendix F with links to documents	M	
1/1/2025	901.2.2.5 and 901.2.2.6	Added “as indicated”	M	DPH

[1] The revisions outlined in this Table are from 2024 to current. For revisions prior to 2024, please see prior versions of the policy.

PREFACE

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

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

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

Family Planning Services and Planning for Healthy Babies (P4hb)
Chapter 600: Special Conditions of Participation

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

Chapter 600 in the following provider manuals provides the Special Conditions of Participation for providers delivering family planning services.

Family planning providers must ensure they meet the qualifications associated with their provider specialty or category.

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

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

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

Chapter 700: Special Eligibility Conditions

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

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

Chapter 800: Prior Approval

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

Chapter 900: Scope of Services

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

901. Covered Services

901.1. Covered services include at a minimum:

901.1.1. Education and counseling (including behavioral counseling) necessary to make informed choices and understand contraceptive methods;

901.1.2. Initial and annual complete physical examinations including a pelvic examination and Pap test;

901.1.3. Follow up brief and comprehensive visits;

901.1.4. Pregnancy testing;

901.1.5. Contraceptive methods, supplies, insertion and removal of long acting reversible contraceptive types, and follow-up care;

901.1.6. Sterilizations for members at least twenty-one (21) years of age at the time consent is obtained who are mentally competent and who voluntarily give informed consent in accordance with state policies and procedures;

901.1.7. Diagnosis of sexually transmitted infections;

901.1.8. Treatment of sexually transmitted infections; and

901.1.9. Infertility assessments – Infertility assessments are not covered under the Planning for Healthy Babies program.

901.2. Initial and Annual Comprehensive Family Planning Visits

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

901.2.1. Comprehensive medical history;

901.2.2. Comprehensive physical examination including;

901.2.2.1. height and weight;

901.2.2.2. vital signs including a blood pressure check;

901.2.2.3. breast examination (as indicated);

901.2.2.4. pelvic examination (as indicated);

901.2.2.5. hemoglobin or hematocrit (as indicated);

901.2.2.6. urinalysis (as indicated);

901.2.2.7. Pap smear as indicated;

901.2.2.8. serological test for syphilis when appropriate;

901.2.2.9. tests for gonorrhea when appropriate;

901.2.2.10. chlamydia testing when appropriate;

901.2.2.11. Human Immunodeficiency Virus (HIV) testing;

901.2.2.12. intrauterine device (IUD) monitoring, if IUD present

901.2.3. Medical decision making of high complexity

901.2.4. Counseling and/or coordination of care with other providers including:

901.2.4.1. provision and explanation of a contraceptive method;

901.2.4.2. education on a reproductive life plan;

901.2.4.3. referral and/or treatment of an abnormal finding

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

901.3. Brief Medical Visit

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

901.3.1. Problem focused history;

901.3.2. Problem focused examination including;

901.3.2.1. hemoglobin or hematocrit check (as indicated);

901.3.2.2. vital signs including blood pressure check;

901.3.2.3. screening for sexually transmitted infections (as indicated)

901.3.3. Straightforward medical decision making

901.3.4. Counseling and/or coordination of care with other providers including:

901.3.4.1. review of Pap smear results;

901.3.4.2. provision and explanation of a contraceptive method;

901.3.4.3. referral for sterilization; and

901.3.4.4. referral and/or treatment of an abnormal finding

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

901.4. Comprehensive Medical Visit

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

901.4.1. Expanded problem focused or detailed history

901.4.2. Expanded problem focused or detailed examination including:

901.4.2.1. vital signs including blood pressure check;

901.4.2.2. repeat Pap smear (as indicated); (see note below)

901.4.2.3. urinalysis (as indicated);

901.4.2.4. screening for sexually transmitted infections (as indicated);

901.4.2.5. wet mount (as indicated)

901.4.3. Medical decision making of low to moderate complexity

901.4.4. Counseling and/or coordination of care with other providers including:

901.4.4.1. prescription for the treatment of a diagnosed sexually transmitted infection;

901.4.4.2. review of Pap smear results;

901.4.4.3. referral for sterilization; and

901.4.4.4. referral and/or treatment of an abnormal finding

Providers should use CPT codes 99213 (for an established patient; typically a 15 minute visit) or 99214 (for an established patient; typically a 25 minute visit) when conducting the Comprehensive Medical Visit. The FP Modifier must be used with either of these codes.

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

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

901.5. Supply Visit

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

901.6. Implantable Contraceptive Capsules

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

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

901.6.1. J7307 Etonogestrel (Implanon/Nexplanon) Implant System - Modifier FP
11981 Insertion, Implantable Contraceptive Device – Modifier FP

901.6.2. 11976 Removal, Implantable Contraceptive Capsule – Modifier FP
11982 Removal, non-biodegradable drug delivery implant – Modifier FP

901.6.3. 11983 Removal with reinsertion, non-biodegradable drug delivery implant – Modifier FP

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

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

901.7. Intrauterine Devices

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

according to the manufacturer's recommendations.

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

901.7.1. J7300 Paragard / Intrauterine copper contraceptive – Modifier FP

901.7.2. J7296 Kyleena Levonorgestrel-Releasing Intrauterine Contraceptive System, 19.5 MG – Modifier FP

901.7.3. J7297 Liletta IUD Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG, 6 year - Modifier FP

901.7.4. J7298 Mirena IUD Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG, 6 year - Modifier FP

901.7.5. J7301 Levonorgestrel-Releasing Intrauterine Contraceptive System (Skyla), 13.5MG- Modifier FP.

901.7.6. 58300 Insertions, Intrauterine Device – Modifier FP 58301 Removal of intrauterine device – Modifier FP

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

901.8. Injectable Contraceptives

The Depo-Provera injection may be billed with any type of visit code. Coverage is limited to one injection every three months or one every 12-13 weeks.
Providers should use the code below when billing for this service. The FP modifier must be used with this code.

901.8.1. J1050 Medroxyprogesterone Acetate 1 mg (Injection) - Modifier FP

901.8.1.1. 1 mg = 1 unit. Provider must bill the appropriate units administered to the patient.

901.9. Other Contraceptive Methods

Other contraceptives are available as a Pharmacy Benefit. The Preferred Drug List (PDL) can be found at PDL (georgia.gov).

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

901.9.1. 57170 Diaphragm or cervical cap fitting with instructions – Modifier FP

901.9.2. A4267 Contraceptive Supply, Condom, Male, - Modifier FP

Condoms may be billed with any type visit code.

901.10. Infertility Assessment

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

901.11. Clinical Laboratory and Anatomical Pathology Services

901.11.1. Pregnancy Test

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

901.11.1.1. it is performed at the time family planning services are initiated for an individual;

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

901.11.1.3. it is performed during the infertility assessment.

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

The FP modifier must be used with this code.

901.11.2. Gonorrhea Testing

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

901.11.3. Syphilis Testing

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

901.11.4. HIV Testing

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

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

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

901.12. FFS Medicaid Coverage of Plan B One-Step®

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

901.13. FFS Medicaid Coverage of Human Papilloma Virus (HPV) Vaccine

Fee For Service Medicaid allows coverage of the Human Papilloma Virus (HPV) vaccine under the following categories of service (COS):

901.13.1. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

901.13.1.1. For ages nine (9) through twenty (20) years

901.13.1.2. Refer to Appendix C of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) policy manual

901.13.2. Physician Services

901.13.2.1. For ages twenty-one (21) through forty-five (45)

901.13.2.2. Refer to Appendix B-2 of the Physician Services policy manual

901.13.3. Pharmacy Services

901.13.3.1. For ages nine (9) through forty-five (45) years

901.13.3.2. Refer to Appendix L of the Pharmacy Services policy manual

901.14. Referral for Sterilizations

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

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

901.14.2. The individual is mentally competent.

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

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

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

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

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

902. Services not covered under the Family Planning Services Program

902.1. Abortions or abortion-related services performed for family planning purposes.

902.2. Indirect services to members, such as telephone contacts

902.3. Case management

902.4. Family Planning services provided to a woman who is known to be pregnant.

902.5. Sterilization of recipients institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities

902.6. Hysterectomies performed for family planning purposes

903. Co-payment

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

Chapter 1000: Basis For Reimbursement

1001. Reimbursement Methodology

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

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

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

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

Appendix A
Reimbursement Rates for Family Planning Services

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

Appendix B
Informed Consent for Voluntary Sterilization, DMA-69

A. INFORMED CONSENT FOR VOLUNTARY STERILIZATION, DMA-69

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

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

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

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

(a) If paragraph 2 is designated, the applicable box must be checked and the information requested must be entered.

(b) If the box indicating “premature delivery” is checked, the individual’s date of expected delivery must be given on the line provided.

(c) If the box indicating “emergency abdominal surgery” is checked, the circumstances of the emergency surgery must be described on the line provided.

(d) The physician who performs the surgery must sign and date the consent form after the surgery is performed. Signature stamps are not acceptable.

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

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

iv. The only consent forms acceptable to the Division are the “Informed Consent for Voluntary Sterilization (DMA-69)” and the Spanish version (DMA-69A). No other form can be used. A copy of the properly executed "Informed Consent for Voluntary Sterilization" must be attached to the physician's claim form when submitted to the fiscal agent for payment. In addition, a copy of the consent form must accompany any other claims for services rendered in conjunction with the sterilization (i.e., hospital, anesthesiology, etc.). The attending physician is responsible for providing a copy of the properly executed consent form to each Medicaid provider associated with the case.

Supplies of “Informed Consent for Voluntary Sterilization”, DMA-69, may be ordered by

completing the “Request for Forms,” which you can find in the Georgia Department of Community Health Billing Manual UB 04 or at www.mmis.georgia.gov.

Appendix C
Gainwell Technologies

A. Member and Provider Correspondence

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

B. Electronic Data Interchange (EDI)

877-261-8785

i. Asynchronous

ii. Web portal

iii. Physical media

iv. Network Data Mover (NDM)

v. Systems Network Architecture (SNA)

vi. Transmission Control Protocol/Internet Protocol (TCP/IP)

C. Provider Inquiry Numbers:

800-766-4456 (toll free)

D. Web contact address

www.mmis.georgia.gov

Appendix D
Sample Claim for Billing J7301



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
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? PLACE (State) YES NO					b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES NO					c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATIO MM DD YY FROM MM DD Y 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 Y 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 N
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.		

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

SAMPLE

CMS 1500 Field Locator Instructions

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

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/GAINWELL TECHNOLOGIES:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier

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

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

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

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

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

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

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

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

Appendix F
Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

A. Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

For information on the Georgia Families, Georgia Families 360, or Non-Emergency Medical Transportation program, please access the overview document at the following link:

i. **Policy Fee Schedule(s):**
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Fee%20Schedules/tabId/20/Default.aspx

ii. **Georgia Families Overview:**
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

iii. **Georga Families 360 Overview:**
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

iv. **Non-Emergency Medical Transportation Overview:**
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

Appendix G
Planning For Healthy Babies

A. Program Overview

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

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

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

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

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

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

B. Eligibility and Enrollment

i. P4HB eligible women must be enrolled in a CMO to receive services under the demonstration. In

addition, each woman must:

1. Be a US citizen or person with qualified proof of citizenship
2. Be ages 18 through 44 years
3. Be a Georgia resident
4. Be able to become pregnant
5. Not be eligible for any other Medicaid program or managed care program
6. Meet family gross income requirements of no more than 211% of the federal poverty level (FPL)
7. If losing Medicaid pregnancy coverage at the conclusion of 1 year postpartum, not otherwise be eligible for Medicaid or the Children's Health Insurance Program (CHIP)

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

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

ii. P4HB Required Verification for IPC/RM

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

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

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

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

Once the woman begins participating in the program through the utilization of services, she is considered a P4HB participant.

C. SCOPE OF SERVICES

i. Family Planning Only Services

1. Family planning initial or annual exams (one per year)

(a) Initial comprehensive and Annual Examinations

(b) Infertility assessment services, including infertility review, education, physical examination, appropriate lab testing and counseling and referral related to infertility are excluded benefits for P4HB participants.

2. Follow up family planning or family planning related service visits

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

(a) Contraceptive services and supplies clearly provided or performed for the primary purpose of family planning

(i) Method initiation

(ii) See Section 901.6 Implantable Contraceptive Capsules; 901.7 Intrauterine Devices; 901.8 Injectable Contraceptives; 901.9 Other Contraceptive Methods.

(iii) Procedures or services clearly provided or performed for the primary purpose of family planning

(1) periodic or inter-periodic contraceptive management

(2) patient education and counseling

(b) Follow-up on abnormal testing during a family planning visit. For example:

(i) Rescreening for an abnormal pap smear

(ii) Screening or rescreening for a Sexually Transmitted Infection (STI)

(iii) Colposcopy (and procedures done with/during a colposcopy).

(iv) A LEEP procedure.

(v) Treatment/drugs for STIs, except for HIV/AIDS and hepatitis, when the STI's were identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs will also be covered.

(vi) Treatment/drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, when these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter

for the treatment/drugs will also be covered

(vii) Treatment of major complications such as:

(1) A perforated uterus due to an intrauterine device insertion;

(2) Severe menstrual bleeding caused by a Depo-Provera; injection requiring a dilation and curettage

(3) Surgical or anesthesia-related complications during a sterilization procedure.

3. Referrals

(a) Primary care services are not covered for women enrolled in the Family Planning Only component of the demonstration. Women should be referred for **conditions identified during a family planning visit** to a primary health care provider who can offer affordable primary care services. These include FQHCs, RHCs and free clinics.

(b) P4HB enrollees should be referred to community resources such as WIC and DFCS.

4. Family planning lab tests

May be performed to address family planning problems when those problems are identified during a family planning visit (see 901.2 – 901.4)

(a) Pregnancy tests (see 901.11 for details)

(b) Pap Smear

(c) STI tests

5. Tubal Ligation (Sterilization)

Sterilizations are covered when provided in a family planning setting and when the P4HB enrollee:

(a) Is at least twenty-one (21) years of age at the time consent is obtained;

(b) Is mentally competent;

(c) Voluntarily gives informed consent in accordance with the State Policies and Procedures for Family Planning Clinic Services. This includes the completion of all applicable documentation;

(d) Is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

(e) Additionally:

(i) At least thirty (30) Calendar Days, but not more than one hundred

and eighty

(ii) (180) Calendar Days, have passed between the date of informed consent and the date of sterilization.

(iii) An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a P4HB enrollee who is visually impaired, hearing impaired or otherwise disabled; and

(iv) A hysterectomy is not considered a covered service for P4HB enrollees.

(f) Please see section 902 for referral requirements

(g) Please see Appendix B for the consent form for sterilizations, DMA-69

6. Pharmacy services

(a) For prescriptions for family planning related services and devices and for multivitamins with Folic Acid only.

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

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

7. Abortions or abortion-related services

Not considered a covered service for P4HB enrollees.

D. Interpregnancy Care Component

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

Services	Notes/ Limitations
Primary care	PCP coordinates care for the enrollee and makes referrals to CMO and non-CMO specialty care as needed. Five office/ outpatient visits per year.
Management and treatment of chronic diseases	

Substance abuse treatment (detoxification and intensive outpatient rehabilitation)	Enrollees can self-refer to an in-network provider for an initial mental health or substance abuse visit but prior authorization may be required for subsequent visits. Enrollees may also receive detoxification and intensive outpatient rehabilitation services only.
Case management/ Resource Mother Outreach	See Resource Mother Outreach below
Limited Dental	A list of covered procedures is available on the CMO plan web portal.
Prescription Drugs (non-family planning)	

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

E. Resource Mother Outreach Component

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

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

1. Complete P4HB enrollee intake based on interviews with the P4HB enrollee, her family, significant other and appropriate community agencies.

2. Demonstrate skillful use of observation and assessment tools to evaluate the P4HB enrollee's needs.

3. Monitor the P4HB participant's progress towards treatment goals.

4. Meet with the P4HB participant via phone or in person to increase the participant's adoption of healthy behaviors, including healthy eating choices and smoking cessation.

5. Support P4HB participant's compliance with primary care medical appointments including assistance with non-emergency transportation arrangements; serve as the liaison between the P4HB participant and their family members, significant other, nurses, physicians, and organizational components to facilitate communication, linkage and continuity of service.

6. Consult with physicians, nurses, social workers, and case managers about problems identified and assist in the development of an appropriate action plan.

7. Document compliance with appointments and enrollment and participation in planned

services and benefits in the P4HB participant's case management record and/or required P4HB Program forms.

8. Prepare and disseminate pertinent reports for/to supervisors, colleagues and other appropriate individuals. Maintain program statistics for purposes of evaluation and research.

9. Submit all data, forms and documentation per P4HB program guidelines.

10. Provide short-term case management and referral services to the P4HB participant with an emergency situation.

11. Support the P4HB participant's compliance with medications to treat chronic health conditions including assisting her with obtaining needed medications and reinforcing the need for medication compliance;

12. Assist the P4HB participant with the coordination of social services support for family and life issues; implement and organize the delivery of specific social services within the community and maintain an updated resource file.

13. Assist the P4HB participant in locating and utilizing community resources including legal, medical, financial assistance, and other referral services; assist with linking her to community resources such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

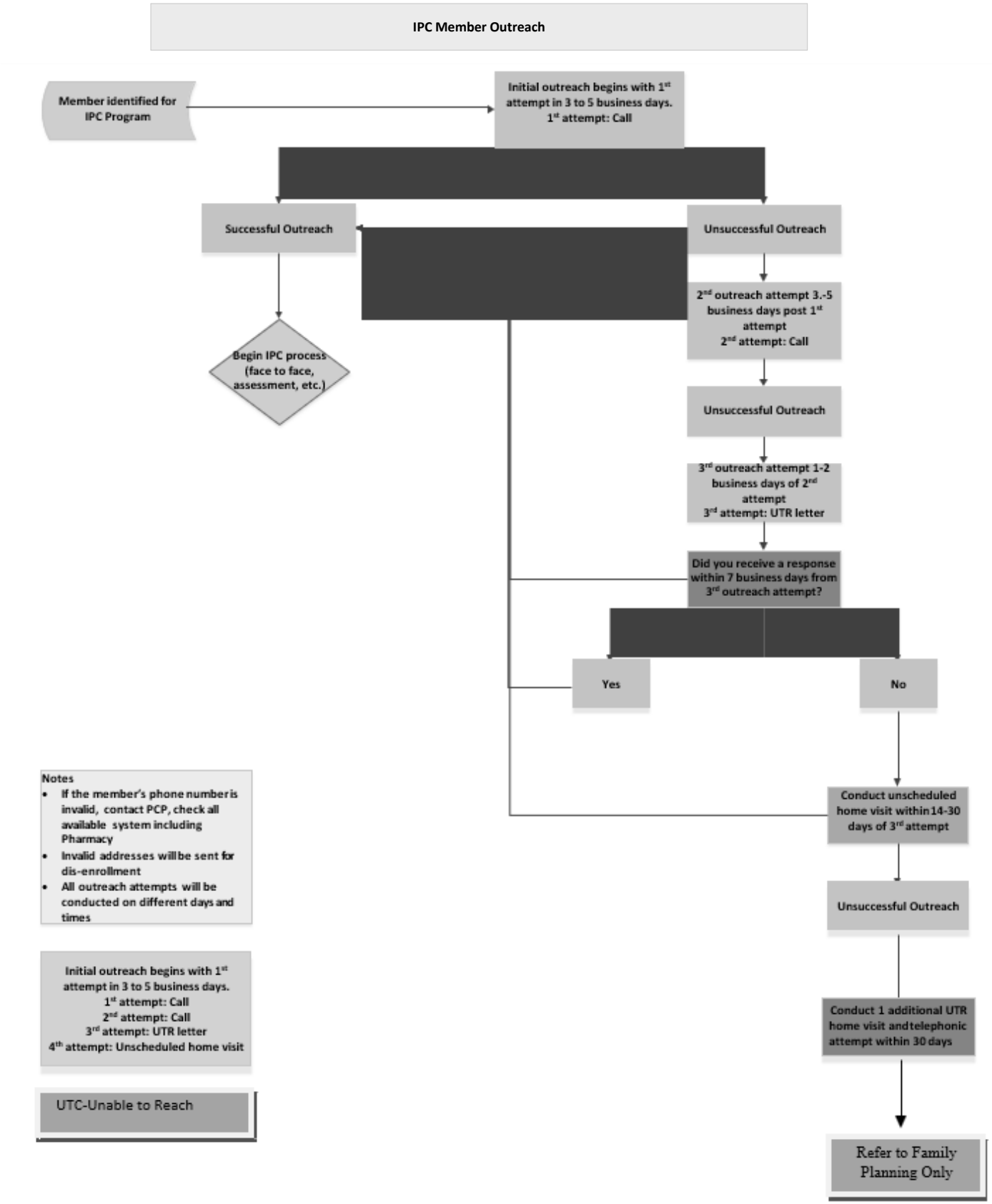
14. Provide emotional support for the P4HB participant following substance abuse treatment;

15. Provide mentoring for the P4HB participant;

16. Assist the P4HB participant to obtain regular preventive health visits and appropriate immunizations for their child;

17. Provide the P4HB participant with the peer and emotional support needed to meet the health demands of her VLBW infant;

18. Encourage the P4HB participant to implement the parenting and child safety concepts taught during classes she will be encouraged to attend.


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

F. P4HB Disenrollment

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

i. Become pregnant

ii. Receive a sterilization procedure and complete all necessary follow-up

iii. Move out of the state

iv. Become incarcerated

v. Change income status

vi. Become unable to become pregnant

vii. Women who have aged out

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

G. Redeterminations

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

What verification is required?

i. Physician's Statement for P4HB Inter-Pregnancy Care and Resource Mother

ii. Hospital Confirmation of Birth Record that includes birth weight

iii. Care Management Organizations (CMO) Report

H. Planning for Healthy Babies (P4HB) and other COA

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

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

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

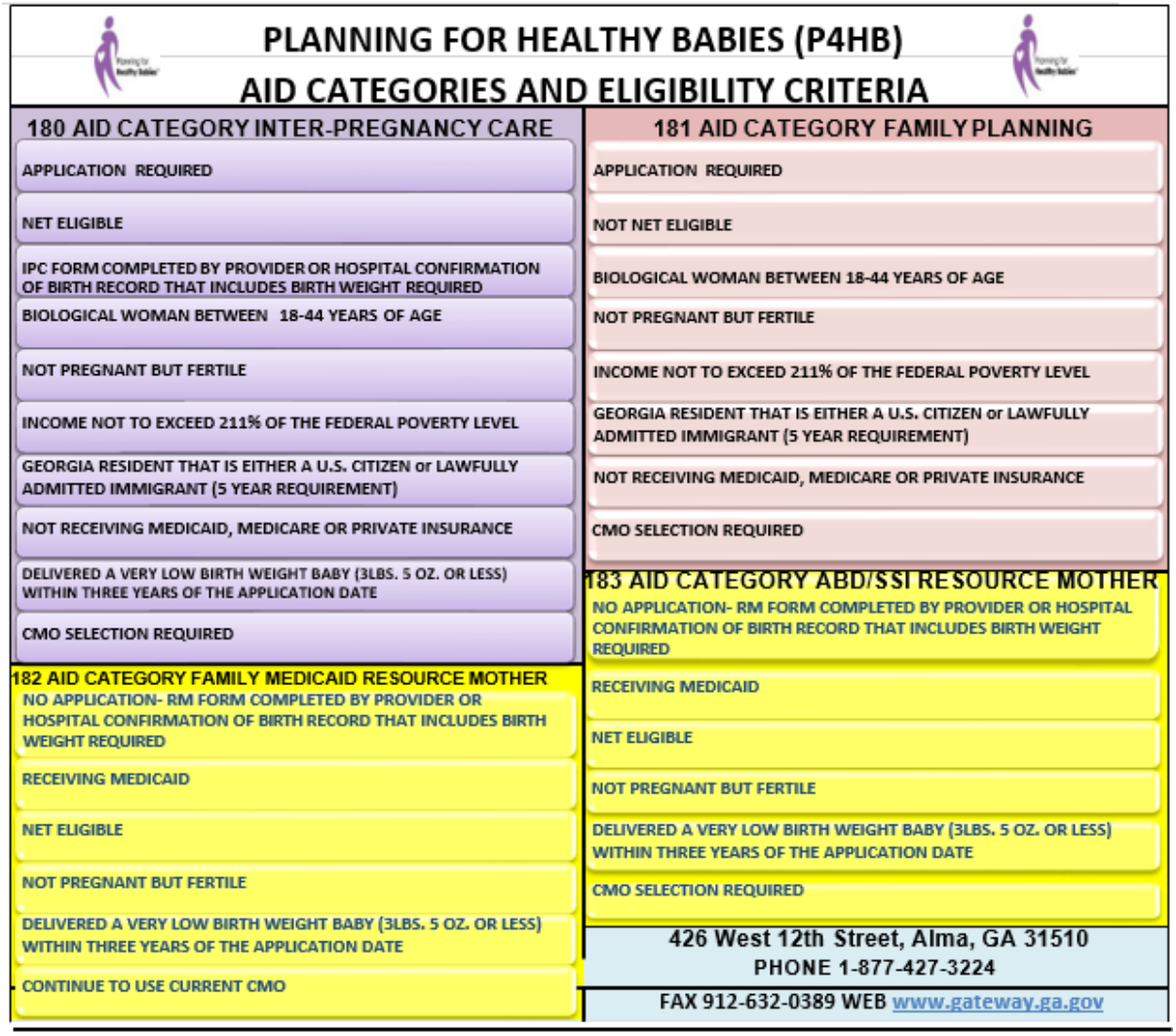
Women applying for IPC 180 and RM 182 & 183 must have delivered a very low birth weight (VLBW) baby. Even if the member delivers multiple births on the same day or a different day, the birth of the last

child delivered is used to count toward the 24 months. Therefore, the member will be disenrolled after 24 months of participation with an eligibility re-determination after 12 months. After her 24 months have ended, the IPC women may be eligible for FP only services as long as she meets the eligibility criteria. The RM mother will be eligible for FP services if she has an active Parent Caretaker or ABD/SSI case in Gateway.

i. Prior to Exhausting the 24 Months

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

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



Appendix H
P4HB Provider Inquiry Numbers

877-P4H-B101 or 877-744-2101

Planning for Healthy Babies

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

The web contact address is: www.dch.georgia.gov/planning-healthy-babies

Appendix I
ICD-10 Overview

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