PART II

POLICIES AND PROCEDURES

For

CHILDERN'S INTERVENTION SERVICES (CIS)



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

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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.)
4/1/2026	Chapter 1000	2026 HCPCS Codes – 92592, 92593	D	
4/1/2026	Chapter 1000	2026 HCPCS Codes – 98979,98984,98985	A	
4/1/2026	Chapter 800	Reconsideration Request	M	
1/1/2026	Chapter 800	Therapy Evaluations	M	
10/1/2025	Chapter 1000	CPT code 96112 & 96113 – Reimbursement Rate Adjustment	M	
10/1/2025	Chapter 1000	Additional clarification on CPT code 96112	M	
7/1/2025	Chapter 1000	Clarification of CPT code 97550	M	
7/1/2025	Chapter 1000	Clarification of CPT codes 96112 & 96113	M	
4/1/2025	Appendix A	Office of Child Health Resources	M	
4/1/2025	Chapter 600	Record Retention Requirements	M	
1/1/2025	Appendix I	Appendix I Resource Links – contains information for Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation	M	
10/1/2024		No Changes		
7/1/2024	Chapter 1000	HB 916 Rate Increase for PT, ST, OT, and Audiology	M	
7/1/2024	Chapter 1000	Open Procedure Codes 92592& 92593	A	
4/1/2024	Chapter 1000	2024 HCPCS Codes	A	
1/1/2024	Appendix A	Office of Child Health Contact Information	M	
1/1/2024	Chapter 1000	Procedure 96112 & 96113 reimbursable for OT & PT	M	
1/1/2024	Chapter 1000	Open procedure code 92556	A	
1/1/2024	Chapter 1000	Increase service limit – procedure code 92652	M	
1/1/2024	Chapter 800	Remove requirement for physician order for follow-up newborn hearing screening	M	

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

Part II: The Children's Intervention Services Program
Chapter 600 Special Conditions of Participation

601. General

The Children's Intervention Service (CIS - Category of Service 840), program offers coverage for restorative and/or rehabilitative services to eligible members in non-institutional settings. Note: Hospital employed therapists who are enrolled in the CIS Program may provide services and bill for services rendered in the hospital outpatient facility or outpatient clinic. Services must be determined medically necessary and be recommended and documented as appropriate interventions by a physician for the maximum reduction of physical disability or developmental delay and restoration of the member to the best possible functional level. Medical necessity means medical services or equipment based upon generally accepted medical practices in light of conditions at the time of treatment which are: appropriate and consistent with the diagnosis of the treating physician and the omission of which could adversely affect the eligible member's medical condition; compatible with the standards of acceptable medical practice in the United States; provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; not provided solely for the convenience of the member or the convenience of the health care provider or hospital; not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage; and there must be no other effective and more conservative or substantially less costly treatment, service and setting available.

The CIS program is comprised of seven intervention services that must be provided by qualified providers. The seven services are: audiology, nursing, nutrition provided by licensed dietitians, occupational therapy, physical therapy, counseling provided by licensed clinical social workers and speech-language pathology. Qualified providers must be currently licensed in the State of Georgia as audiologists (018), licensed clinical social workers (107), occupational therapists (151), physical therapists (201), registered nurses (234), speech-language pathologists (251), or licensed dietitians (108).

602. Enrollment

All providers who meet the Conditions of Participation in Medicaid's Part I Policies and Procedures for Medicaid and PeachCare for Kids Manual (Part I Manual) and the special conditions listed in Section 603 below are eligible to enroll. Professional practitioners must enroll as individual providers and attach a copy of their professional license. They must also maintain documentation that the continuing education requirements have been met.

602.1. In a group practice, hospital or agency, each provider must enroll separately and bill for services directly provided under their own provider number. For purposes of this policy, a group practice is defined as a partnership, a corporation, or an assemblage of therapists in a space-sharing arrangement in which the therapists each maintain offices and the majority of their treatment facilities in a contiguous space. Services performed by non-enrolled providers in a group practice are not covered.

602.2. Indiscriminate billing under one provider's name or provider number without regard to the specific circumstances of rendition of the services is specifically prohibited and will be grounds for adverse action. (See Chapter 400 of Part I)

602.3. Clinical Fellows attempting to fulfill the necessary hours for licensure according to the guidelines in the State Practice Act will be allowed to render services in the CIS program under the direct supervision of a Georgia licensed, enrolled speech language pathologist. This requirement is also known as the Paid Clinical Experience (PCE). The Department will not allow clinical fellows to enroll into Georgia Medicaid and bill under their own Medicaid provider number. The services will be billed by the licensed, enrolled speech language pathologist.

602.3.1. The Clinical Fellow will need to continue working under the supervision of the licensed SLP until they have been licensed successfully and enrolled as a Medicaid provider. Medicaid will not reimburse the CF until they have a Medicaid number and the number will not be issued until they are licensed, credentialed and enrolled.

602.3.2. The Paid Clinical Experience Fellow and qualifications and responsibilities of the PCE Supervisor must follow State of Georgia rules and regulations (Rule 609-3-.04). The Clinical Fellow's work will be documented in member charts and in the supervisor's monitoring and evaluation records.

603. Special Conditions of Participation

In addition to the general conditions of participation in the Georgia Medicaid program contained in the Part I Manual, Section 106, providers in the CIS program must meet the following conditions:

603.1. Maintain a copy of professional license;

603.2. Adhere to the service limitations stipulated in the written service plan or program;

603.3. Maintain a copy of the written service plan, prescription, progress notes, etc. in the child's confidential medical file or record;

603.4. Assure there is no duplication of the service(s) provided to a member by two or more CIS provider types or by a CIS provider and a school-based (Children's Intervention School Services - CISS) provider.

603.5. Notify the Provider Enrollment Unit via mail, phone, or web site of any changes in enrollment status, such as: new address and or telephone number; additional practice locations; change in payee; or voluntary termination from the program. See Appendix E for contact information. Each notice of change must include the date on which the change is to become effective.

603.6. Bill the Division your "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 an equivalent period of time.

603.7. Bill the Division the procedure code(s) which best describes the level and complexity of the service rendered (See Section 900);

603.8. Maintain member confidentiality at all times;

603.9. Maintain written documentation of all services provided to members for a minimum of 10 years after the date of service; (See Section 903 for record requirements). (Rev. 04/2025)

603.10. All providers are required to maintain on file, on site verification indicating they have obtained a minimum of 1/3 of their required professional state licensing board Continuing Education Units (CEU) in pediatrics. In addition, registered nurses must obtain and keep on file, on site verification of 10 clock hours or one CEU in pediatrics every two years.

603.10.1. All providers must maintain required continuing education documentation on file for audit purposes. Continuing education documents must be readily available and accessible at the time of the audit.

Chapter 700: Special Eligibility Conditions

701. Eligibility

Children's Intervention Services are provided to Medicaid eligible members from birth to twenty-one (21) years of age with physical disabilities or a developmental delay, who have been prescribed rehabilitative or restorative intervention services by the child's primary care practitioner (PCP) or other prescribing practitioner at the request of the PCP. These children are included in one of the following categories:

701.1. Children with a Letter of Medical Necessity (LMN), or Plan of Care (POC) established or approved by their PCP;

701.2. Infants and toddlers who are eligible under the Individuals with Disabilities Education Act (IDEA, Part C) and meet eligibility for the Early Intervention program (Babies Can't Wait), and have an authorized Individualized Family Service Plan (IFSP) developed by the multi-disciplinary team. A plan of care or letter of medical necessity (POC/LMN) as well as the IFSP are required for services billed under the CIS program.

Chapter 800: Medical Necessity and Prior Approval

801. Medical Necessity Documentation

Providers must document medical necessity for service delivery under the CIS program**.**

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

This documentation includes: documentation of the medical diagnosis, the Letter of Medical Necessity, the Plan of Care, and the provider's progress notes. The Plan of Care (POC) and the Letter of Medical Necessity (LMN) may be combined into one document as long as all elements stated below are included and the PCP has reviewed and approved the document by affixing their signature to the document or by including an electronic signature in the document. The POC, signed by the member's PCP, is equivalent to the PCP's Letter of Medical Necessity.

Electronic signatures are acceptable on CIS documentation. Refer to Medicaid Part I Policies and Procedures for information on electronic signature criteria.

801.1. Documentation Requirements

The PCP's Letter of Medical Necessity or the POC approved by the PCP must contain the components listed below. The LMN or the PCP approved POC, at a minimum, must be submitted for the Medicaid member as documentation of medical necessity.

801.1.1. Member's name and member ID number

801.1.2. Date of Birth

801.1.3. Diagnosis and/or condition requiring treatment

801.1.4. Modalities

801.1.5. Procedures (i.e., description of the services requested)

801.1.6. Evaluation and date the evaluation was conducted (if one was completed)

801.1.7. POC completion date (this must be on or after the evaluation date)

801.1.8. Effective POC start and end dates along with the frequency and duration of services.

801.1.8.1. The effective POC start date must be on or after the

therapist completion date, PCP signature and date, and must be within thirty (30) calendar days of the therapist completion date. If the PCP's signature date is after the effective date, then the POC will be valid from the PCP's signature date to the end date. However, the effective date still must be within 30 days of the therapist completion date.

801.1.9. Location of services (clinic, home, telehealth, etc.) must be clearly identified within the POC. Address of clinic on letterhead or cover page does not qualify as identifying the location of service.

801.1.10. Team members that are treating the patient (i.e., OT, SLP, PT, etc.)

801.1.11. Current level of function

801.1.12. Patient's progress to date

801.1.13. Functional outcomes (potential for rehabilitation, long term goals of therapy

801.1.14. Goals to be achieved as well as timelines to reach projected goals

801.1.15. Any other relevant medical information.

801.1.16. The therapist that develops the POC must sign and date the document on the date it is completed. The therapist must sign and date the POC prior to the PCP's signature and date. The PCP may sign and date the POC on the same date the therapist signs and dates the POC.

801.2. Plan of Care (POC)

801.2.1. All services rendered under the CIS Program, including services for the Babies Can't Wait (BCW) program, must be furnished under a plan of care or letter of medical necessity (POC/LMN) signed and dated by the PCP prescribing the services. If the therapist prepares the POC or LMN, it must be signed by the therapist as well as the PCP prescribing the services. A signed and dated copy of the POC/LMN must be on file in the child's records and available for audit purposes. Under most circumstances, the prescribing practitioner should be the child's PCP. If the prescribing practitioner is not the child's PCP, the prescribing practitioner must send the PCP a copy of the POC/LMN within five (5) business days of completion or receipt of the document.

801.2.2. If a member is receiving services under the Babies Can't Wait Program (BCW), and if the need for services is in excess of those determined necessary by the BCW multidisciplinary team (MDT), this must be documented in the POC/LMN.

801.2.3. The signed and dated POC/LMN must identify the rehabilitation potential, set realistic goals and measure progress. The goals and service

needs must not be duplicative of those established for children receiving PCP defined/approved medically necessary services in the school setting. Goals defined in the IEP, established under IDEA criteria for educational purposes only, that have not been deemed medically necessary by the child's PCP are not considered to be duplicative of the goals defined as part of the medical necessity documentation in the CIS POC/LMN. The CIS POC/LMN document must also contain the type of modalities and procedures, frequency of visits, estimated duration, diagnosis, functional goals and recovery potential, as well as the additional information as specified under the prior approval process (See Section 802.2).

801.2.4. Duplicated services are defined as medically necessary therapy services that provide the same general areas of treatment, treatment goals, or ranges of specific treatment or processing codes, notwithstanding a difference in the setting, intensity, or modalities of skilled services, and address the same types and degrees of disability as other concurrently provided services (via other community, school or hospital-based providers).

801.2.5. The signed and dated POC/LMN with the prescribing practitioner's signature (and therapist's signature) is required for services rendered under the CIS program. The POC/LMN must be on the letterhead of the practitioner or CIS provider. This document with the original signatures (electronic or fax signatures are acceptable only if these documents are legible) must be on file in the CIS providers' (therapists, nurses, dietitians, licensed clinical social workers) records. When a fax document or signature is included in the medical record, the document with the original signature must be retrievable from the original source. (Note: If the CIS provider has been provided the authorization to use a prior authorization (PA) from another CIS provider within the same specialty, a fax copy of the POC/LMN in the rendering CIS provider's records will suffice, but only for the duration of that PA request).

801.2.6. If the POC/LMN was prepared on the CIS provider's letterhead, the CIS provider must submit the original POC/LMN to the PCP and receive from the PCP the POC with the PCP's original dated signature (electronic or fax document is acceptable if the document is legible). When a fax document or signature is included in the medical record, the document with the original signature must be retrievable from the original source.

801.2.7. The POC/LMN with the PCP's signature (electronic and fax signatures are acceptable if legible) must be in the official clinical record prior to the effective date of the POC.

801.2.8. If the POC/LMN is on the PCP's letterhead, this document must have the original handwritten signature (electronic or fax signature is acceptable) from the PCP. All POC/LMN must be re-signed, reviewed and dated no less than every six (6) months by the prescribing practitioner. If the prescribing practitioner is not the member's PCP, a copy of the revised

plan of care should be sent to the PCP within 5 business days.

801.2.9. The amount, frequency and duration of the services must be reasonable under accepted medical standards of practice.

801.2.10. The services must relate directly and specifically to a POC agreed upon by the member's PCP.

801.3. Individualized Family Service Plans (IFSP) - BCW

801.3.1. An Individualized Family Service Plan (IFSP) is required for members who are eligible under the Early Intervention program (Babies Can't Wait). The IFSP is a written plan for providing early intervention services approved by the parent(s) and authorized by the PCP. It is developed jointly by the Multidisciplinary Team (MDT), which includes the family, the Service Coordinator, and appropriate licensed practitioner(s). It is based on a multi-disciplinary and family-directed assessment of the unique strengths and needs of the infant or toddler and the identification of early intervention services appropriate to meet such needs.

801.3.2. The IFSP includes the recommended services necessary to enhance the development of the child and the capacity of the family to meet the special needs of the child, along with the amount, frequency, duration and method of delivering the services.

801.3.3. Therapy evaluations including physical therapy, occupational therapy, and speech-language pathology evaluations do not require a referral or separate prescription from a physician in order to be initiated or performed. Licensed therapy providers may independently perform evaluations consistent with their professional scope of practice and applicable state licensure regulations. Therapy services will require a signed POC. (Rev. 01/2026)

The child's primary care practitioner or other prescribing practitioner, at the request of the PCP, must prescribe and/or refer a child for IFSP therapy services and other medical services. The PCP's written referral to the audiologist will serve as the medical necessity document for a child suspected of a hearing loss. Additionally, audiologists may provide services to children who have an IFSP, which includes testing as a necessary service. To receive Medicaid reimbursement, a dated and signed POC/LMN (as described above) for therapy services must be on file. The POC/LMN must have the date and PCP's original signature (electronic or fax signature is acceptable if legible). A separate prescription for service delivery is not required because the PCP's signature on the dated POC/LMN serves as the prescription for services. A referral from a PCP for speech-language pathology, counseling, and nutrition services must also be on file.

NOTE: The above CIS policy requirement will remain in effect. However, if the child is requiring subsequent tests/evaluations following

a failed Newborn Hearing Screening, this policy requirement does not apply. (Rev. 01/2024)

801.3.4. Babies Can't Wait is not a mandatory program, and parents may choose not to participate. The POC/LMN is required to indicate whether the parent chooses to receive the recommended services as documented in the IFSP or chooses a modified version of the recommended services. A review of the IFSP is necessary for all children receiving services through the Babies Can't Wait Program for coordination of care and services. A copy of the IFSP will be obtained from the parent and submitted as part of the PA request. BCW is not required to list the actual service(s) in the "Other Services" section of the IFSP; as such, the provider will still be considered for PA approval. (Rev. 10/2019)

801.3.5. A therapist cannot change the amount, duration and frequency of the service documented on an IFSP without the consensus of the MDT and the child's PCP. In the event the level of service needs to be changed, the therapist must notify the service coordinator and the child's PCP. If necessary, the service coordinator will convene a meeting including the parent and therapist. It is the expectation that the BCW MDT, the PCP, and other CIS providers collaborate and coordinate care to document justification of services to be provided prior to the initiation of services.

801.3.6. In order for services to be reimbursable, the IFSP must be current and the POC/LMN must be current and signed and dated by the PCP. A separate prescription for service delivery is not required because the PCP's signature and date on the POC/LMN will serve as the prescription of services. A PCP's referral is needed for speech therapy, counseling, and nutrition services. IFSPs, at a minimum, are reviewed every six months.

Note: The IFSP must be signed by the parent and at a minimum, the service coordinator. The six month review of the IFSP must be signed by the parent and the service coordinator. This does not negate the need for the POC/LMN which must be signed by the prescribing PCP.

802. Prior Approval

802.1. Services Which Require Prior Approval

802.1.1. As a condition of reimbursement, the Division requires that services which exceed the service limit established in policy be approved prior to the time they are rendered. Prior approval from the Division pertains to medical necessity only; the member must be Medicaid-eligible at the time the service is rendered.

802.1.2. The service limit established for the Children's Intervention Services program is eight units per month, per specialty. Once eight units have been exhausted, any additional units require prior authorization. Once the eighth unit has been billed for a member in a month, all subsequent claims will deny unless the units have been prior authorized. (Rev. 01/2021)

802.1.2.1. When entering a request for additional units to be prior authorized, please remember the eight units are included when reviewing and approving the request. Ex. If a child needs 3/week speech therapy which equals 12 units per month, with all sufficient documentation attached the request will be approved for 4-5 units based on the number of weeks in the month.

Total units = 12 units

Provider's eight units are included. 12 – 8 = 4

Units approved on the request will be 4

802.1.3. The Division may require prior approval of all or certain procedures performed by a specified provider based on the findings or recommendations of the Division, its authorized representatives or agents, the Secretary of the U.S. Department of Health and Human Services or the applicable State Examining Board. The Commissioner may invoke this action as an administrative recourse in lieu of or in conjunction with an adverse action described in Part I, Chapter 400. In such instances, the Division will serve written notice to the provider of this requirement and the grounds for such action. Children's Intervention services which exceed the limitations established in policy must receive prior approval.

802.1.4. Prior authorization is not required for evaluation services.

802.2. Procedures for Obtaining Prior Authorization

802.2.1. A PA is only granted for services that are documented to be medically necessary and appropriate. A PA is good for up to 180 calendar days. PA is based solely on the medical needs of the child.

802.2.2. The Plan of Care (POC) and the Letter of Medical Necessity (LMN) can be combined into a single document, as described in Section 801. If there is a discrepancy between the effective dates of the POC/LMN and the PA request period, the POC/LMN effective dates will take precedence.

802.2.3. CIS providers must submit the cover page from the IFSP and/or the IEP which identifies the member and the pages of the IFSP and/or IEP which pertain to therapy services. The CIS provider must collaborate with the CISS provider to ensure services are not duplicated in these two settings.

802.2.4. If there is no IFSP or IEP, please provide a detailed explanation in the "Text Message Section" for the on-line PA request. Also attach the Attestation Form found in Appendix N.

802.2.5. All supporting documentation, i.e., the POC/LMN and the progress notes, must be updated and signed as specified in policy for additional services above those specified in Policy.

802.2.6. Providers are required to provide standardized test results for ongoing therapy requests. Standardized testing is an important component to determine the nature and extent of any deficits relative to age appropriate norms. Standardized testing can help determine whether a child has a significant delay that requires correction or amelioration and shall be required once per year. Standardized testing may be conducted prior to one year as deemed appropriate. Standardized test results will not be used as the sole determinant as to the medical necessity of requested services.

802.2.7. If the provider submits the standardized testing embedded in the body of the LMN/POC, please make it clear where this information is located by circling or blocking this information so that it is easily accessible by the preliminary review team. Do not highlight as this may cause difficulty in reading the scores and results. The standardized testing dates should align with the effective dates of the POC to ensure the standardized testing is valid for the duration of the PA.

802.2.8. If the CIS provider feels that the member is not amenable to standardized testing, that provider may provide rationale which will be reviewed on a case by case basis by the medical review team. Please indicate the reason why standardized testing is not appropriate on a separate document.

802.2.9. Requests for prior authorization for services that exceed the maximum units established in policy may be made only if the additional services are medically justified. Note: Social Security numbers are not required. Prior authorizations (PA) must be approved prior to rendering the service.

802.2.10. PAs should be submitted thirty (30) calendar days prior to the date services are to begin. This will allow time for the PA to be peer reviewed and approved. The requested PA start date must be specified on the PA request.

802.2.11. Providers must submit Prior Authorization requests and all supporting documentation via the web portal for members who receive services through the CIS program. Instructions for electronically attaching supporting documentation can be accessed in Appendix K. The signed and dated POC/LMN and all supporting documentation must have the member's ID number. The POC/LMN along with other required information should be electronically attached to the PA request (See Appendix K). Providers should strive to send the POC/LMN and all supporting documentation the same day the PA is entered via the web. Web requests that do not have the supporting documentation attached within five (5) calendar days of submission of the PA request will be issued an initial "technical denial" and the provider will receive notification of what supporting documentation is missing and have the opportunity to submit this documentation. Missing documentation must be submitted within ten (10) calendar days of the initial "technical denial."

802.2.11.1. The documentation should be electronically attached to the PA request. (See Appendix K.) Place the PA denial number on the missing documentation that is submitted. If missing information is not received within ten (10) calendar days from the date of the initial "technical denial", the provider will receive a final technical denial and will have to re-submit the entire PA request.

802.2.12. All supporting documentation for a technical denial must be submitted via the CIS reconsideration link at the web portal. (See Appendix K)

802.2.13. Modifier 59 is not required when requesting a PA. However, when applicable, modifier 59 must be placed on the claim along with all other required modifiers.

802.2.14. The IFSP must be reviewed and re-signed every 6 months. Additionally, the attestation statement must be updated every 6 months. The IEP must be reviewed yearly. If the child has an IEP/IFSP, it along with the POC/LMN must be submitted with the request. If the child does not have an IFSP or IEP, please make a detailed notation in the text message box on the web portal submission page as well as submission of Appendix N (Attestation Form (IFSP/IEP).

802.2.15. The provider's progress notes showing details of previous therapy interventions and the member's response to said therapy sessions must be submitted with each PA request. Please submit current / last 3 months progress notes for review. If 3 months of progress notes are not available for submission, please indicate the reason on the PA request form. Progress notes must reflect the member's name and identification number; date(s) of service; time of visit; duration of visit; description of services rendered and response of member. A significant change in condition may warrant the need for a PA request with intensive services. When applicable, please ensure the notes from intensive services are included with subsequent PA requests. (Rev. 07/2019) (Rev. 04/2020)

802.2.16. A separate prescription for services is not required. The PCP's original signature on the dated POC/LMN serves as the prescription for services (electronic and fax signatures are acceptable if legible).

802.2.17. A signed and dated POC/LMN is required for services rendered under the CIS program. The IFSP or IEP, and progress notes (if the child has been receiving services) must be included with the request.

802.2.18. You must submit the cover page from the IFSP and/or the IEP which identifies the member and the pages of the IFSP and/or IEP which pertain to therapy services. After the initial request for additional units, you may send only the PA request and the progress notes if the other supporting documentation is current (POC/LMN, IEP, IFSP) and you feel the progress notes alone provide the medical necessity justification for the units requested. If you are only sending in the PA request form and the progress notes, you must note the previous PA number on the PA

request form (under text comments section) so that the medical review team can access the POC/LMN, IEP and/or IFSP.

NOTE: If any of the supporting documents have been updated, or the request for additional services warrants an update, please forward all supporting documentation with any subsequent PA requests.

802.2.19. PA requests will undergo Peer Review which includes review of the member's clinical records.

802.2.20. PA requests must have all the required supporting documentation before approval will be granted.

802.2.21. While PAs may be granted for up to 180 calendar days (6 months), PAs must be requested in monthly increments; i.e., 1/1/24 – 1/31/24; 2/1/24 – 2/28/24, etc. PA requests for greater than 180 calendar days or that span in months will be denied.

802.2.21.1. When you submit a PA request, the effective start date of service cannot be prior to the date you submit the PA request; i.e., if you submit a PA on 1/10/24 and you would like to provide services during the month of January, the first month request period would be from 1/10/24 – 1/31/24.

802.2.21.2. When submitting a PA request for six months, please be aware that the peer reviewers will only review those months for which all required documentation is provided and the IEP is active. For example, if the provider requests six months of therapy, yet the IEP is expired for three of those months, only the covered three months will be reviewed. The only exception would be if the IEP expires during non-school time.

802.2.22. PA requests per child may be split between two providers (of the same specialty or providers that share billable procedure codes) or one provider may receive all approved PA units. If a PA will be shared between two providers, please indicate on the PA request form. It is the responsibility of the provider who requests and receives the PA units to coordinate sharing of the PA. (Rev. 04/2020)

802.2.23. If there are questions regarding PA submissions, providers should review the PA status on the web portal first. (See Appendix O) Any additional questions can be directed to Alliant Health Solutions via the Contact Us link on the web portal. (See Appendix I). For claims issues and billing questions, please contact the Gainwell Technologies Contact Center at (800) 766-4456. For CIS Policy questions, please contact DCH's CIS Program Specialist at twilson@dch.ga.gov. (Rev. 10/2018)

802.2.24. All Web submissions will initially 'suspend' until a reviewer views the

PA request.

802.2.25. Providers must have all supporting documentation with original signatures (electronic and fax signatures are acceptable if they are legible) readily available on site in the patient's medical record for audit purposes.

802.2.26. There are no "retro-authorizations." PA must be obtained prior to rendering the service. All 'retro' requests for routine therapy services will be denied – see Section 802.2.36 for requesting a PA for an emergent need.

802.2.27. Requests for PA should include the total number of units requested per each specific procedure code requested (i.e., 12 units 97533; 6 units 92609, not 18 units of 97533 and 92609).

802.2.28. Dates of Services cannot overlap between PAs. Providers who submit a new PA request for services that will overlap a current approved or denied PA must submit a request to withdraw the overlapping approved hours from the original PA. If this request to withdraw the overlapping hours from the original PA is not submitted, the new PA request will deny for duplication of services. Requests for prior authorization of units above policy limits can be submitted thirty (30) calendar days prior to beginning services.

802.2.29. Requested Units: Enter the total number of units requested.

802.2.30. Units/Day: Document the maximum units per day as stated in policy.

802.2.31. Frequency/Month: Enter the number of units requested per month.

802.2.32. Requested Months: This number will always be one per month since policy states that PAs are viewed on a month by month basis. Each PA request can be for a maximum of up to 6 months.

802.2.33. Providers must electronically attach required PA supporting documentation (Appendix K). If providers need to contact Alliant Health Solutions, please utilize the "Contact Us" on the web portal. (Appendix I)

802.2.34. The signed and dated LMN/POC must include the rendering therapist's signature as well as the signature of the PCP.

802.2.35. Request for units above those allowed by policy must contain all information as specified in policy. If there is an IEP or IFSP, it must be submitted for review. If there is no IEP/IFSP, providers must indicate in detail the reason for the missing IEP/IFSP (in the appropriate section) i.e., child is in private school, child is home schooled, not currently enrolled in school system, not in BCW, etc. If the child is home schooled, the provider must provide documentation to this effect; i.e., a copy of the "Declaration of Intent to Utilize a Home Study Program."

Documentation of private school attendance is required as well – this could be in the form of an attestation from the parent as to the private school that the member attends and that the child does not have an IEP. If a member does not have an IFSP or IEP, please submit the Attestation form (IFSP/IEP) found in Appendix N of this Manual.

802.2.36. If during the course of your treatment of a client (with an existing PA) an emergent need arises, you may provide service and request a PA after providing the service; i.e., a retro PA request. The following criteria must be met:

802.2.36.1. The request for prior approval of an emergent need must be filed within fifteen (15) calendar days of the date of service.

802.2.36.2. An updated LMN/POC signed and dated by the PCP and therapist must accompany the request.

802.2.36.3. These requests will only be honored with supporting documentation of the emergent need. There are no retro PA approvals for routine therapy services.

802.2.36.4. Only the following therapy codes can be utilized when requesting a retro PA for services provided as an emergent need:

802.2.36.4.1. Speech Therapy:

Code 92526-treatment of swallowing dysfunction

802.2.36.4.2. Occupational Therapy:

Code 97760-Orthotics management & training

Code 97530-therapeutic activities

Code 97761-prosthetic training

Code 97140-manual therapy

Code 97542-wheelchair management

802.2.36.4.3. Physical Therapy

Code 97110-therapeutic procedure

Code 97716-gait training

Code 97140-manual therapy

Code 97530-therapeutic activities

Code 97542- wheelchair management

802.2.37. CIS providers may not withdraw and then resubmit a PA request for the same services just withdrawn if all the following statements are applicable:

802.2.37.1. The PA was denied after peer review for insufficient documentation to substantiate medical necessity, and

802.2.37.2. The PA request is for the same service(s) that was previously denied for insufficient documentation to substantiate medical necessity following peer review, and

802.2.37.3. The provider did not provide any additional documentation needed to substantiate medical necessity.

802.2.37.4. If you have received a partial denial on a PA request, you may not withdraw denied procedure codes of a partially approved PA and resubmit those codes on a new PA.

802.2.38. If a provider makes an error on a PA submission, the provider should request that the PA be withdrawn so that a correct PA may be submitted. This can be accomplished by using the Change Request link on the web portal (See Appendix I).

802.2.39. All supporting documentation must be legible and current according to policy. PA documentation that is not legible or is out of date may cause the PA to receive a technical denial.

802.2.40. If a request for additional units is denied, the provider has the right to submit a request for "A Reconsideration of the PA Request" within thirty (30) calendar days of the peer denial. Only submit the necessary additional documentation supporting the request for reconsideration. There is no need to resubmit all information sent with the original request. Please electronically request a reconsideration review via the web portal and attach your supporting documentation at that time. See Appendix L for instructions.

802.2.40.1. Providers are only permitted to submit one (1) reconsideration following the first peer denial. If the reconsideration results in a second (2nd) peer denial, the provider must submit a new PA request. (Rev. 04/2026)

802.2.41. If you have submitted a timely request for a reconsideration of a PA request and have received a final denial, please refer to Part I Policies

and Procedures for Medicaid/PeachCare for Kids for the instructions to appeal the decision.

802.2.42. Reconsideration of PA requests are not appropriate for PAs that have received technical denials. A technical denial means that there are missing documents and the case cannot be referred to a peer consultant for final determination. If you receive an "initial technical denial", you have ten (10) calendar days to submit the required supporting documentation. If you receive a "final technical denial", the PA should be resubmitted with all the required documentation.

802.2.43. Providers have the option to submit a "change request" via the web portal requesting a modification to a prior approval request; however the following criteria must be met:

802.2.43.1. A significant change in condition must be documented by submission of an updated LMN/POC signed by the PCP and therapist and be forwarded to the medical review team.

802.2.43.2. For a member whose name and Medicaid ID number has changed due to an adoption, the change request must also include the new Medicaid ID number. If there have been any paid claims against the PA, the GAMMIS will not accept changes made to the PA.

802.2.43.3. If a change in modality is requested, the units to be withdrawn (for substitution) must be specified.

802.2.43.4. This is applicable to PAs for which reconsideration has not been requested.

802.2.43.5. Instructions for this process are found in Appendix M.

802.2.44. If you have received a partial denial on a PA request for documentation that has expired, you should attach the updated documents via the Change Request link to the PA that was partially tech denied for expired paperwork.

802.2.45. CIS providers must submit claims with procedure codes linked to a prior authorization (PA) separately from claims with codes not linked to a PA. When submitting claims associated with a PA, if all codes on the claim are authorized by the same PA, the PA should be documented at the header. PAs recorded at the header level apply to all codes listed on the claim. If the codes on the claim are authorized by different PAs, the provider must include the appropriate PA on the detail line linked with the authorized code. If the provider documents an incorrect PA number on a claim detail line, the code linked to the PA number will be denied payment.

802.3. Family of Codes:

Children's Intervention Services providers may request units for a "family of codes" as follows:

802.3.1. When obtaining a PA using the family of codes, providers of different specialties cannot share the PA even if they share a common procedure code. For example, a PA granted to a physical therapist under the family codes cannot be used by an occupational therapist who shares a common procedure code with the physical therapist. The modifiers on the PA for PT will not match the modifiers on the claim for OT, so the claim will deny. Each specialty must request a separate prior authorization or the claim will deny for PA/ provider specialty mismatch.

802.3.2. If the provider would like to request a PA for their specific specialty for a family of codes, the provider should only request one (1) procedure code from the family of codes for the month with the total number of units for the month. When the PA is accessed from the claims system, it will list all procedure codes in the family of codes. This means that the provider can bill any procedure codes from the family of codes for the approved number of units for the month.

802.3.3. When requesting a PA using family of codes, multiple lines will no longer be accepted in the centralized PA portal. (Rev. 04/2020)

802.3.4. When the family of codes is sent to the claims system, the system will re-order the procedure codes and will display the lowest numbered code in the family on the procedure detail line. For example, if a PA was requested for speech therapy code 92526, then procedure code 92507 will always display on the first detail line. Providers may bill any code in the family appropriate to your specialty and up to the approved units. If the family of codes request is not submitted correctly, then the provider will need to withdraw the PA request and submit a new PA with the required documentation. Please note that this is not grounds for reconsideration or a change request.

802.3.5. Physical Therapy/Occupational Therapy (Note therapists may only use codes approved for their discipline as stated in the CIS Policy Manual)

802.3.5.1. 97110 – Therapeutic procedure

97112 – Neuromuscular re-education

97116 – Gait training

97530 – Therapeutic activities

97535 – Self care/home management training

802.3.6. Speech Therapy Family

802.3.6.1. 92507 – Speech language therapy

92526 – Treatment of swallowing dysfunction

CHAPTER 900: Scope of Services

901. General

The services covered under this program are audiology, nursing, nutrition services provided by licensed dietitians, occupational therapy, physical therapy, counseling provided by clinical social workers and speech-language pathology. Services may be provided in the practitioner's office, the member's home, or child care setting or other community setting. Note: Hospital employed therapists who are enrolled in the CIS Program may provide services and bill for services rendered in the hospital outpatient facility or outpatient clinic. In the provision of services, the child should be seen in the context of the family and the family should be assisted in understanding the special needs of the child in order to enhance the child's development. Procedure codes which may be billed in the CIS program are listed under Chapter 1000 – Basis for Reimbursement. All services reimbursable under this program are listed. If a service is not listed, it is not covered.

902. Covered Services

902.1. Audiology Services include but are not limited to:

902.1.1. Auditory acuity (including pure tone air and bone conduction), speech detection, and speech reception threshold;

902.1.2. Auditory discrimination in quiet and noise;

902.1.3. Impedance audiometry, including tympanometry and acoustic reflex;

902.1.4. Central auditory function;

902.1.5. Testing to determine the child's need for individual amplification

902.1.6. Auditory training;

902.1.7. Speech reading;

902.1.8. Aural rehabilitation; Individual treatment to children with auditory problems. This includes speech, language and voice problems as a result of hearing loss; and

902.1.9. Augmentative communication.

902.2. Nursing services include but are not limited to:

902.2.1. Skilled, intermittent nursing care (e.g., suctioning, dressing changes, and catheterization);

902.2.2. Administration of medication as prescribed by the child's PCP;

902.2.3. Administration of treatment regimens as prescribed by the child's PCP;

902.2.4. Assessment of the capabilities of the child, his family, and other caretakers to carry out nursing care, medication administration or monitoring, and specific ordered treatments;

902.2.5. Teaching nursing self-care to the child and family or caretaker.

902.3. Occupational Therapy services include but are not limited to:

902.3.1. Activities of daily living;

902.3.2. Sensory or perceptual motor development and integration;

902.3.3. Neuromuscular and musculoskeletal status (muscle strength and tone, reflex, joint range of motion, postural control, endurance);

902.3.4. Gross and fine motor development;

902.3.5. Feeding or oral motor function;

902.3.6. Adaptive equipment assessment;

902.3.7. Adaptive behavior and play development

902.3.8. Prosthetic or orthotic training; and

902.3.9. Fabrication or observation of orthotic devices.

902.4. Physical Therapy services include but are not limited to:

902.4.1. Neuromotor or neurodevelopmental assessment;

902.4.2. Musculo-skeletal status (including muscle strength and tone, posture, joint range of motion);

902.4.3. Gait, balance, and coordination skills;

902.4.4. Postural control;

902.4.5. Cardio-pulmonary function;

902.4.6. Activities of daily living;

902.4.7. Sensory motor and related central nervous system function;

902.4.8. Oral motor assessment;

902.4.9. Adaptive equipment assessment;

902.4.10. Gross and fine motor development;

902.4.11. Fabrication and observation of orthotic devices; and

902.4.12. Prosthetic or orthotic training.

902.5. Counseling services provided by licensed clinical social workers include but are not limited to:

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

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

902.6. Speech-Language Pathology services include but are not limited to:

902.6.1. Expressive language;

902.6.2. Receptive language;

902.6.3. Auditory processing, discrimination, perception, and memory;

902.6.4. Vocal quality;

902.6.5. Resonance patterns;

902.6.6. Phonological;

902.6.7. Pragmatic language;

902.6.8. Rhythm or fluency;

902.6.9. Feeding and swallowing assessment;

902.6.10. Articulation therapy;

902.6.11. Language therapy;

902.6.12. Augmentative communication treatment or instruction;

902.6.13. Voice therapy; and

902.6.14. Oral motor dysfunction, swallowing therapy.

902.7. Nutrition services include but are not limited to:

902.7.1. Nutritional history;

902.7.2. Dietary intake;

902.7.3. Anthropometric measurements;

902.7.4. Evaluation of laboratory work;

902.7.5. Evaluation of feeding behavior and environment;

902.7.6. Biochemical and clinical variables; and

902.7.7. Food habits and preferences.

903. Record Requirements and Service Limitations

Each practitioner must maintain legible, accurate, and complete charts and records in order to support and justify the services provided. Chart means a summary of each encounter of essential medical information on an individual member. Record means dated reports supporting claims submitted to the Division for services provided in an office, home, or other acceptable place of service. Records of service shall be entered in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible and shall include at a minimum:

903.1. date (s) of service; time of visit; duration of visit; description of services rendered and response of member.

903.2. member's name and date of birth;

903.3. signature and title of person performing the service after each encounter, progress notes are typically written/signed on the date of service; however, DCH will allow up to 3 business days for the notes to be finalized; NOTE: Alliant Health Solutions review progress notes with prior authorization (PA) requests; however PA requests should not be denied due to progress notes not being signed timely. (Rev. 07/2018) (Rev. 10/2018)

903.4. chief complaint or reason for each visit;

903.5. pertinent medical history;

903.6. pertinent findings on examination;

903.7. medications, equipment or supplies prescribed or provided;

903.8. description of treatment (each encounter);

903.9. recommendations for additional treatments, procedures, or consultations;

903.10. x-rays, tests, and results;

903.11. all required documentation; i.e., signed and dated POC/LMN IFSP if eligible under Early Intervention, services provided, outcomes, etc. records must be available to DCH and its agents and to the U.S. Department of Health and Human Services upon request. Documentation must be timely, complete, and consistent with the by-laws and medical policies of the office or facility where the service is provided.

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

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

904. Non-Covered Services

904.1. Services provided to Early Intervention (Babies Can't Wait) eligible children who do not have an authorized current IFSP.

904.2. Services provided in a school setting.

904.3. Services provided to children who do not have a written service plan.

904.4. Services provided in excess of or other than those indicated on the IFSP or written service plan without prior approval.

904.5. Services provided to a child who has been admitted to a hospital or other institutional setting as an inpatient.

904.6. Service of an experimental or research nature.

904.7. Services in excess of those deemed medically necessary by DCH, its agents or the federal government, or for services not directly related to the child's diagnosis, symptoms or medical history.

904.8. Failed appointments or attempts to provide a home visit when the child is not at home.

904.9. Services which are not described in Chapter 900 of this manual.

904.10. Services which are provided in a manner which is non-compliant or inconsistent with the provisions of this manual.

904.11. Services normally provided free of charge to indigent patients.

904.12. Services provided for temporary disabilities which would reasonably be expected to improve spontaneously as the member gradually resumes normal activities.

904.13. Services provided by individuals other than the enrolled licensed practitioner of the healing arts. Note: OTA, PTA, SLPA (aides or assistants) etc. are not allowed to provide services under the CIS Program. An exclusion to the above reference – students in an approved academic program and pursuing the requirements of their academic program are allowed to participate in CIS therapy sessions under the guidance of the licensed (supervising) practitioner. The licensed (supervising) practitioner must reference and follow the guidelines of their respective governing therapy practice act / association. (Rev. 04/2023)

904.14. Audiology services that are a part of the Health Check screen will not be reimbursable by the Children's Intervention Services Program.

904.15. Universal hearing screenings for newborns which do not meet the recommendations established by the American Academy of Pediatrics.

904.16. Group Therapy

904.17. Billing for documentation time

904.18. Co-treatment.

904.19. Habilitative services that assist in acquiring, retaining and improving the self-help, socialization, and adaptive skills of the child.

904.20. Co-teaching.

904.21. Children's Intervention Services do not include educational services otherwise available through a program funded under 20 USC Chapter 3, section 1400 of the Individuals with Disabilities Education Act (IDEA). Congress reauthorized the IDEA in 2004 and most recently amended the IDEA through Public Law 114-95, the Every Student Succeeds Act, in December 2015. Information about the IDEA Act is found on the U.S. Department of Education site at: U.S. Department of Education. (Rev. 10/2021)

Chapter 1000: Basis For Reimbursement

1001. Reimbursement Methodology

The Division will pay the lower of the lowest price regularly and routinely offered to any segment of the general public for the same service or items on the same date(s) of service, the lowest price charged to other third party payers, or effective with dates of service July 1, 2003, the statewide maximum allowable reimbursement which is 84.645% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2000 for Region IV (Atlanta). All procedure codes recognized and adopted after the 2000 RBRVS are subject to the statewide maximum allowable reimbursement - 84.645% of the Region IV Medicare RBRVS in effect at the time the procedure code was adopted.

Effective for dates of service on or after July 1, 2016, the state's maximum allowable rate for codes 97001 – 97004, 97110, 97112, 97116, 97140, 97530 and 97535 is 80% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2014 for Region I (Atlanta).

All Reimbursement Rates for CIS program services were updated effective October 1, 2011 after the provider rate decrease, documented in the July 1, 2011 manual, was abandoned. As of April 1, 2015, the descriptions for the HIPAA Compliant CPT Codes have been removed from this manual. Please consult the latest version of the Current Procedural Terminology for the procedure code descriptions.

Note: When billing procedure codes, 1 unit equals a minimum of 15 minutes unless otherwise specified. Please refer to CMS for the codes that may not be billed in combination per NCCI edits and the medically unlikely edits (MUEs). These codes and MUEs may change each quarter. A provider who wishes to appeal a claim that denied for an NCCI edit or the MUE units must follow the appeals process outlined in the Part I Policies and Procedures for Medicaid/PeachCare for Kids. The National Provider Identifier (NPI) number of the child's PCP is required on all claims submitted to DCH.

1001.1. Nursing Services

HIPAA Compliant CPT Code	1st Modifier	2nd Modifier	Maximum Allowable	Service Limits
T1502	HA	TD	$5.78	
T1002	HA		$5.78	

1001.2. Nutrition Services

HIPAA Compliant CPT Code	1st Modifier	2nd Modifier	Maximum Allowable	Service Limits
97802	HA		$28.09	1 visit per year
97803	HA	TS	$23.94	12 visits per year
97804	HA		$13.00	12 visits per year

1001.3. Counseling Services

HIPAA Compliant CPT Code	1st Modifier	2nd Modifier	Maximum Allowable	Service Limits
96156	HA		$84.57	
96158	HA		$57.70	
96159	HA		$20.15	
96167	HA		$61.98	
96168	HA		$21.98	

1001.4. Audiology Services

HIPAA Compliant CPT Code	1st Modifier	2nd Modifier	Maximum Allowable	Service Limits
92507	UC	HA	$65.64	8 units per month
92550		HA	$19.00	2 units per year
92552		HA	$30.47	2 units per year
92555		HA	$23.58	2 units per year
92556		HA	$36.52	2 units per year
92557		HA	$42.04	2 units per year
92567	UC	HA	$18.46	4 units per year
92568		HA	$13.38	2 units per year
92579		HA	$38.57	4 units per year
92582		HA	$70.43	4 units per year
92622		HA	$65.60	
92623		HA	$16.90	
92650		HA	$63.66	2 units per year
92651		HA	$77.15	2 units per year
92652		HA	$100.94	3 per year
92653		HA	$73.91	3 per year
92587	HA	HA	$52.51/unit	2 units per year
92588	HA	HA	$70.52/unit	3 units per year
92601	UC	HA	$138.15	3 units per

				year
92602	UC	HA	$87.48	Limited to 1 unit per calendar year.
92603	UC	HA	$78.29	
92604	UC	HA	$78.29	Limited to 7 units per calendar year. 1 unit = 1 visit.
98975	UC	HA	$15.84	
98980	UC	HA	$41.09	
98981	UC	HA	$33.39	

1001.5. Occupational Therapy Services

HIPAA Compliant CPT Code	1st Modifier	2nd Modifier	Maximum Allowable	Service Limits
96112	GO	HA	$128.61	2 units per calendar year
96113	GO	HA	$60.64	2 units per calendar year
97165	GO	HA	$86.35	1 per year
97166	GO	HA	$86.35	1 per year
97167	GO	HA	$86.35	1 per year
97168	GO	HA	$59.59	1 every 180 days
97113	GO	HA	$31.65	Limited to 8 units per calendar month or combination of 8 units per calendar month
97140	GO	HA	$24.18	Limited to 8 units per calendar month or combination of 8 units per calendar month

97530	GO	HA	$31.94	8 units per calendar month or combination of 8 units per calendar month
97533	GO	HA	$54.66	8 units per calendar month or combination of 8 units per calendar month
97535		HA	$28.23	8 units per calendar month or combination of 8 units per calendar month
97537		HA	$27.34	8 units per calendar month or combination of 8 units per calendar month.
97542	GO	HA	$27.34	8 units per calendar month or combination of 8 units per calendar month.
97550	GO	HA	$44.05	8 units per calendar month or combination of 8 units per calendar month.
97551	GO	HA	$21.86	8 units per calendar month or combination of 8 units per calendar month.
97552	GO	HA	$18.55	8 units per

				calendar month or combination of 8 units per calendar month.
97750	GO	HA	$29.06	8 units per calendar month or combination of 8 units per calendar month
97760		HA	$41.72	Limited to 8 units per calendar month or combination of 8 units per calendar month.
97761	GO	HA	$35.96	Limited to 8 units per calendar month or combination of 8 units per calendar month.
97763	GO	HA	$45.74	8 units per calendar month or combination of 8 units per calendar month
97129	GO	HA	$20.76	8 units per calendar month or combination of 8 units per calendar month
97130	GO	HA	$19.84	8 units per calendar month or combination of 8 units per

				calendar month
98975	GO	HA	$15.84	
98979	GO	HA	$22.63	
98980	GO	HA	$42.02	
98981	GO	HA	$33.39	
98984	GO	HA	$40.84	
98985	GO	HA	$34.52	

1001.6. Physical Therapy Services

HIPAA Compliant CPT Code	1st Modifier	2nd Modifier	Maximum Allowable	Service Limits
96112	GP	HA	$128.61	2 units per calendar year
96113	GP	HA	$60.64	2 units per calendar year
97161	GP	HA	$86.35	1 per year
97162	GP	HA	$86.35	1 per year
97163	GP	HA	$86.35	1 per year
97164	GP	HA	$59.87	1 every 180 days
97110		HA	$25.91	8 units per calendar month or combination of 8units per calendar month
97112		HA	$29.07	8 units per calendar month or combination of 8units per calendar month
97113	GP	HA	$31.65	8 units per calendar month or combination of 8units per calendar month
97116		HA	$25.33	8 units per calendar month or combination of 8 units per

				calendar month
97022		HA	$14.68	8 units per calendar month or combination of 8 units per calendar month
97024		HA	$9.22	8 units per calendar month or combination of 8 units per calendar month
97032		HA	$14.50	8 units per calendar month or combination of 8 units per calendar month
97035		HA	$10.69	8 units per calendar month or combination of 8 units per calendar month
97124		HA	$25.90	8 units per calendar month or combination of 8 units per calendar month
97140	GP	HA	$24.18	8 units per calendar month or combination of 8 units per calendar month
97530	GP	HA	$31.94	8 units per calendar month or combination of

				8 units per calendar month
97542	GP	HA	$27.34	8 units per calendar month or combination of 8 units per calendar month
97550	GP	HA	$44.05	8 units per calendar month or combination of 8 units per calendar month.
97551	GP	HA	$21.86	8 units per calendar month or combination of 8 units per calendar month.
97552	GP	HA	$18.55	8 units per calendar month or combination of 8 units per calendar month.
97750	GP	HA	$29.06	8 units per calendar month or combination of 8 units per calendar month
97761	GP	HA	$35.96	8 units per calendar month or combination of 8units per calendar

97763	GP	HA	$45.74	8 units per calendar month or combination of 8units per calendar month
98975	GP	HA	$15.84	
98979	GP	HA	$22.63	
98980	GP	HA	$42.02	
98981	GP	HA	$33.39	
98984	GP	HA	$40.84	
98985	GP	HA	$34.52	

1001.7. Speech-Language Pathology Services

HIPAA Compliant CPT Code	1st Modifier	2nd Modifier	Maximum Allowable	Service Limits
92507	GN	HA	$65.64	8 visits per calendar month; 1 unit per visit
92521		HA	$113.99	2 units per year; 1 unit per visit; 1 unit per 180 days
92522		HA	$95.30	2 units per year; 1 unit per visit; 1 unit per 180 days
92523		HA	$195.47	2 units per calendar year; 1 unit per visit; 1 unit per 180 days
92524		HA	$94.15	2 units per year; 1 unit per visit; 1 unit per 180 days
92526		HA	$72.83	8 visits per calendar month; 1 unit per visit
92567	GN	HA	$18.46	4 units per calendar year
92597		HA	$85.57	1 per calendar year; 1 unit per visit

92601	GN	HA	$138.15	1 unit per calendar year.
92602	GN	HA	$87.48	7 units per calendar year. 1 unit = 1 visit.
92603	GN	HA	$129.52	1 unit per calendar year.
92604	GN	HA	$78.29	7 units per calendar year. 1 unit = 1 visit.
92607	U1	HA	$109.28	2 units per year; 1 unit per visit; 1 unit per 180 days
92609	U1	HA	$88.65	8 visits per month; 1 unit per visit
92610		HA	$117.54	2 per year 1 unit per visit; 1 unit/180 days
96105		HA	$62.10	2 units per calendar year;1 unit per visit; 1 unit/180 days
96110		HA	$11.77	2 units per calendar year; 1 unit per visit
96112	GN	HA	$128.61	2 units per calendar year; 1 unit per visit
96113	GN	HA	$60.64	2 units per calendar year; 1 unit per visit
97129	GN	HA	$20.76	8 units per calendar month or combi-nation

				of 8 units per calendar month
97130	GN	HA	$19.84	8 units per calendar month or combination of 8 units per calendar month
97533	GN	HA	$54.66	8 units per calendar month or combination of 8 units per calendar month
97550	GN	HA	$44.05	8 units per calendar month or combination of 8 units per calendar month.
97551	GN	HA	$21.86	8 units per calendar month or combination of 8 units per calendar month.
97552	GN	HA	$18.55	8 units per calendar month or combination of 8 units per calendar month.
98975	GN	HA	$15.84	
98979	GN	HA	$22.63	
98980	GN	HA	$42.02	
98981	GN	HA	$33.39	
98984	GN	HA	$40.84	
98985	GN	HA	$34.52	

1001.8. Providers cannot use code 92609 unless the child has had an evaluation for a speech-generating device (SGD).

1001.9. The U1 modifier must be added to procedure codes 92607 and 92609 to indicate the services are related to a mobile SGD (92607) and the use of the mobile SGD with an Alternative Augmentative Communication (AAC) software application (92609).

1001.10. Modifier 59 is not required when requesting a PA. However, if applicable, modifier 59 should be placed on the claim along with all other required modifiers.

1001.11. All PAs must be submitted with the same modifiers (except as noted above for the NCCI edit, modifier 59) that will be used for billing purposes. The modifiers on the PA and the claim must match.

1001.12. Claims will suspend to Alliant Health Solutions to be manually priced at half the rate for reduced services when the 52 modifier (along with the HA modifier) is placed on the claim for procedure code 92523.

1001.13. In response to COVID-19 and the public health emergency declaration, the Department of Community Health (DCH) will allow therapy services to be rendered via telehealth. Each billed procedure code must be submitted with the usual program modifier(s). Place of service code 02 must be submitted on the claim to indicate the services are delivered through telehealth. (Rev. 04/2020)

1001.14. Clarification on the use of CPT code 97550 - Use of this code must be documented in the plan of care with specific information on how and why it is medically necessary to provide caregiver training without the member present. CPT code 97550 should not be used for review of goals or review of the latest therapy session. This code should be specific training for a technique, procedure, equipment use, or care and programming for more complicated equipment. This code does not substitute for home program instruction and review. Documentation should reflect separate time and scheduling for this training outside of care of the member. (Rev. 07/2025)

1001.15. Clarification on the use of CPT code 96112 and 96113 – Use of CPT code 96112 goes beyond the scope of a typical evaluation by the individual professional. It includes standardized testing when done in its entirety but should not be used for portions of a standardized test or developmental tests for the purpose of screening only. Portions of a standardized test are allowed for the CIS requirement of standardized testing; however, portions of standardized testing will not be considered adequate to support use of 96112. For use of 96112, the standardized testing must be medically necessary, comprehensive and separately documented from any other discipline specific evaluation. The documentation should include scoring and interpretation of results. (Rev. 07/2025)(Rev. 10/2025)

1001.15.1. CPT code 96113 is an add-on code to allow additional time following the use of CPT code 96112. When requesting, 96113, you must also request 96112 on the same PA and it should be accompanied by significant documentation to support the need for both. (Rev. 07/2025)

Appendix A
Office of Child Health Resources

A. The link below allows families to find resources in their area related to Babies Can't Wait, Children 1st, and Children's Medical Services (CMS) among many other programs.

i. Women and Children | Georgia Department of Public Health

Instructions – Select Child Health, then Babies Can't Wait. Under the Women and Children Services Finder, click the Locate Services feature.

Appendix B
Other Related Medicaid Programs Which Provide Services to Children

A. Related Medicaid Programs

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

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

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

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

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

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

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

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

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

Appendix C
Ordering, Prescribing, and Referring (OPR) Update

A. Ordering, Prescribing, and Referring (OPR)

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.

i. For the NEW CMS-1500 claim form:

   1. 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).

ii. For claims entered via the web:

   1. 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.

iii. For claims transmitted via EDI:

   1. 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 D
Georgia Health Partnership (GHP)

A. Provider Correspondence

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

B. Electronic Data Interchange (EDI)

1-877-261-8785 or 770-325-9590

i. Asynchronous

ii. Web Portal

iii. Physical Media

iv. Network Data Mover (NDM)

v. Systems Network Architecture (SNA)

vi. Transmission Control Protocol (TCP/IP)

C. Provider Contact Center

800-766-4456 (Toll free) or 770-325-9590

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

Appendix E
Additional Billing Information

A. Billing / CMS 1500 Information

i. Providers no longer need the authorization number of the primary care physician (PCP) to file a claim. Field 17 A is no longer required.

ii. Prior approvals may be submitted via the web portal.

iii. Travel is no longer a billable service.

iv. Coordination and collaboration with the Primary Care Physician is required.

v. Dates of Service (DOS)

1. The "To" and "From" date of service is always the same. The date must contain month, day and year in MM/DD/YY format (e.g., enter April 1, 2003 as 04B/01/03 to 04/01/03.

vi. Place of Service (POS)

1. The only valid POS codes are 11 (office), 12 (home), 22 (outpatient hospital) and 99 (other).

vii. Procedures Codes

1. See Part II-Chapter 1000 of the Children's Intervention Services Policies and Procedures manual for appropriate procedure codes. Only the procedure codes listed in the policy manual are covered codes.

viii. Diagnosis Codes

1. Effective October 1, 2015, use the Tenth Edition (ICD-10) code sets. ICD-10-CM replaces the ICD-9-CM (diagnosis) codes (Volumes 1-2) and ICD-10-PCS replaces the ICD-9-CM (procedure) codes (Volume 3).

ix. Charges

1. Enter the cost of your "usual and customary" charge for the procedure multiplied times the units of service.

x. Days or Units

1. Enter the number of units provided

Appendix F
Babies Can't Wait and the CMS 1500 Form

A. Field 32 on CMS 1500 Form

i. For services provided to Early Intervention (Babies Can't Wait) children, indicate the letters E.I. and the Health District number where the services were provided. (See Appendix A in the CIS Policies and Procedure Manual for listing of Health Districts). For Services provided to a child who is not an Early Intervention child, indicate the word "other" and the health district number where the services were provided.

ii. Field 32 on the 1500 claim form is now the Serial Number on the software WINASAP. The information which is Other and the Health District Number or EI and the Health District Number will have to be input into each line. WINASAP has about four lines, so the information will have to be entered in the four lines.

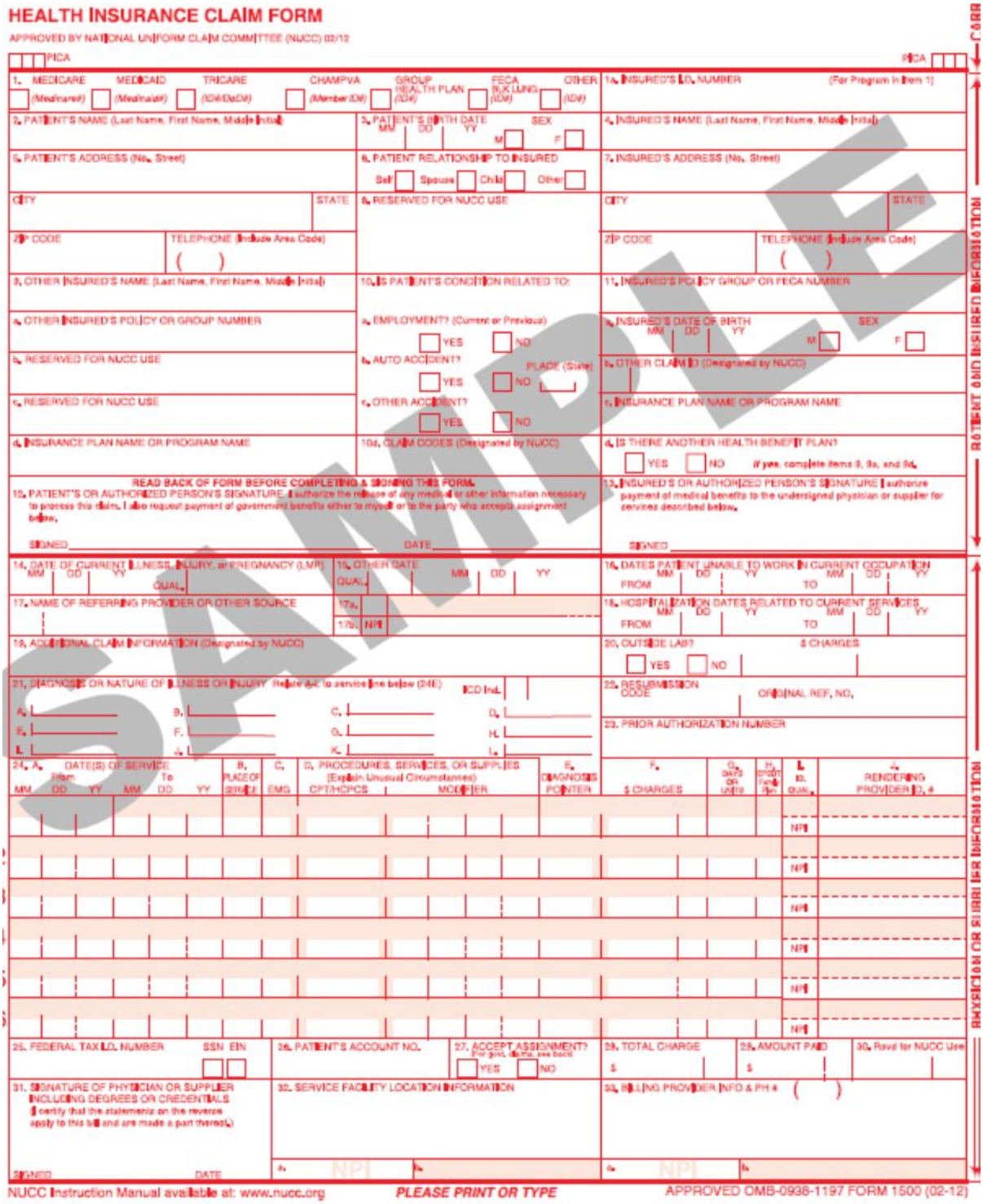
iii. When billing via the web, Field 32 on the 1500 claim form via the Web is now the Serial Number. The information which is Other and the Health District Number or EI and the Health District Number is to be inputted in this field.

iv. When billing via the web portal, no attachment is required and the provider can simply report a reason code.

v. If a member has private insurance (primary) and Medicaid (secondary), claims must be submitted electronically via the Web portal. If the primary insurance has paid, enter the correct amount in the appropriate field and the claim will adjudicate. If the primary insurance denied the claim, the following actions should be taken:

1. If using the Web portal—Complete the appropriate additional information screens to show who the primary plan insurance is and that it allowed and/or paid $0.00; enter the adjustment reason code used by the primary insurance to deny/adjust the claim along with the amount associated with that denial/payment adjustment. (Example: PR-1 the amount entered was applied to the annual deductible.)

Appendix G
CMS-1500 Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
											NPI
											NPI
											NPI
											NPI
											NPI
											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Appendix H
Resource Links

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. **Georgia Families Overview:**

https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

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

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

Appendix I
How To Submit Questions to Alliant Health Solutions

ALLIANT | GMCF
MAKING HEALTH CARE BETTER

Provider Correspondence via the Workspace

Purpose

Provider Correspondence functionality allows Providers to submit questions to Georgia Medical Care Foundation (GMCF) reviewers via the *Provider Workspace*. The workspace includes the following features to accommodate this type of correspondence.

- **Contact Us:** This link is used to submit a correspondence and is found in the following workspace locations:
  - Bottom of the *Provider Workspace* page
  - Provider Inquiry Form (DMA-520A) submission page and search page
  - *Review Request* page for a PA request. Search for a PA, open the *Review Request* page, and click Contact Us.

- **Search My Correspondence:** A correspondence search link is available at the bottom of the workspace page and may be used to search for all correspondence associated with a provider's ID number.

- **Provider Messages:** A 'Provider Messages' drop list has been added to the top of the workspace. This list displays the last 10 processed and unprocessed correspondences submitted by the provider, or created and submitted to the provider by GMCF staff (see figure 1). Unprocessed correspondences are correspondences for which GMCF has not yet submitted a 'GMCF Response'; while processed correspondences are correspondences for which a 'GMCF Response' has been submitted.

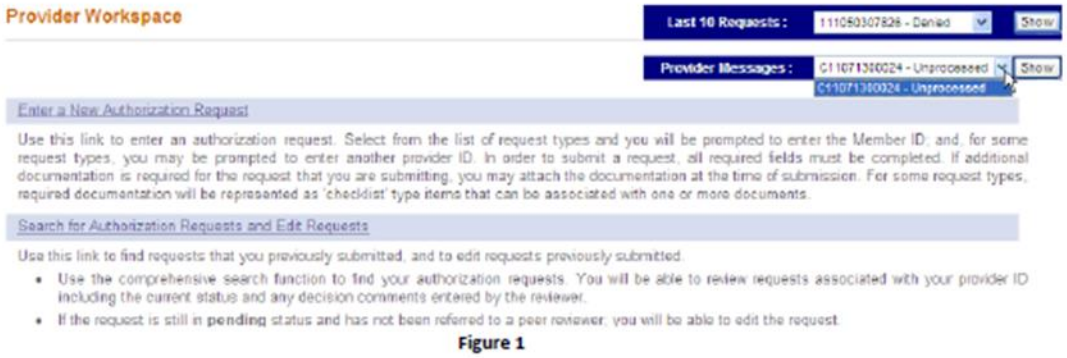


Figure 1

- **Notification Alert:** The following alert notification has been posted to the top of the workspace page announcing the new correspondence functionality. Providers can remove by clicking **Close Notification**.

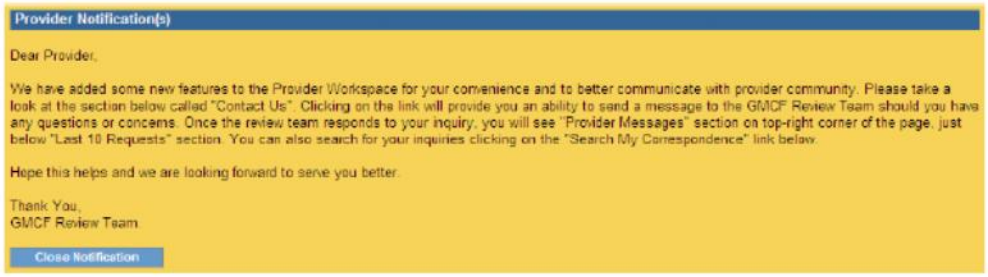


Figure 2

Instructions

Submit a Correspondence

Follow this procedure to submit a correspondence to GMCF:

1. Click **Contact Us** on the workspace to open the correspondence contact form.

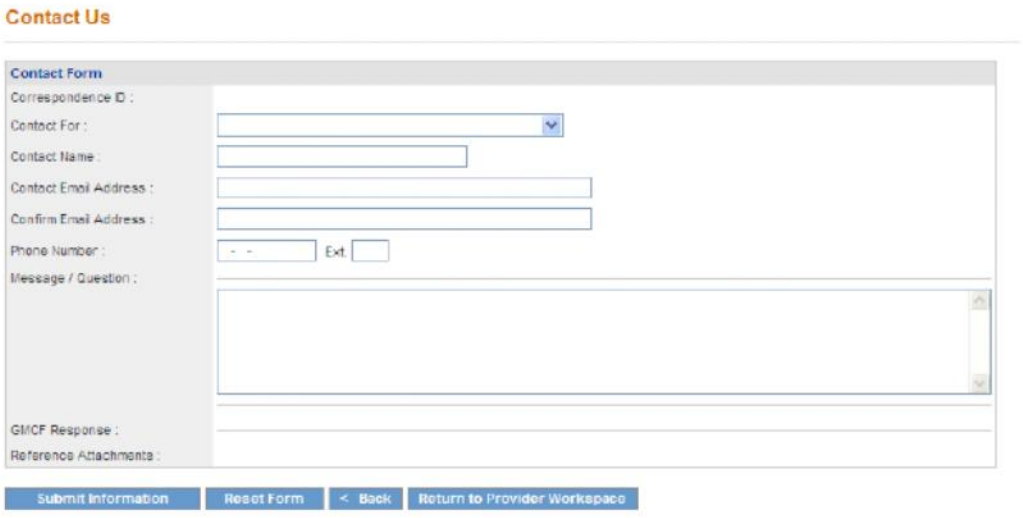


Figure 3

2. Select a 'Contact For' category:



Figure 4

3. If the 'Contact For' category selected is for a prior authorization (PA)/waiver type or for Medical Claims, a box will display for the PA ID or Inquiry Number as shown in the following figures.

'Contact For' is a PA Type

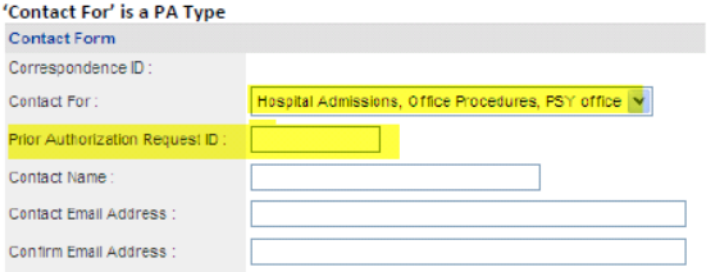


Figure 5

'Contact For' is Medical Claims

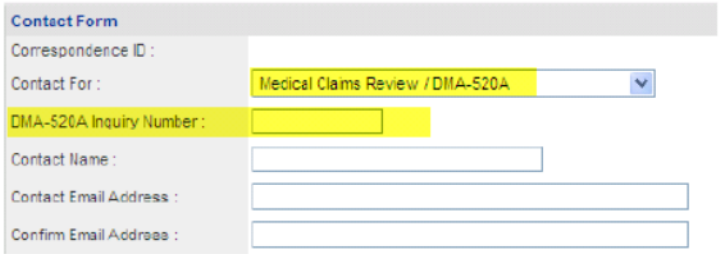


Figure 6

NOTE: If the contact form is opened from the *Review Request* page for a specific PA, or from the Inquiry appeals page for a specific appeal inquiry, then the 'Contact For' type and PA ID or Inquiry ID will be populated by the system. Otherwise, the 'Contact For' type and PA ID or Inquiry Number should be entered.

4. Enter the name of the person submitting the correspondence in the 'Contact Name' box.

5. Enter the contact person's email address in the 'Contact Email Address' box, and then enter again in 'Confirm Email Address' box to verify (required).

6. Enter the contact person's phone number in the 'Phone Number' box.

7. Enter the message or question in the 'Message/Question' box.

   (*GMCF Response and Reference Attachments*: Once GMCF submits a response; this section displays the GMCF response and any documents attached by staff.)

8. Click **Submit Information.** If the submission is successful, a message displays in red below the contact form. The message includes the correspondence ID. Providers can use the correspondence ID to later search for the correspondence and view the GMCF response.

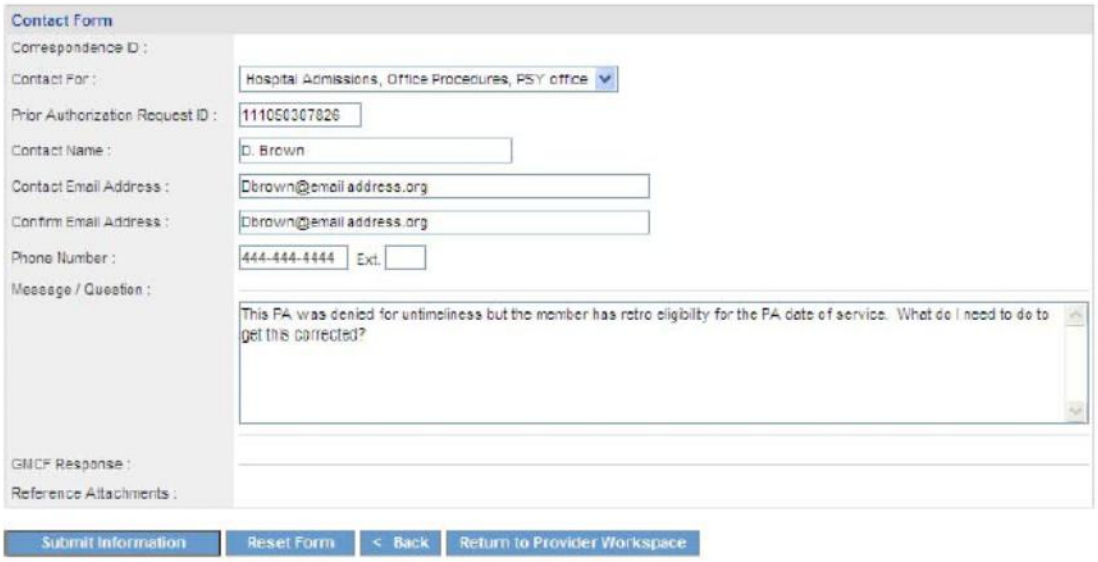
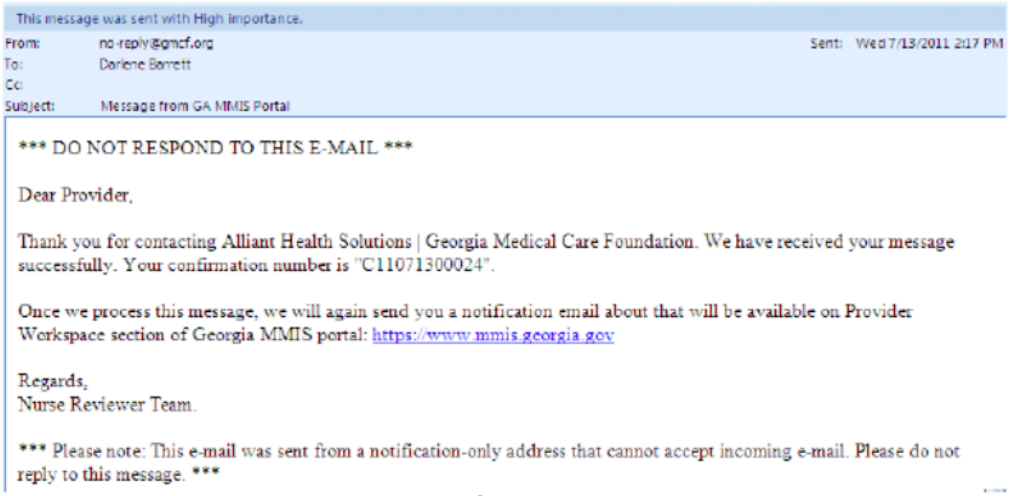


Figure 7

9. The message also indicates that an email has been sent to the contact email address. The email notifies the provider that the question has been received. This email is strictly a notification. Do not respond to the email.

   Here is a sample of the email:



This message was sent with High importance.

From: no-reply@gmcf.org Sent: Wed 7/13/2011 2:17 PM
To: Darlene Barrett
Cc:
Subject: Message from GA MMIS Portal

*** DO NOT RESPOND TO THIS E-MAIL ***

Dear Provider,

Thank you for contacting Alliant Health Solutions | Georgia Medical Care Foundation. We have received your message successfully. Your confirmation number is "C11071300024".

Once we process this message, we will again send you a notification email about that will be available on Provider Workspace section of Georgia MMIS portal: https://www.mmis.georgia.gov

Regards,
Nurse Reviewer Team.

*** Please note: This e-mail was sent from a notification-only address that cannot accept incoming e-mail. Please do not reply to this message. ***

Figure 8

Search for Correspondence and GMCF Responses

Follow this procedure to find correspondences and view GMCF responses:

1. If the correspondence was submitted recently, first check the 'Provider Messages' drop list at the top of the workspace page. Find the 'Correspondence ID'; highlight the ID; and click **Show** to open the contact form.

   OR

2. Click **Search My Correspondence** at the bottom of the workspace to open the *Search Provider Inquiry/Correspondence* page. The provider ID is inserted by the system.

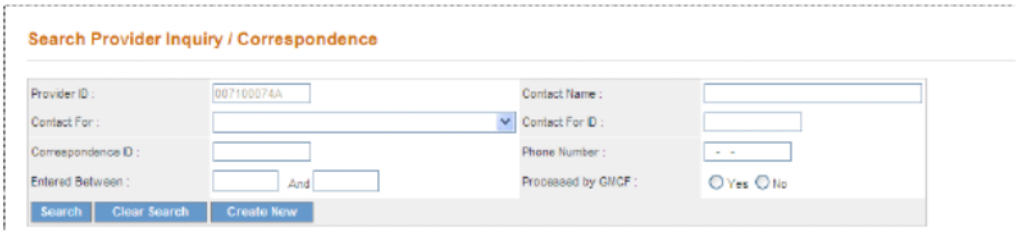


Figure 9

3. Although you may search using any of the search values, the best way is to use the correspondence ID provided in the email notification. Enter the correspondence ID in the 'Correspondence ID' box.

4. Click **Search**. The correspondence will display in the search results table.



Figure 10

5. Click the Corr ID number underlined in blue font to open the contact form and view the GMCF response.

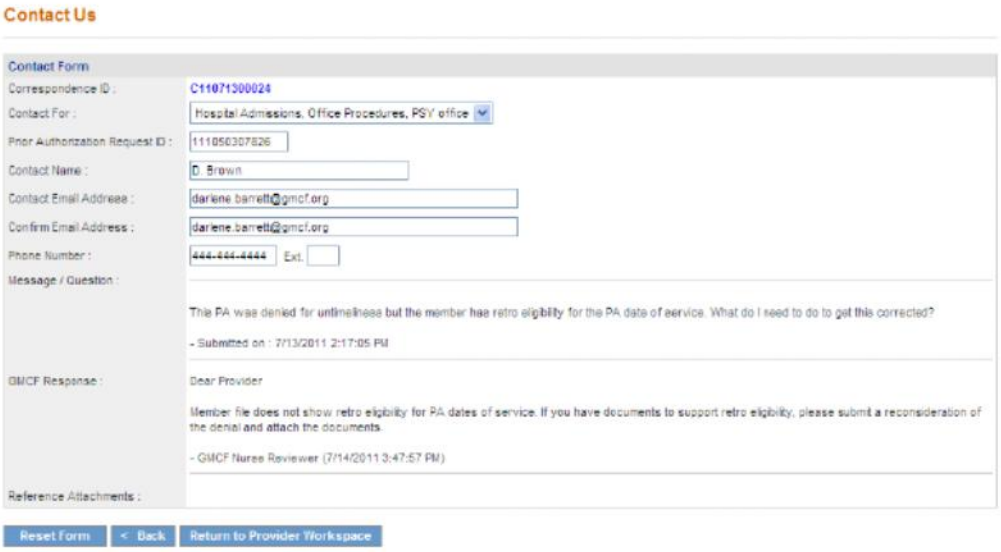
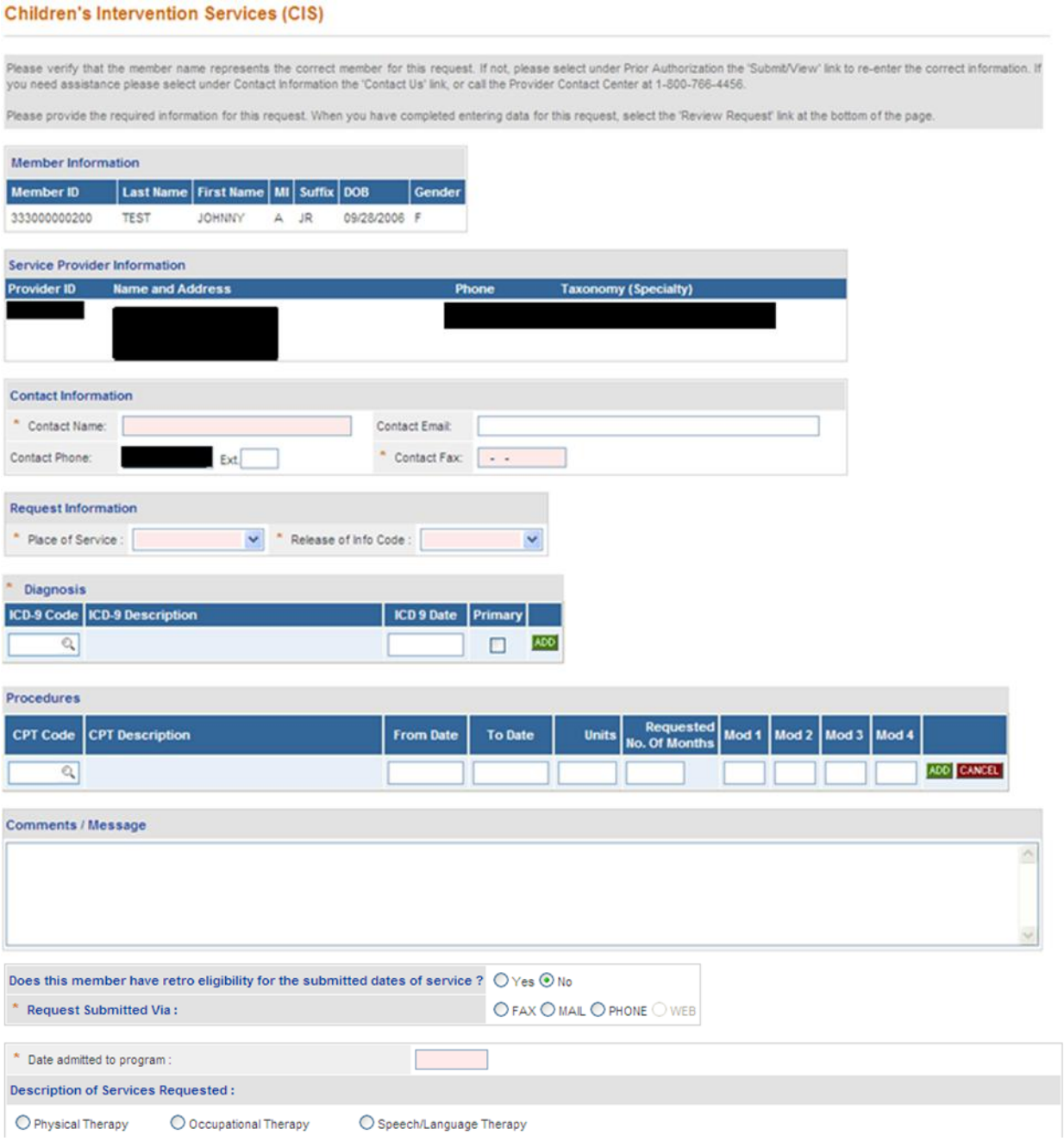


Figure 11

6. If staff attaches documents to the response, the files will be listed next to 'Reference Attachments'. Click the file name to open the attachment.

7. Click **Back** to return to correspondence search, or click **Provider Workspace** to return to the workspace page.

Appendix J
CIS Electronic Prior Authorization Request Form



Children's Intervention Services (CIS)

Please verify that the member name represents the correct member for this request. If not, please select under Prior Authorization the 'Submit/View' link to re-enter the correct information. If you need assistance please select under Contact Information the 'Contact Us' link, or call the Provider Contact Center at 1-800-766-4456.

Please provide the required information for this request. When you have completed entering data for this request, select the 'Review Request' link at the bottom of the page.

Member Information

Member ID	Last Name	First Name	MI	Suffix	DOB	Gender
333000000200	TEST	JOHNNY	A	JR	09/28/2006	F

Service Provider Information

Provider ID	Name and Address	Phone	Taxonomy (Specialty)
[redacted]	[redacted]	[redacted]	

Contact Information

* Contact Name: Contact Email:

Contact Phone: [redacted] Ext: * Contact Fax: - -

Request Information

* Place of Service : * Release of Info Code :

* Diagnosis

ICD-9 Code	ICD-9 Description	ICD 9 Date	Primary	
				ADD

Procedures

CPT Code	CPT Description	From Date	To Date	Units	Requested No. Of Months	Mod 1	Mod 2	Mod 3	Mod 4	
										ADD CANCEL

Comments / Message

Does this member have retro eligibility for the submitted dates of service ? Yes No

* Request Submitted Via : FAX MAIL PHONE WEB

* Date admitted to program :

Description of Services Requested :

Physical Therapy Occupational Therapy Speech/Language Therapy

Justification and Circumstances for Required Services :

Medical necessity and expected outcomes.

Primary Care Physician Name:

Outcomes

A. What would you like to see change as a result of early intervention ?

(Goals and Expectations)

B. What is happening now (Evaluation / Assessment information) ?

(Describe what is taking place at this time relative to the Goals and Expectations)

C. Progress Statement: How will we know we are making progress with this child ?

(What will be different relative to the Goals and Expectations ?)

Is this PA request a continuation from a previous PA?	Yes No	If Yes, Previous PA#:	
Is there a current Individualized Education Plan (IEP)?	Yes No	If Yes, IEP Date:	
		If No, please explain why :	
Is there a current Individualized Family Sevice Plan (IFSP) on file ?	Yes No	Date Signed :	
Is there a current Attestation form attached (child does not have an IEP or IFSP)?	Yes No	If Yes, date Attestation form was signed :	
Is there a current Letter of Medical Necessity, Written Service Plan or Plan of Care?	Yes No	If Yes, LMN/WSP/POC date:	
Are current standardized testing results attached?	Yes No	If Yes, standardized testing date:	
Are there current progress notes attached?	Yes No	If Yes, most current progress note date:	
If No, is this a new patient?	Yes No	If No, please explain why there are no progress notes :	
Is there a valid parental consent on file and the parent has not withdrawn consent ?	Yes No	Date Signed :	
Name of Service Coordinator :		Title :	

Review Request

Appendix K
Instructions for Electronic Attachment of Supporting Documentation to a PA Request

Instructions for Electronic Attachment of Supporting Documentation to a PA Request
(Refer to the Medicaid Medical Management Services, *Provider Workspace* User Manual available on the Georgia web portal for a complete list of all PA instructions.)

Georgia Medical Care Foundation

2.4 Attach Documentation to Requests

2.4.1 Purpose

Some request types require the submission of additional documentation. From the *Provider Workspace*, providers may attach the required information to PA request; and view documents that were previously attached. Electronic attachment of documents is quick and easy and can potentially speed up the review process. Once a document is attached to a request, GMCF staff has immediate access to the attachment and are able to view the information as part of the PA review process.

2.4.1.1 Attachment Guidelines

There are some restrictions/limitations that apply to attachments as follows:

- Documents may be attached to a PA request when the request is submitted, or to existing PA requests that are pending and not referred. Attachments may also be made via the *Change Request* or *Reconsideration Request* processes
- **Documents may not be attached to the following PA/review types unless the attachment is part of a change request or reconsideration request**: Hospital Outpatient Therapy; Medications PA (Physician and Facility); Radiology PA (Physician and Facility); Additional Psychiatric/Psychological Services; Additional Office Visits; and Swingbed requests. Additional documentation is not required for these request types; and all pertinent clinical information and justification for services should be entered on the request forms.
- In order to attach a document to a request, the document must be saved to one of the provider's system drives.
- The following file types are acceptable for attachments: TXT, DOC, DOCX, PDF, TIF, TIFF, JPG, JPEG, and JPE.
- **Do not** include the following symbols as part of the file name: \, /, #, <, >, ', ".
- The name of the file to be attached cannot have the same name of a file that is already attached.
- The file size for an individual attachment MUST be less than 20 MB in size; so if a file is especially large, divide the file into two files.
- Multiple documents may be attached to one PA request. However, the documentation that is attached should only relate to the member associated with the PA, and not relate to any other members.

2.4.2 Attachment Instructions

Follow these instructions to attach documents to existing requests or to requests upon initial submission.

1. **To attach a file to an existing request:**

   - Open the *Provider Workspace*.
   - Click **Attach Documentation to Existing Requests** OR click **Search for Authorization Requests and Edit Requests** to open the *PA Search* page.
   - Search for and open the PA request to which a document or documents are to be attached. If files have already been attached to the request, the files will display in the **Attached Files** table.
   - If the PA request meets attachment criteria, the **Attach File** link will be available.

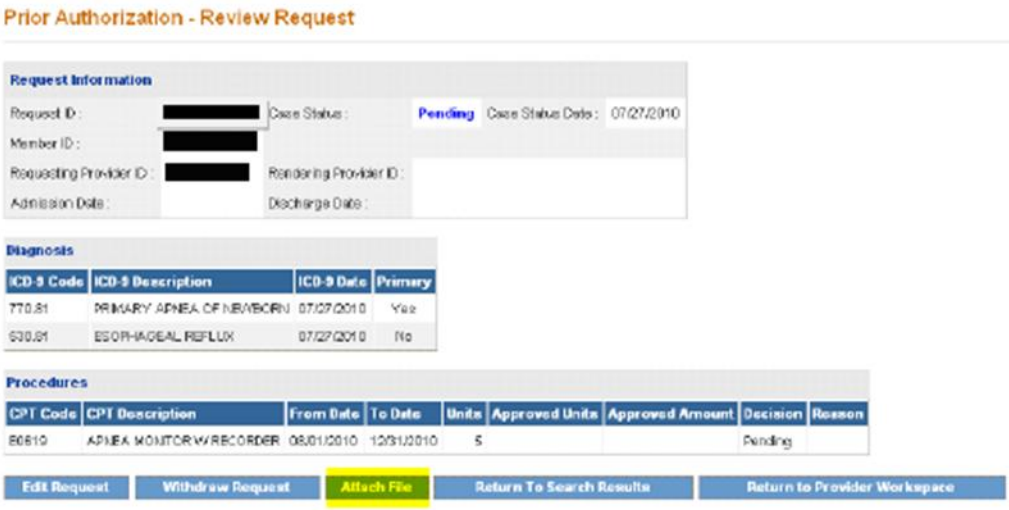


Figure 37 Attach File Link

- Click attach file, and on the page that displays, go to the **Create an Attachment** section.

2. **To attach a file when submitting the request:**

   - Complete the PA request and click **Submit Request**.
   - On the page that displays after clicking **Submit Request**, go to the **Create Attachment** section.

3. **Create an Attachment:**

   - Under create an attachment, click **Browse** to open the file directory.



Figure 38 Create an Attachment

   - Find the file that is to be attached. Select the file by double clicking the file, or highlight the file and then click **Open**.

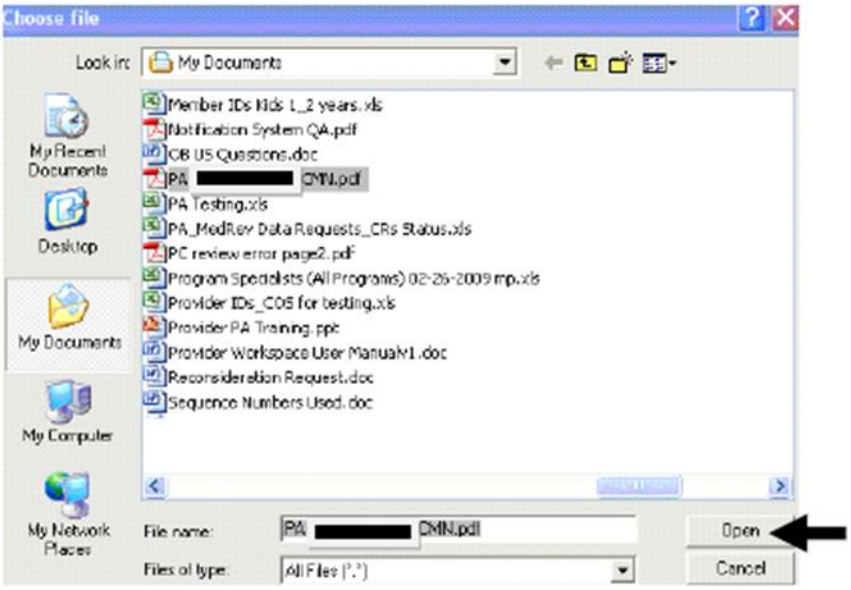


Figure 39 Find and Select File

- Once the file is selected, it will display in the box next to browse.

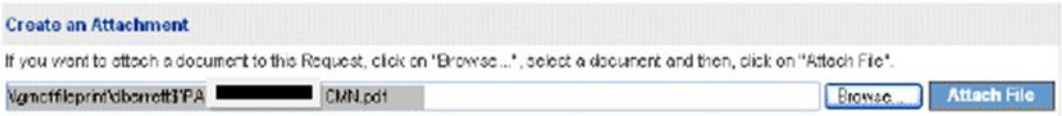


Figure 40 File Name Inserted

- To attach the selected document, click the **Attach File** button. If the file is uploaded, the 'File uploaded successfully' message displays, and a link to the attachment will display in the **Attached Files** table.

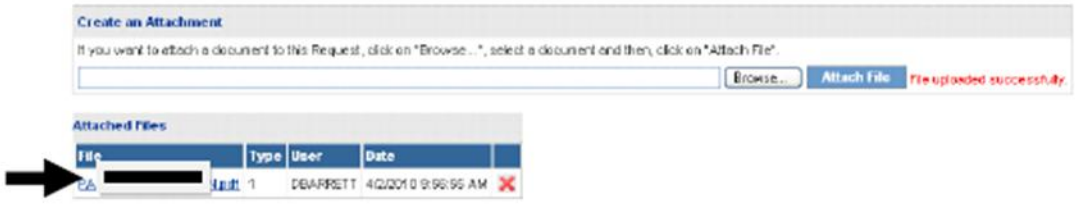


Figure 41 File Uploaded #1

4. **Associate an Attachment type with a file:**

For some request types and procedure codes, the 'type' of each required document displays next to a checkbox. The purpose of the checkbox is to associate the actual file attached with the specific additional information required by policy. Figure 42 shows the checkboxes for a Durable Medical Equipment request for oxygen services. Each procedure code on this request requires a *Certificate of Medical Necessity*; and procedures, E0431 and E1390, also require a copy of testing results.

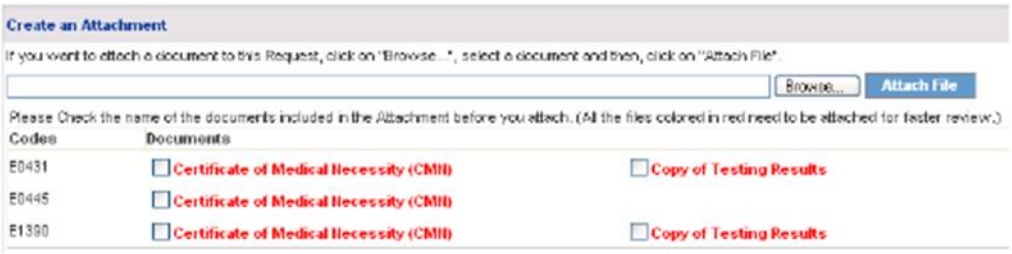


Figure 42 Document Checkboxes

5. To attach a file or files to a PA when checkboxes for documents types are available, first determine if one file that includes all the required information is to be attached, or individual files are to be attached.

One Attachment for all Checkboxes:

- If **one file is to be attached** and that file includes all the required information, click all the checkboxes and then attach the one file.
- If the attachment is successful, a file upload message displays; the attached file is added to the **Attached File**s table; and the file is associated with each procedure code and document type.

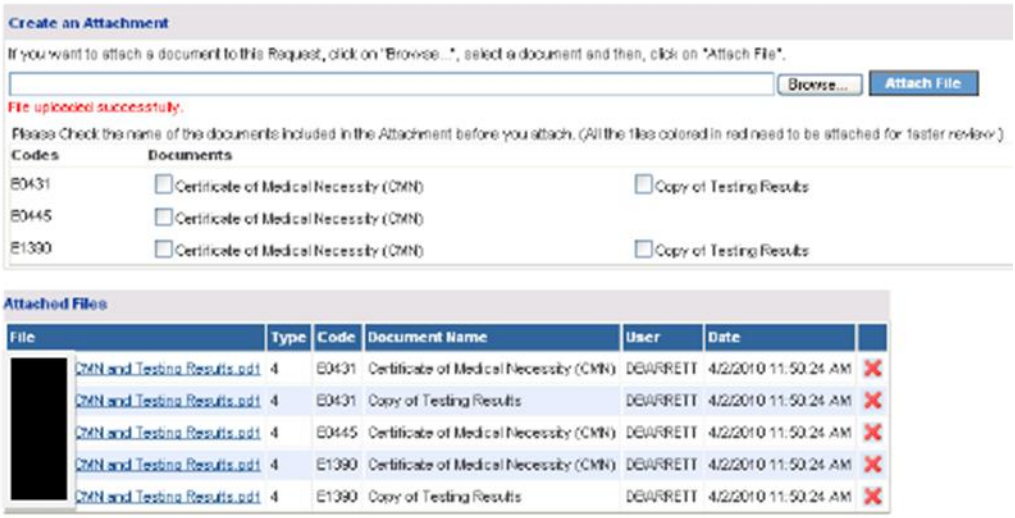


Figure 43 One File for All Checkboxes

One Attachment for Each Checkbox:

- When each file to be attached relates to a different required document, first click the applicable checkbox and then find/attach the file related to the checkbox selected.



Figure 44 One File per Checkbox

- To attach additional files, repeat the same process. Select the check box or checkboxes and then attach the file. The checkbox that was not selected will still display in red, indicating that the required document still needs to be submitted.



Figure 45 File Uploaded #2

Appendix L
How to Submit a Reconsideration Request

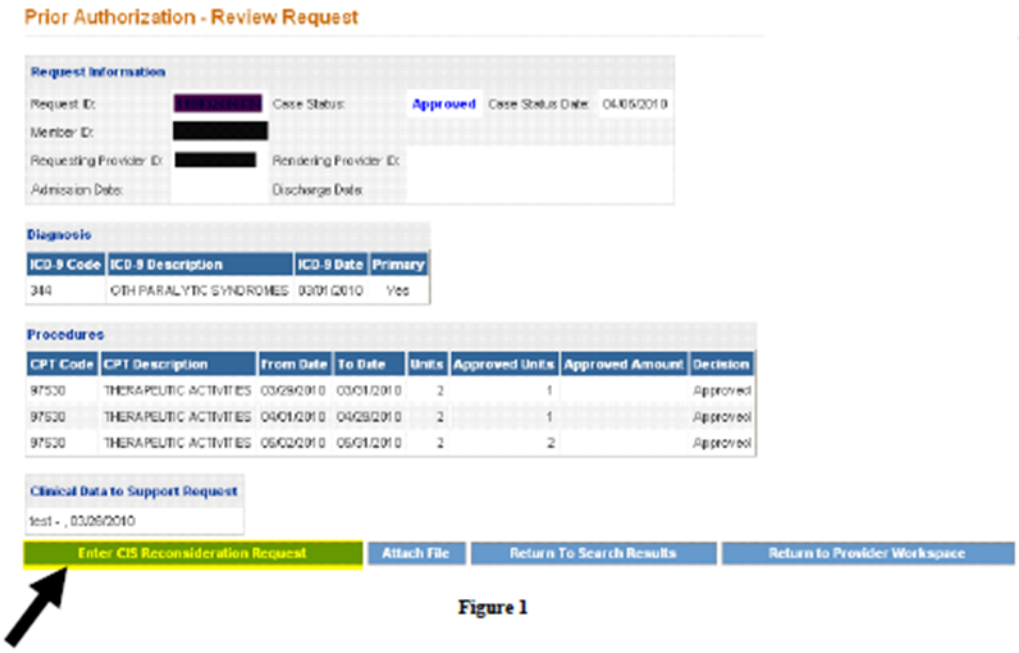


Figure 1

3. Click **Enter CIS Reconsideration Request** at the bottom of the page to open the *CIS Reconsideration Request Information* page.

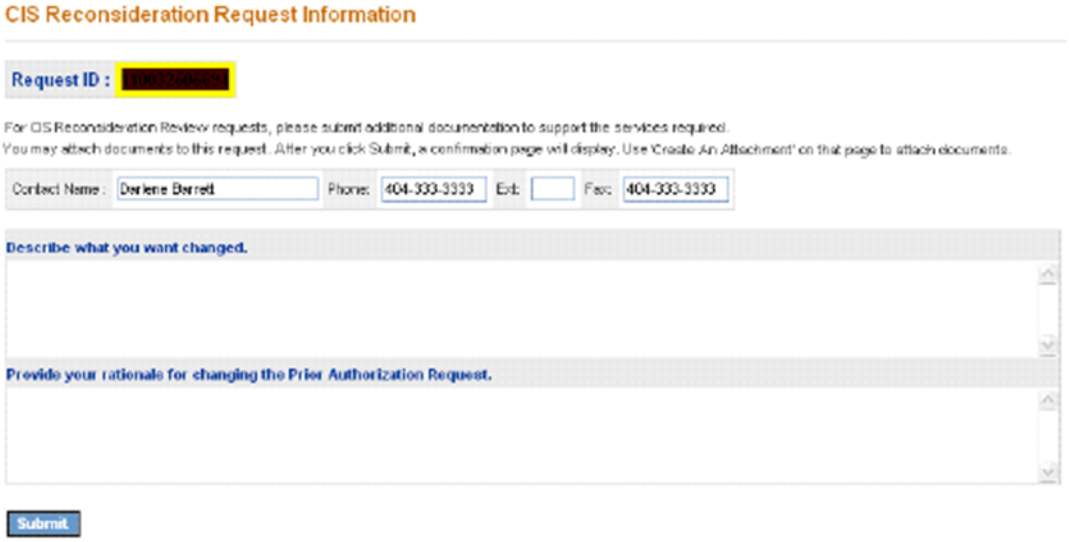


Figure 2

4. The contact information for the requesting provider is inserted by the system. Verify that the information is correct. If not correct, edit the information. This is important since the contact name/fax number is used for the faxed notification.

5. **What you want changed**: In the first text box, clearly describe what you want changed as a result of the reconsideration review: indicate the codes; dates of service and the units required.

6. **Rationale**: In the second text box, provide additional clinical information that supports the request for reconsideration review and specifically addresses the need for the services requested.

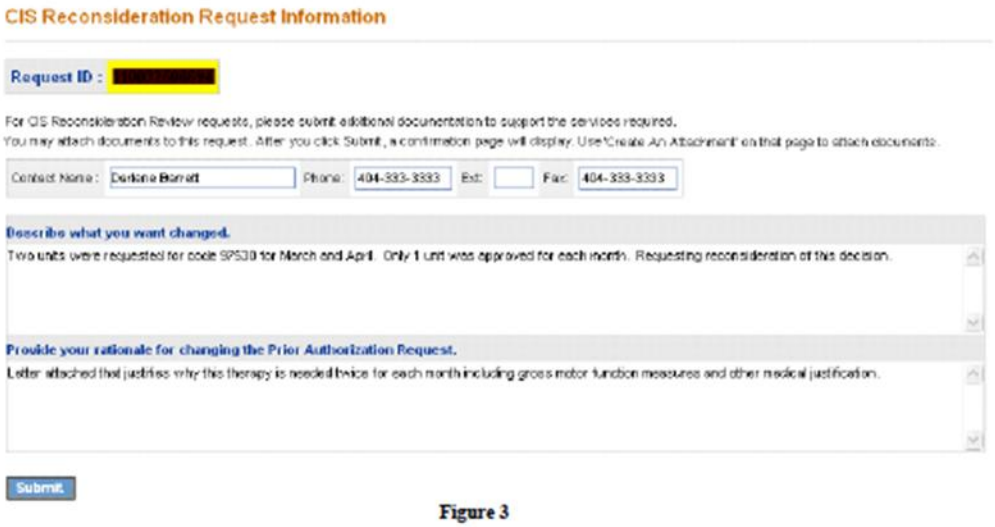


Figure 3

7. Click **Submit**. If the submission is successful, a page displays confirming that the reconsideration has been entered successfully. Additional supporting documentation may be attached at this point.

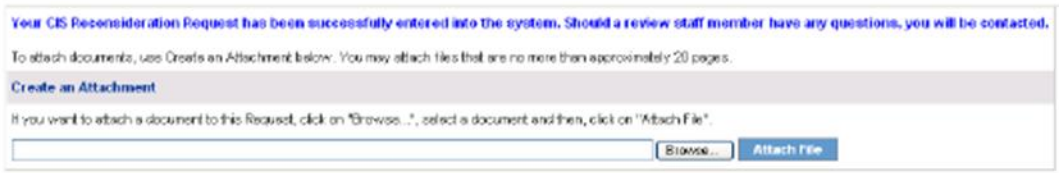


Figure 4

8. Click **Browse** to find the file to be attached.

9. To select a file, highlight the file and click **Open,** or double click the file.

10. The file name will appear in the box next to browse.

11. Click **Attach File**. If the file is uploaded, the 'File uploaded successfully' message displays, and a link to the attachment will display in the **Attached File**s table.

Appendix M
How to Submit a PA Change Request

2.5 Submit/View PA Change Requests

2.5.1 Purpose

This functionality allows providers to find and view change requests previously submitted, and submit new change requests. Once staff processes the change request, an automatic fax notification is sent to the contact name and fax number entered on the change request. The notification indicates that the change request was granted or was not granted. If not granted, an explanation is provided.

2.5.1.1 Change Request Guidelines

Change requests are permitted for all review types except ICWP DMA-6 and GAPP DMA-6A. In general, change requests must be submitted within 30 calendar days of the PA request date or date of service whichever is greater. For most PA types, only three (3) change requests per PA may be submitted. However, there are exceptions to these rules based on review type as noted below:

- Children's Intervention Services PAs: There are no restrictions to the number of change requests per PA; or when change requests may be submitted. Change requests may be submitted at any time as long as the case has not received a Final Tech Denial. In addition, change requests must met the following criteria:
  - A significant change in condition must be documented by submission of an updated treatment plan signed by the physician and therapist.
  - If a change in modality is requested, the units to be withdrawn (for substitution) must be specified.
  - Change requests may be submitted for PAs for which reconsideration has not been requested.

- Durable Medical Equipment PAs: There is no time restriction for submission of change requests for DME PAs.

- Medications Prior Authorizations: There is no time restriction for submission of change requests for Medications PAs.

- PASRR: Change requests may be submitted for a PASRR Level I if the Level I decision is pending (not referred for OBRA - Level II).

2.5.2 Change Request Submission Instructions

Follow these instructions to enter a change request:

1. From the *Provider Workspace*, select **Submit/View PA Change Requests**.

2. Search for the PA request and open the *Review Request* page. **Note:** When the *Review Request* page is opened for a request which does not meet the change request criteria, a message will appear at the top of the page indicating that a change request cannot be entered.



Figure 46 Enter Change Request

3. Click **Enter Change Request** at the bottom of the page to open the *Change Request Information* page.

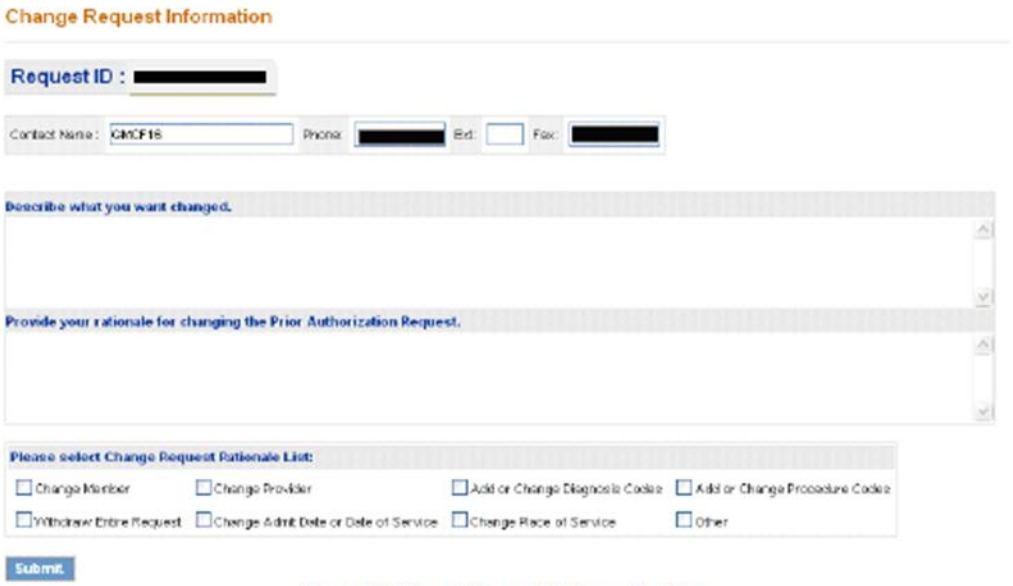


Figure 47 Change Request Information Page

4. On the *Change Request Information* page, the provider's contact person name, phone and fax number are inserted by the system. If this information is not correct, change the information to ensure that the change request notification is sent to the correct contact person.

5. **Describe the change needed**. In the textbox provided, describe specifically what needs to be changed.

6. **Rationale for change**. In the textbox provided, provide justification for the requested change.

7. Next, select one or more checkboxes from the 'Rationale List' corresponding to the change(s) requested. If none apply to the change requested, select 'Other'.

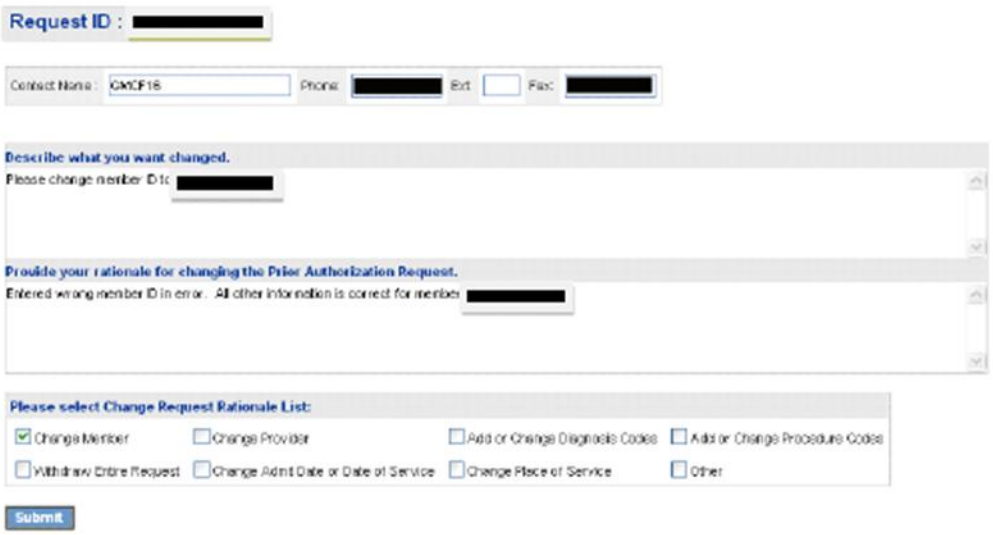


Figure 48 Completed Change Request

8. Click **Submit** to submit the request. If the submission is successful, a page displays confirming that the change request has been entered successfully. Additional supporting documentation may be attached at this point. Follow the same attachment procedures as described in **Section 2.4.2**.

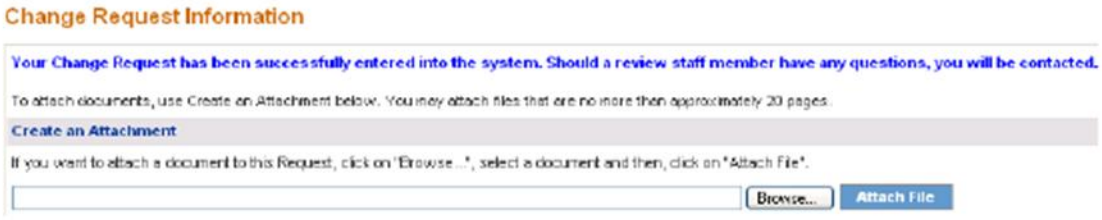


Figure 49 Change Request Submitted

Appendix N
Attestation Form (IEP/IFSP)

Provider Attestation Regarding IEP/IFSP for Outpatient Therapy Services

_____

Member Name

_____

Member ID Number

I have conducted a reasonable review of the facts regarding the therapy services recommended for the above referenced member, including a discussion with the parent regarding other services that are currently provided. Based upon my review and attestation from the parent, the member does not have an existing Individualized Educational Plan (IEP) or Individualized Family Service Plan (IFSP).

I understand that under my provider participation agreement, applicable regulators including the Centers for Medicare and Medicaid Services, and the Georgia Department of Community Health or their representatives may inspect and evaluate my records related to members and the provision of and payment for services to audit compliance with this review requirement, and other contractual requirements and federal and state laws and regulations.

NOTE: If the member does have an existing IEP or IFSP, it should be submitted, along with the request for treatment. Providers must date this form as of the date of signature.

_____
Provider Signature

_____
Print Name

_____
Title

_____
Provider Medicaid Identification Number

_____
Date

_____
Contact Phone Number

_____
Contact Fax Number

Appendix O
How to Check the Status of your Prior Authorization

2.3.2 PA Search Instructions

Follow these instructions to search for requests:

1. Click **Search for Authorization Requests and Edit Requests** from the *Provider Workspace* to open the *Prior Authorization Request Search* page. The Provider ID, associated with the web portal login credentials, is populated by the system.

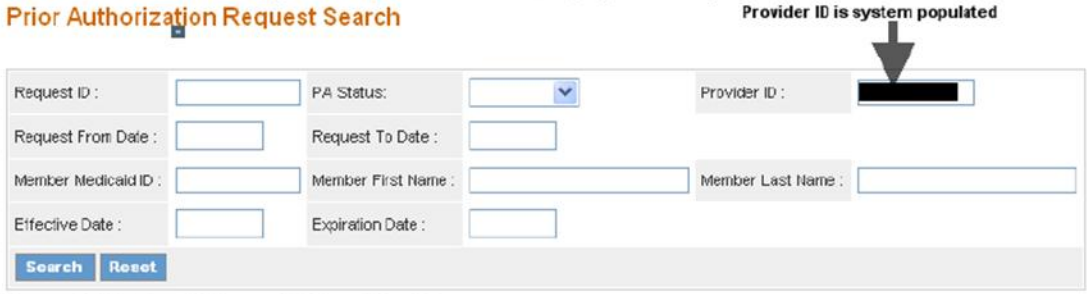


Figure 28 PA Search Page with Provider ID

2. Enter search parameters and click **Search** to activate the search process.
In the following figure, the search parameters are 'Provider ID' and 'Request ID' (blacked out), and, as a result, the search returns one request.

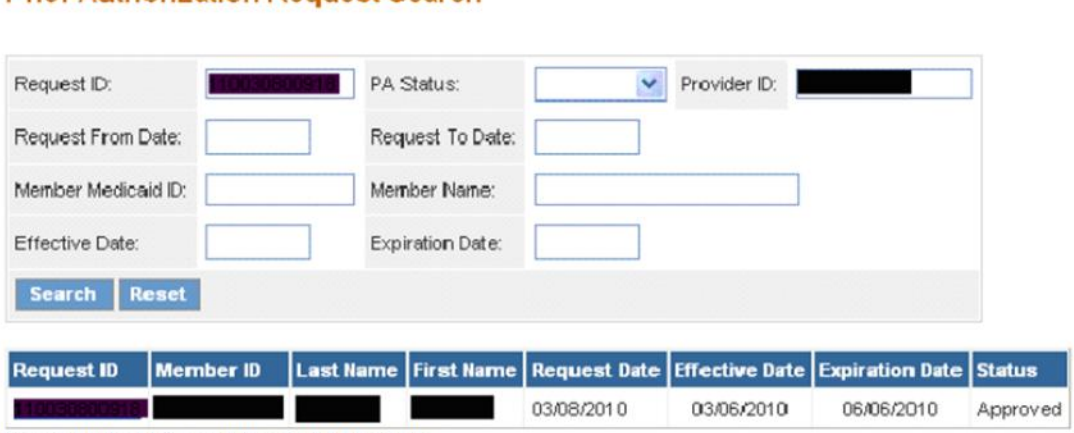


Figure 29 Provider and Request ID Search

3. When the request ID is not used, the search may return multiple results depending on the search criteria used. The search parameters in the following example are 'Provider ID' and 'Request From Date'.

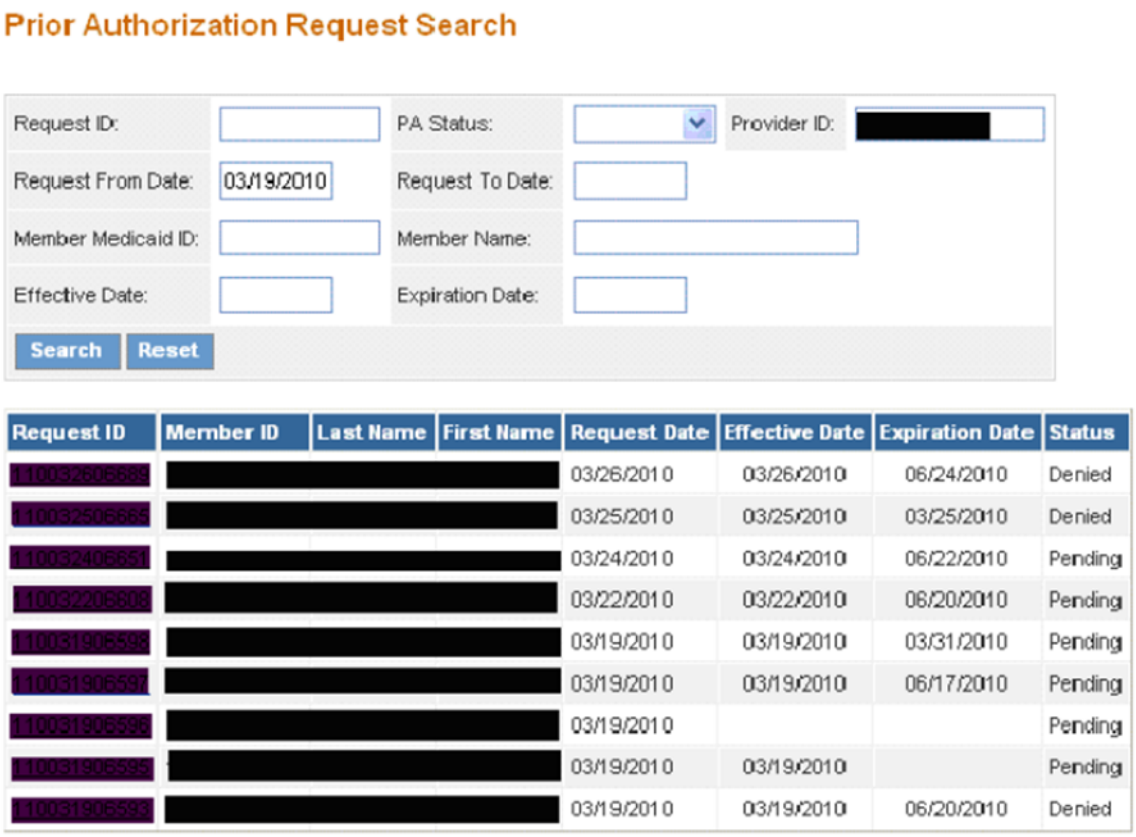


Figure 30 Multiple Search Results

4. To view one of the requests in the search results, click the **Request ID** (in the screen shot above, the request IDs have been blacked out). When a request ID is selected, the *Review Request* 'summary' and decision page displays. This page provides a quick overview of the request information and displays the case status and procedure decision status.

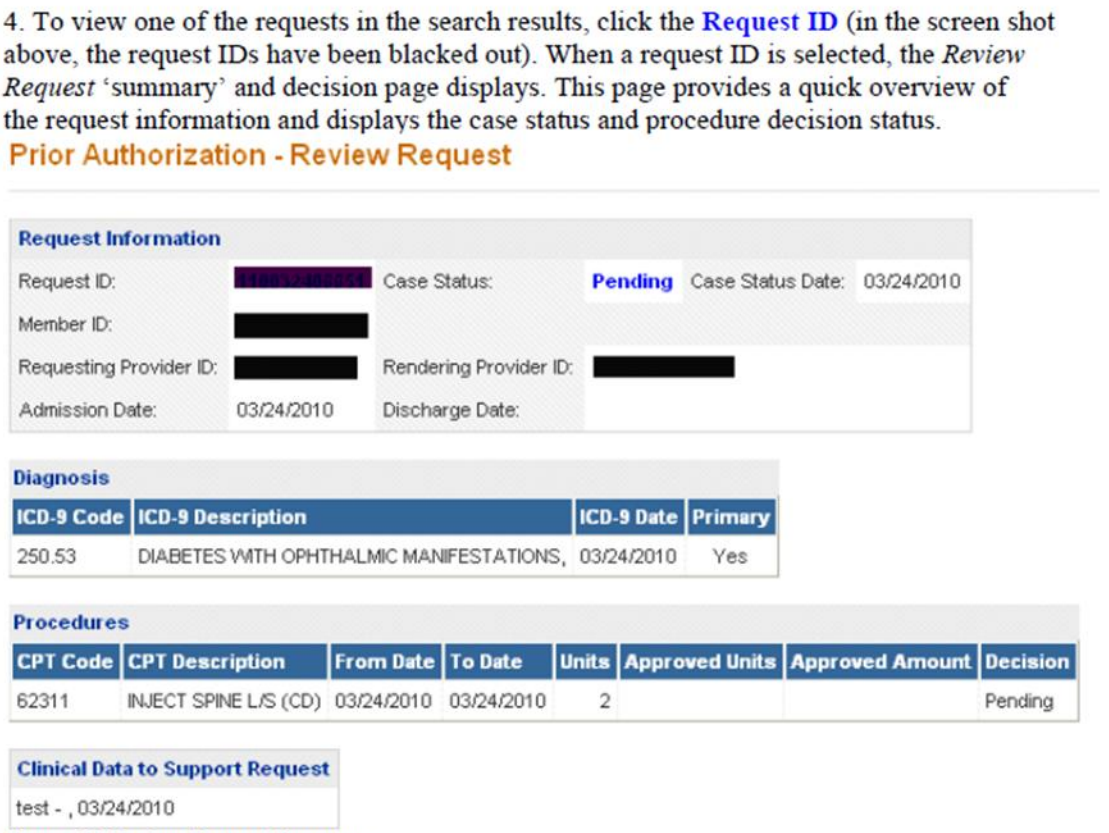


Figure 31 Review Request Summary

5. To review all the information initially entered on the request; click the **Request ID** in the **Request Information** section.

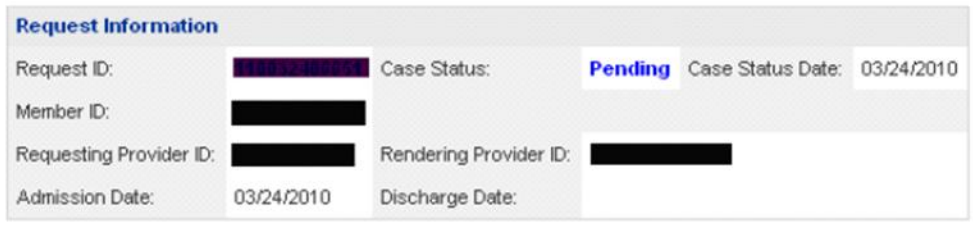


Figure 32 Review Detail PA Information

6. When the request ID is selected, the *Review Request* 'detail' page opens and displays all the information entered on the request. Click **Back** to return to the summary and decision page.

7. If the PA selected from search results is denied, the denial reason code and specific denial reasons display on the summary and decision page. **If the PA has procedure codes, hold the mouse pointer over the denial reason code at the end of a procedure line to display the specific denial rationale for that procedure line.**



Figure 33 View Denial Rationale

Taken from the Medicaid Medical Management Services, *Provider Workspace,* User Manual Version 1.7.