Telehealth Guidance

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAID
April 1, 2024

Policy Revisions Record

Telehealth Guidance 2024

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
January 1, 2019	Page 6	Clarification verbiage added in Coverage section in # 1.	M	N/A
January 1, 2018		Revised CPT Code description	M	N/A
Oct. 1, 2018		Added Audiology Codes and language related to Behavioral Health Services (Telemental Health)	A	N/A
April 1, 2019		Added other forms of Telehealth and respective regulations and codes pertaining thereof	A	N/A
July 1, 2019		Added Telehealth/Telehealth services for Autism Spectrum Disorders, Physicians,	A	
July 1, 2019		Online Prescribing	D	
July 1, 2019		Physician Services	A	
July 1, 2019		Community Behavioral Health and Rehabilitation	M	
January 1, 2020		Addition of Asynchronous service definition	M	Y Article 1 of Chapter 24 of Title 33 O.C.G.A.
January 1, 2020		License to practice medicine obtained through the Inter-state Compact will be issued by the State's Medical Composite Board.	A	Y Article 1 of Chapter 24 of Title 33 O.C.G.A.
April 1, 2020		Clarification of Telemedicine Codes as it relates to Public Health Emergency	A	

January 1, 2021		Change document to reflect new fiscal intermediary from DXE Technology to Gainwell Technologies	M	
July 1 2021		Deleted WellCare from Telemedicine Guidance	D	
July 1 2021		Added GA Families Appendix	A	
January 1 2022		Deleted Attestation information from page 15	D	
January 1 2022		Added additional language under Billing and Payment for professional services furnished via telehealth	A	
April 1 2022		Deleted dental code D9999 and Added dental code D0140	D	
April 1 2022		Added POS 10	A	
January 1 2023		Added CPT Modifier 93	A	
July 1 2023		Updates to Community Behavioral Health and Rehabilitation Services Section	M	

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Policy Revisions Record of Telehealth Guidance

Program Overview

The Department of Community Health (DCH) Telehealth and Telehealth policies are slated to improve and increase access and efficiency to health care services by enabling medical services to be delivered via telehealth methods in Georgia. Telehealth services are not an expansion of Georgia Medicaid covered services but, an option for the delivery of covered services. Telehealth will allow DCH to meet the needs of members and providers, while complying with all applicable Federal and State statutes and regulations. The quality of health care services delivered must be maintained regardless of the mode of delivery.

Telehealth is the use of medical information exchange from one site to another via electronic communications to improve patient's health status. It is the use of two-way, real time interactive communication equipment to exchange the patient's information from one site to another via an electronic communication system. This includes audio and video communications equipment. Closely associated with telehealth is the term "telehealth," which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Telehealth is the use of telecommunications technologies for clinical care (telehealth), patient teachings and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.

The intent of our telehealth services policy is to improve access to essential healthcare services that may not otherwise be available for Medicaid eligible members. Telehealth is not a separate medical specialty. Products and services related to telehealth are often part of a larger investment by health care institutions in either information technology or the delivery of clinical care. When an enrolled provider determines that medical care can be provided via electronic communication with no loss in the quality or efficacy of the member's care, telehealth services can be performed.

An interactive telecommunications system is required as a condition of payment. The originating site's system, at a minimum, must have the capability of allowing the distant site provider to visually examine the patient's entire body including body orifices (such as ear canals, nose, and throat). Depending upon an enrolled provider's specialty and scope of practice, the distant provider should also have the capability to hear heart tones and lung sounds clearly (using stethoscope) if medically necessary and currently within the provider's scope of practice. The telecommunication system must be secure and adequate to protect the confidentiality and integrity of the information transmitted.

Medicaid covered services are provided via telehealth for eligible members when the service is medically necessary, the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the member's needs

Service Definitions

Asynchronous or "Store and Forward": Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous communication does not include telephone calls, images transmitted via fax machines and text messages without visualization of the patient (electronic mail)

The sending of x-rays, computerized tomography scans, or magnetic resonance images are common store and forward applications. The original image may be recorded or forwarded in digital or analog format and may include video 'clips' such as ultrasound examinations, where the series of images that are sent may show full motion when reviewed at the receiving location.

Distant Site: The telehealth site where the practitioner/provider is legally allowed to practice in Georgia while providing health care services.

Practitioners at the distant site may furnish and receive payment for covered telehealth services provided that such services are acting within the scope of practice of such health care practitioner or professional, within the guidelines of applicable Medicaid policy for service rendered and in accordance with the provisions of the Georgia State Code Section 43-34-31.

Originating Site: For members receiving Telehealth or Telehealth services the originating site is the location where the member will receive services through a telecommunications system.

Telehealth is a broad definition of remote healthcare that does not always involve clinical services. Telehealth can be used in telecommunications technologies for patient education, home health, professional health education and training, administrative and program planning, and other diverse aspects of a health care delivery system.

Telehealth involves the use of two-way, real time interactive communication equipment to exchange medical/clinical information between a healthcare practitioner and the member from one site to another via a secure electronic communication system. This includes audio and video communications equipment designed to facilitate delivery of healthcare services in a face- to-face interactive, though distant, engagement.

TeleMental Health is a term defined by Ga. Comp. R. & Regs. R. 135-11-01. and is applicable only to Licensed Social Workers, Professional Counselors and Marriage & Family Therapists when either 1) practicing telehealth as defined above, or 2) providing telephonic intervention when allowable via DCH/DBHDD guidelines). Per this rule and regulation, there are specific practice guidelines and mandatory training pertaining to what is identified as TeleMental Health. Providers shall adhere to these rules and regulations when TeleMental Health is provided by one of these named practitioners.

Synchronous services that are occurring in "real-time", as demonstrable in two-way consult between a member in concert with their practitioner/provider and another practitioner/provider at a distant.

Security and Confidentiality:

In compliance with all applicable Federal and State statutes and regulations, providers of the CBHRS program are permitted to incorporate usage of Telehealth for certain services they provide. The goal for enabling telehealth methods is to improve and increase access and efficiency of behavioral health service delivery to Georgia Medicaid members. Appropriate use of Telehealth shall always consider its secure and confidential use. Special considerations in the use of electronic-facilitated treatment must include informed consent of the individual served, authorization through the process of Individualized Recovery Plans, educational components in assessment and service delivery which indicates ongoing agreement with the treatment method and under what circumstances electronic communications may and may not be used.

Telehealth Services must be HIPAA compliant and in accordance with Safety and Privacy regulations. All transactions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmitted information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver. All interactive video telecommunications must comply with HIPAA patient privacy regulations at the site where the member is located, the site where the consulting provider is located and in the transmission process. All communications must be on a secure network in compliance with HIPAA Encryption (Encryption is the conversion of plaintext into cipher text using a key to make the conversion) and Redundancy requirements.

Telehealth- Interstate Medical Licensure Compact

DCH is committed to providing all our stakeholders with the safest environment possible as well as access to qualified healthcare providers. The *Interstate Medical Licensure Compact (ILMC)* offers an expedited licensing process for physicians that are interested in practicing medicine in the state of Georgia yet are licensed within another state. The Compact was created with the goal of expanding access to health care, especially to those in rural and underserved areas of the state, and to facilitate the use of telehealth technologies in the delivery of health care.

Licensure Requirements

The Georgia Composite Medical Board is authorized to administer the compact in this state. Under the compact, physicians must meet certain requirements, including: possess a full and unrestricted license to practice medicine in a Compact state; possess specialty certification or be in possession of a time unlimited specialty certificate; have no discipline on any state medical license; have no discipline related to controlled substance; not be under investigation by any licensing or law enforcement agency; have passed the USMLE or COMLEX within three attempts; and have successfully completed a graduate medical education (GME) program.

License to practice medicine obtained through this compact will be issued by the State's Medical Composite Board.

A physician will apply for expedited licensure by designating a member state as the state of principal licensure and select Georgia to which the medical license is desired. The state of principal licensure will then verify the physician's eligibility and provide credential information to the Interstate Commission. The Commission will then collect the applicable fees and transmit the physician's information and licensure fees to the additional states. Upon receipt in the additional states, the physician will be granted a license.

Additional information will be housed with the Georgia Composite Medical Board.

Billing and payment for professional services furnished via telehealth

Submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service. The GT modifier is required as applicable, and/or the use of either POS 02 or POS 10. POS 02 will indicate Telehealth services that were utilized at a location other than at the patient's home. The GQ modifier is still required as applicable. By coding and billing with the covered telehealth procedure code, you are certifying that the member was present at an eligible originating site when you furnished the telehealth service. Telehealth services provided by the Distant Site providers must also bill with the appropriate CPT and/or HCPS code with the POS code 02 for timely payment. POS 10 will indicate Telehealth services were provided in the patient's home.

Providers may not bill for services or charge a fee for missed appointments. Cost associated with the use of technology or data transmission are not covered under Medicaid and cannot be charged to the member.

CPT modifier ''93'' can be appended to claim lines, as appropriate, for services furnished using audio-only communications technology.

Billing and payment for the originating site facility fee

Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014 with a payment of $20.52. Hospitals are eligible to receive reimbursement for a facility fee for telehealth when operating as the originating site. Claims must be submitted with revenue code 780 (telehealth) and type of bill 131. There is no separate reimbursement for telehealth services when performed during an inpatient stay, outpatient clinic or emergency room visit or outpatient surgery, as these are all-inclusive payments.

Coverage Requirements

To provide coverage of medically necessary services provided using telecommunication systems the following requirements must be met:

1. The referring provider must be enrolled in GA Medicaid and comply with policy and procedures as outlined in applicable Georgia Medicaid manuals.

2. The member must be present and participating in the visit.

3. The referring health care practitioner must obtain written consent from the eligible Georgia Medicaid member prior to rendering service. The consent must state that the member agrees to participate in the telehealth-based service. Copies of this form (refer to Appendix A) should be in the medical record of both the originating and distant site providers. The consent form must include a description of the risks, benefits and consequences of telehealth and be

included in the member's medical record. Providers may utilize a consent form other than the one attached to this guide; however, it must, at a minimum, contain the same requirements, standards and information listed on the member consent form in Appendix A.

4. The referring provider must be the member's attending physician, practitioner, or provider in charge of their care. The request must be documented in the member's record. The physician or practitioner providing the referral must provide pertinent medical information and/or records to the distant site provider via a secure transmission. Notwithstanding the foregoing, referrals for evaluation of physical, mental, or sexual abuse may be made by an appropriate agency or group, including but not limited to, law enforcement or social services agencies

5. The referring provider must be requesting the opinion, advice, or service of another provider for a specific medical problem, illness or injury.

6. The consulting provider must be an enrolled provider in Medicaid in the state of Georgia and must document all findings and recommendations in writing, in the format normally used for recording services in the member's medical records. Both the originating site and distant site must document and maintain the member's medical records. The report from the distant site provider may be faxed to the originating provider. Additionally, all electronic documentation must be available for review by the Georgia Department of Community Health, Medicaid Division, Division of Program Integrity, and all other applicable divisions of the department.

7. All telehealth activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA): Standards for Privacy of individual identifiable health information and all other applicable state and federal laws and regulations.

8. All services that require prior approval must be prior approved. The provider at the distant site must obtain prior approval when services require prior approval.

9. If the member is a minor child, a parent/guardian must present the child for telehealth services and sign the consent form unless otherwise exempted by state or federal law. The parent/guardian need not attend the telehealth session unless attendance is therapeutically appropriate.

10. The member retains the right to withdraw at any time.

11. All existing confidentiality protections and HIPAA guidelines apply.

12. The member has access to all transmitted medical information, except for live interactive video (if there is no stored data of the encounter).

13. There will be no dissemination of any member images or information to other entities without written consent from the member.

Documentation Requirements

The appropriate medical documentation must appear in the member's medical record to justify medical necessity for the level of service reimbursed. The record must reflect the level of service billed and must be legible. Documentation must be maintained at both the originating and distant sites to substantiate the services provided. Services must be clearly and separately identified in the member's medical record. Documentation must indicate the services were rendered via telehealth and the location of the originating and distant sites. All other Georgia Medicaid documentation guidelines apply to services rendered via telehealth. Examples include but are not limited to: chart notes, start and stop times, date of visits, provider's signature, service provider's credentials, signed member consent form, and physician findings, diagnosis, illness, prescribed treatment, and so forth.

Covered Telehealth Service Delivery Modalities

- Interactive audio and video telecommunications must be used, permitting real time communications between the distant site provider or practitioner and the member.
- All transactions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information.
- Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.
- All interactive video telecommunications must comply with HIPAA patient privacy regulations at the site where the member is located, the site where the consulting provider is located and in the transmission process.
- All communications must be on a secure network in compliance with HIPAA Encryption and Redundancy requirements. Encryption is the conversion of plaintext into cipher text using a key to make the conversion**.**

Non-covered Services Modalities:

- Telephone conversations.
- Electronic mail messages.
- Facsimile.
- Video cell phone interactions.
- The cost of telehealth equipment and transmission.
- Failed or unsuccessful transmissions.
- Services rendered via a webcam or internet-based technologies (i.e., Skype, Tango, etc.) that are not part of a secured network and do not meet HIPAA encryption compliance.

Authorizations

This guidance is written in accordance with the following Federal and State rules and regulations in addition to current specific Department policy manuals.

- Georgia Secretary of States Rules and Regulations 135-11-01 TeleMental Health
- State Plan Amendment 15-0008 Telehealth and Telehealth Services
- State Plan Amendment 15-0012 Transportation Facility Sites
- State Plan Amendment, 17-0002 Community Behavioral Health Rehabilitation Services
- Part II Policies and Procedures for Federally Qualified Health Center Services and Rural Health Clinic Services Section 970
- Part II Policies and Procedures for Dentistry Services
- Part II Policies and Procedures for Children's Intervention School Services Section 602.5
- Part II Policies and Procedures for Community Behavioral Health and Rehabilitation Services Appendices G and O
- Part II Policies and Procedures Manual for Autism Spectrum Disorder (ASD) Services

The state understands that there may be areas within the above referenced documents that differ in use of terminology. Additionally, if this guidance is found to conflict with state, federal, regulatory, or scope of service guidance, please apply the more stringent guidance.

State's Response during State and National Emergencies

The guidance contained within this document relates to services rendered and billed during normal circumstances. In the event of an officially declared National or State emergency, guidance may be modified to address members' and providers' needs. Providers are asked to refer to the most current Banner Messages, DCH website (dch.georgia.gov) and Providers Notices as to any policy updates.

Services that will be moving back to traditional forms of services are Adult Day Health and performing initial assessments via telehealth. Those services have until November to begin to move back to traditional plans of care. The 90-calendar day transition period with respect to telehealth will expire at 11:59 p.m. on August 9, 2023. In reference to the use of non-HIPAA compliant modalities to render services. Providers should be doing the following:

A. Verify that they are using a HIPAA -compliant telehealth platform that securely handles/transmits protected health information (PHI), and ensure they have a proper contract in place with any vendor that handles PHI.

B. Review their workflows and update practices that are not in line with HIPAA requirements, such as conducting telehealth visits on a mobile device. Audio-only encounters must be conducted using HIPAA requirements, such as conducting telehealth visits on a mobile device. Audio-only encounters must be conducted using HIPAA-compliant technology. Services provided using a traditional landline are not subject to the HIPAA Security Rule because they do not electronically transmit information. However, phones that use electronic communication technologies, such as Voice over Internet Protocol (VoIP), are subject to HIPAA requirements.

Telehealth Reimbursement for Ambulance Providers

Effective April 22, 2016, the Centers for Medicare & Medicaid Services (CMS) approved Georgia Department of Community Health (DCH), Medicaid Division State Plan Amendment (SPA) for Ambulance as telehealth sites. Emergency Ambulances may serve as a telehealth originating site and the ambulance may bill a separate originating site fee. Emergency Ambulance may not serve as a distant site. The following are the definitions for Telehealth Based Services:

A. Originating Sites (HCPCs 03014): Originating site means the location of an eligible Medicaid beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites are reimbursed at 84.645%of the 2012 Medicare fee schedule.

B. Distant Site Practitioners: Distant site means the site at which the physician or practitioner delivering the service is located at the time the service is provided via a telecommunications system. Distant Site Practitioners shall be reimbursed according to the same methodology as if the visit occurred in person. Ambulances are not authorized to provide distant site services.

Please review the information below to obtain a better understanding of what the telehealth billing entails. The prior approval requirements, non-covered, and covered services requirements have not changed. The Telehealth originating fee (03014) cannot be billed in combination with other rendered EMS services.

- Emergency ambulance transportation of more than 150 miles one way from an institution to an institution.
- Emergency transportation services certified by a physician as medically necessary, but not included as a covered service, may be covered for recipients under twenty-one years of age when such services are prior approved by the department.
- All ambulance transportation of more than 50 miles beyond the boundaries of the Georgia state line (out-of-state).
- Transportation that is not of an emergency nature, but the recipient requires services of an EMT and the life sustaining equipment provided in the emergency ambulance
- All ambulance transportation by air ambulance except for recipients zero (0) to twelve (12) months of age who meet certain criteria listed in the policies and procedures manual.
- Limitation: Emergency ambulance services are reimbursable only when medically necessary. The recipient's physical condition must prohibit use of any method of transportation except emergency for a trip to be covered.

Autism Spectrum Disorders (ASD) Services

Practitioners Eligibility to Provide Service:
Practitioners of ASD services can use telehealth to assess, diagnose and provide therapies to patients.

As outlined in Part II-Chapter 600 "*Special Conditions of Participation"* a provider must:

A. Hold either a current and valid license to practice Medicine in Georgia, hold a current and valid license as a Psychologist as required under Georgia Code Chapter 39 as amended, or hold a current and valid Applied Behavior Analysis (ABA) Certification.

B. In addition to licensed Medicaid enrolled Physicians and Psychologists, Georgia Medicaid will enroll Board Certified Behavioral Analysts (BCBAs) as Qualified Health Care Professionals (QHCPs) to provide ASD treatment services. The BCBA must have a graduate-level certification in behavior analysis. Providers who are certified at the BCBA level are independent practitioners who provide behavior-analytic services. In addition, BCBAs supervise the work of Board- Certified Assistant Behavior Analysts (BCaBAs), and Registered Behavior Technicians (RBTs) who implement behavior-analytic interventions.

Member Eligibility

Services to treat Autism Spectrum Disorders (ASD), as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, include assessment and treatment provided to Medicaid beneficiaries in accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit and according to medical necessity. Pursuant to 42 CFR 440.130(c), services must be recommended by a licensed physician or other licensed practitioner of the healing arts acting within their scope of practice under state law to prevent the progression of ASD, prolong life, and promote the physical and mental health of the individual.

Billing

Prior Authorization (PA) is required for all Medicaid-covered:

- Adaptive Behavior Services (ABS)
- Behavioral Assessment and
- Treatment Services

All services are to be billed with modifiers specific for practitioner level and service delivery setting/modality as outlined in the Part II Policies and Procedures Manual for Autism Spectrum Disorder (ASD).

Codes

The following codes can be used to provide ASD services.

Table A

2019 Category I/III CPT Codes for Adaptive Behavior Services Description	2019 Procedure Code	Practitioner Level Modifier	Service Location	Unit	Rate
Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare profession's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	97151	U1	GT	15 min	58.21
		U2	GT	15 min	38.97
		U3	GT	15 min	30.01
Behavior Identification supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minutes	97152	U1	GT	15 min	58.21
		U2	GT	15 min	38.97
		U3	GT	15 min	30.01
		U4	GT	15 min	20.30
		U5	GT	15 min	15.13
Behavior identification supporting assessment, each 15 minutes of technician' time face-to-face with a patient, requiring the following components: a) administered by the physician or other qualified healthcare professional who is on site; b) with the assistance of two or more technicians; c) for a patient who exhibits destructive behavior;	0362T	U1	GT	15 min	58.21
		U2	GT	15 min	38.97
		U3	GT	15 min	30.01

d) completed in an environment that is customized to the patient's behavior		U4	GT	15 min	20.30
		U5	GT	15 min	15.13
Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes	97153	U1	GT	15 min	58.21
		U2	GT	15 min	38.97
		U3	GT	15 min	30.01
		U4	GT	15 min	20.30
		U5	GT	15 min	15.13
Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to- face with two or more patients, each 15	97154	U1	GT	15 min	58.21
		U2	GT	15 min	38.97
		U3	GT	15 min	30.01
		U4	GT	15 min	20.30
		U5	GT	15 min	15.13
Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	97155	U1	GT	15 min	58.21
		U2	GT	15 min	38.97
		U3	GT	15 min	30.01
Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	97156	U1	GT	15 min	21.90
		U2	GT	15 min	17.01
		U3	GT	15 min	13.21
Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/ caregivers, each 15 minutes	97157	U1	GT	15 min	25.34
		U2	GT	15 min	17.00
		U3	GT	15 min	13.21

Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients, each 15 minutes	97158	U1	GT	15 min	25.34
		U2	GT	15 min	14.00
		U3	GT	15 min	13.21
Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components:	0373T	U1	GT	15 min	58.21
- administered by the physician or other qualified healthcare professional who is on site;		U2	GT	15 min	38.97
- with the assistance of two or more technicians;		U3	GT	15 min	30.01
- for a patient who exhibits destructive behavior;		U4	GT	15 min	20.30
- completed in an environment that is customized, to the patient's behavior		U5	GT	15 min	15.13

"OUT-OF-CLINIC" IS BILLABLE FOR DELIVERY OF ASD SERVICES IN ANY OTHER LOCATION OUTSIDE OF THE FOLLOWING:

(1) YOUR AGENCY/CLINIC (IN-CLINIC)

(2) TELEHEALTH

(3) Table B

Practitioner Level Legend	***Level***
Physician, Psychiatrist	U1 - Level 1
Psychologist, BCBA-D	U2 - Level 2
BCBA	U3 - Level 3
BCaBA or Master's Level Behavior Analyst	U4 - Level 4
Registered Behavior Technician	U5 - Level 5

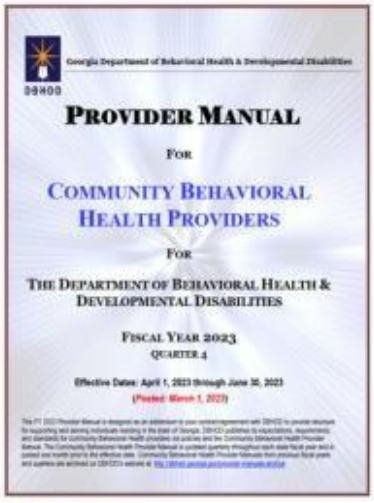
Community Behavioral Health and Rehabilitation Services

Purpose

Use of Telehealth for behavioral health services within Community Behavioral Health and Rehabilitation Services (CBHRS) [**Note:** Within CBHRS, “Telehealth” is referred to as “Telemedicine,” and the latter term will be used throughout this section].

Service Accessibility

Currently, the Departments of Community Health (DCH) and Behavioral Health and Developmental Disabilities (DBHDD) have authorized Telemedicine to be used to provide most of the services in CBHRS to any member who consents to its use, and in accordance with DBHDD’s Provider Manual for Community Behavioral Health Providers (https://dbhdd.georgia.gov/be-connected/community-provider-manuals), referenced hereinafter as “DBHDD’s Provider Manual.”



Within DBHDD’s Provider Manual, DBHDD’s overarching policy on the use of Telemedicine can be found in PART II - Community Service Requirements for BH Providers, Section I – Policies and Procedures, 1. Guiding Principles, B. Access to individualized services, 16. Telemedicine and telephonic interventions. Further Telemedicine guidance and any specific allowances for particular CBHRS service can be found in the Part I – Eligibility, Service Definitions and Service Requirements, Section III – Service Definitions, “Service Accessibility” section of the Service Definition for a given service.

Originating Site

For CBHRS, members may be located at home, schools, and other community-based settings or at more traditional sites named in the Department of Community Health (DCH) Telehealth Guidance manual above.

Training

As outlined in the Rules and Regulations of the State of Georgia *Chapter 135-11-01 TeleMental Health* there are additional guidelines that establish minimum standards for the delivery of services by a licensed Professional Counselor, Social Worker, or Marriage and Family Therapist using technology-assisted media. Specific provisions can be found in the Georgia Rules and Regulations Department 135, Chapter 135-11-01 TeleMental Health.

Consent:

For CBHRS, the *Telehealth Member Consent Form* for each member is outlined in the Telehealth Guidance Document and must be utilized. Complete and detailed Guidance on Telehealth and Telehealth can be accessed by visiting https://www.mmis.georgia.gov/portal/; then clicking Provider Information, Provider Manuals and Telehealth Guidance.

Billing & Reimbursement

For CBHRS, any of the Practitioner Types noted in Table C below may deliver and bill for Telemedicine in accordance with the allowances found in DBHDD's Provider Manual.

While some services within CBHRS allow telephonic interactions, telephonic interventions do not qualify as "Telemedicine" as defined herein, or in the DBHDD's Provider Manual. Also note that within CBHRS, CPT modifier ''93'' is not used to append claim lines for services furnished using audio-only communications technology, as previously described in the "Billing and Payment for professional services furnished via telehealth" section of the Department of Community Health's (DCH) Telehealth Guidance manual above.

Originating fees (as referenced in some of the other Georgia Medicaid programs) are not offered for telehealth when utilized in the CBHRS category of service. Telehealth costs are attributed to the services intervention rates.

Care Management Organizations may have specific billing requirements and practices which will be outlined in their unique agreements with providers. Georgia currently contracts with four Care Management Organizations (Amerigroup, CareSource, and Peach State) for covered lives which includes physical health and behavioral health of all CMO members. All four utilize the Georgia Partnership for Telehealth (GPT) to receive specialty and behavioral health care. With GPT services, the face-to-face video conferencing for visits with specialists, behavioral health providers and others whose offices are often in rural areas ensure better care with improved access. GPT has over 300 practitioners licensed in Georgia for behavioral health and physician health services.

Table C: Practitioner Types for CBHRS

Level 1	Physician, Psychiatrist
Level 2	Psychologist, Physician 's Assistant, Nurse Practitioner, Clinical Nurse Specialist, Pharmacist
Level 3	Registered Nurse, Licensed Dietician, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT)
Level 4	Licensed Practical Nurse (LPN); Licensed Associate Professional Counselor (LAPC); Licensed Master's Social Worker (LMSW); Licensed Associate Marriage and Family Therapist (LAMFT); Certified/Registered Addictions Counselors (e.g. CAC-I/II, CADC, CCADC, GCADC, MAC), Certified Peer Specialists, Trained Paraprofessionals and Certified Psychosocial Rehabilitation Professionals (CPRP) with bachelor's degrees or higher in the social sciences/helping professions
Level 5	Trained Paraprofessionals, Certified/Registered Addiction Counselors (CAC-I, RADT), Certified Peer Specialists, Certified Psychosocial Rehabilitation Professionals, and Qualified Medication Aides with at least a high school diploma/equivalent

Teledentistry

Teledentistry is a combination of telecommunications and dentistry involving the exchange of clinical information and images over remote distances for dental consultation and treatment planning. The State allows for these services within the current Part II Policies and Procedures Manual for Dental Services.

Providers

Licensed Dentists
Licensed Dental Hygienist

Approved Codes for Reimbursement- These can only be used in the Public Health Setting as described within the Dentistry Policy manual.

Table E

Code	Service Description	Billing Note
D9995	Teledentistry – synchronous; real-time encounter	used to bill when there is a synchronous or real-time encounter instead of information that is stored and sent for review. Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.
D9996	Information store and forward to dentist for review	used by the Dental Hygienist when dental information is sent to a licensed Dentist for review via telehealth technology.
D0140	LIMIT ORAL EVAL PROBLM FOCUS	LIMITED ORAL EVALUATION - PROBLEM FOCUSED

Department of Public Health (DPH) Districts and Boards of Health Dental Hygienists shall only perform duties under this protocol at the facilities of the DPH District and Board of Health, at school-based prevention programs and other facilities approved by the Board of Dentistry and under the approval of the District Dentist or dentist approved by the District Dentist.

Telehealth within Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)

FQHCs and RHCs may serve as an originating site for telehealth services, which is the location of an eligible Medicare beneficiary or enrolled Medicaid member at the time the service being furnished via a telecommunications system occurs. FQHCs and RHCs that serve as an originating site for telehealth services are paid an originating site facility fee. FQHC's and RHC's are authorized to serve as a distant site for telehealth services and may bill the cost of the visit.

NOTE: FQHCs and RHCs cannot bill an originating site fee and distant site fee for telehealth services on the same encounter.

Telehealth and Dialysis Services

The Centers for Medicaid and Medicare Services (CMS) has added Dialysis Services to the list of services that can be provided under Telehealth.

The originating facility/site (Dialysis Facility) will bill with the revenue code and procedure codes listed below.

Table F

Revenue Code	Description	Procedure Code	Modifier
780	Telehealth General Classification	Q3014	GT

The distant site/physician providing the service via a telecommunications system will bill using Place of Service 02 to indicate Telehealth and the procedure codes below.

The term "distant site" means the site where the physician or practitioner providing the professional service, is located at the time the service is provided via a telecommunications system.

Table G

Code	Description	Modifier's	Place of Service
90951	End Stage Renal Disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to- face physician visits per month	95, GT, or GQ	02
90952	End Stage Renal Disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to- face physician visits per month	95, GT, or GQ	02
90954	End Stage Renal Disease (ESRD) related services monthly, for patients two (2) - eleven (11) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to-face physician visits per month	95, GT, or GQ	02
90955	End Stage Renal Disease (ESRD) related services monthly, for patients two (2) -eleven (11) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with two (2) or three (3) face-to-face physician visits per month	95, GT, or GQ	
90957	End Stage Renal Disease (ESRD) related services monthly, for patients twelve (12) - nineteen (19) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to-face physician visits per month	95, GT, or GQ	02
90958	End Stage Renal Disease (ESRD) related services monthly, for patients twelve (12) - nineteen (19) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with two (2) -three (3) face-to-face physician visits per month	95, GT, or GQ	02
90960	End Stage Renal Disease (ESRD) related services monthly, for patients twenty (20) years of age and older, with four (4) or more face-to-face physician visits per month	95, GT, or GQ	02

90961	End Stage Renal Disease (ESRD) related services monthly, for patients twenty (20) years of age and older, with two (2) - three (3) face-to-face physician visits per month	95, GT, or GQ	02
90963	Home dialysis services per month, patient younger than 2 years of age	95, GT, or GQ	02
90964	Home dialysis services per month, patient 2-11 years of age	95, GT, or GQ	02
90965	End Stage Renal Disease (ESRD) related services for home dialysis per full month; for patients twelve (12) - nineteen (19) years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents	95, GT, or GQ	02
90966	Home dialysis services per month, patient 20 years of age or older	95, GT, or GQ	02
90967	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients younger than two (2) years of age	95, GT, or GQ	02
90968	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients two (2)- eleven (11) years of age	95, GT, or GQ	02
90969	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients twelve (12)-nineteen (19) years of age	95, GT, or GQ	02
90970	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients twenty (20) years of age and older	95, GT, or GQ	02

Nursing Facility Specialized Services

Though not available in all areas of the State, Medicare-funded mental health services are currently provided to nursing home residents via telehealth, face-to-face visits by providers in the nursing home, and nursing home resident visits to psychiatric/mental health clinics/offices for those individuals able to travel outside the nursing facility.

NOTE: Though 440 codes allow for Medicaid members to have a variety of mental health professionals serve members in nursing facilities, please note that Medicare has more stringent requirements regarding these professionals to serve the Medicare eligible members in nursing facilities. (Please review the approved practitioner levels listed below [*Table C*]). When Nursing Facilities refer/coordinate Specialized Services for the PASRR approved resident, Nursing Facility staff should communicate to the Community Behavioral Health Service Provider (CBHSP), the DCH enrolled MH provider that the member is either dual eligible or Medicare Only.

The NF and CBHS providers will communicate to arrange for the provision of specialized services to residents either in the nursing facility, via telehealth, or at the Community Behavioral Health location. The service location will be determined by the condition of the resident, ability to travel to the nearest clinic, and evaluation of both nursing facility and mental health staff regarding the most appropriate service delivery venue for the individual resident. If the nursing home resident can be assessed and treated in the outpatient clinic, NEMT transportation can be used to facilitate this visit. Those residents whose interest is best served by receiving mental health services in the nursing facility or in a nearby telehealth site can receive services in either of those locations, with the practitioner using out-of-clinic or telehealth procedure codes.

Table H

Level 1	Physician, Psychiatrist
Level 2	Psychologist, Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist, Pharmacist
Level 3	Registered Nurse, Licensed Dietician, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT)
Level 4	Licensed Practical Nurse (LPN); Licensed Associate Professional Counselor (LAPC); Licensed Master's Social Worker (LMSW); Licensed Associate Marriage and Family Therapist (LAMFT); Certified/Registered Addictions Counselors (e.g. CAC-I/II, CADC, CCADC, GCADC, MAC), Certified Peer Specialists, Trained Paraprofessionals and Certified Psychosocial Rehabilitation Professionals (CPRP) with Bachelor's degrees or higher in the social sciences/helping professions

Level 5	Trained Paraprofessionals, Certified/Registered Addiction Counselors (CAC-I, RADT), Certified Peer Specialists, Certified Psychosocial Rehabilitation Professionals, and Qualified Medication Aides with at least a high school diploma/equivalent

PROCEDURE CODES: KEY:

Key: Code Modifiers used:
GT= Via interactive audio and video telecommunications systems
U1 = Practitioner Level 1 (see below for description of all practitioner levels)
U2 = Practitioner Level 2
U3 = Practitioner Level 3
U4 = Practitioner Level 4
U6 = In Clinic
U7 = Out-of-Clinic

For all procedures noted on the next page, practitioners must hold the license appropriate to the activity.

The following procedure codes may be used for service delivery and claims billing for specialized behavioral health services provided to nursing home residents: (Daily/Annual Max Units are effective 4/2013)

Table I

Description	Procedure Code	Modifier	Service Group	Max Daily Units	Max Month Units	Max Year Units
Psychiatric Diagnostic Assessment (session) Or Via Telehealth *Report with 90785 for interactive complexity when appropriate*	90791, 90792 (Formerly 90801, 90802) 90791, 90792	U2 U6, U2 U7 U3U6, U3U7 (Encounter) GT U1, GT U2, GTU3	10103	1 encounter	1	12
Psychiatric Treatment/Pharmacological Management (session) Or *Via Telehealth Report with add-on code for psychotherapy time*	Appropriate Evaluation and Management Code-see below (Formerly 90862)	U1 U6, U1 U7 U2 U6, U2 U7 GT U1, GT U2	10120	2	2	24

Evaluation and Management Codes						
Description	**Procedure Code**	**Modifier**	**Service Group**	**Max Daily Units**	**Max Month Units**	**Max Year Units**
E&M (New Pt - 10 min)	99201	U1 U6, U2 U6, U1 U7, U2 U7, GT U1, GT U2	10120	1	2	24
E&M (New Pt - 20 min)	99202					
E&M (New Pt - 30 min)	99203					
E&M (New Pt - 45 min)	99204					
E&M (New Pt - 60 min)	99205					
E&M (Estab Pt - 5 min)	99211					
E&M (Estab Pt - 10 min)	99212					
E&M (Estab Pt - 10 min)	99212					
E&M (Estab Pt - 15 min)	99213					
E&M (Estab Pt - 15 min)	99213					
E&M (Estab Pt - 25 min)	99214					
E&M (Estab Pt - 40 min)	99215					

Telehealth and School Based Settings

School-Based Settings

Telehealth services provided in school-based settings also referred to as the Local Education Agencies (LEAs) can be provided upon enrollment into COS 600.

Telehealth benefits are allowed if all the following criteria are met:

- The provider is an authorized health-care provider enrolled in Georgia Medicaid
- The client is a child who is receiving the service in a primary or secondary school-based setting.
- The parent or legal guardian of the client provides consent before the service is provided.

Telehealth services provided in a school-based setting are also a benefit if the referring provider delegates provision of services to a nurse practitioner, clinical nurse specialist, physician assistant, or other licensed specialist as long as the above-mentioned providers are working within the scope of their professional license and within the scope of their delegation agreement with the provider.

Health Check Program

LEAs enrolled as Health Check providers to serve as telehealth originating sites only will be allowed to bill the telehealth originating site facility fee (procedure code Q3014). The LEA provider should report procedure code Q3014 along with the EP and GT modifiers, POS 03, and the appropriate ICD-10 diagnosis code(s). The diagnosis code(s) should be the same diagnosis code(s) listed on the distant site (rendering) provider's claim. The rendering provider serving as the telehealth distant site should report the E/M office visit code (992xx) along with the GT modifier (including any other applicable modifiers), the appropriate POS, and the ICD-10 diagnosis code(s). For the originating site (LEA) provider to receive reimbursement for procedure code Q3014, a corresponding paid history claim from the distant site provider must be found in GAMMIS. The distant site provider's claim billed for the same member, same date of service, with an E/M office visit code (992xx), the same ICD-10 diagnosis code(s) and the GT modifier, will confirm that a telehealth service was rendered. If no record of the E/M claim is found that aligns with the LEA provider's originating site claim, the originating site claim will suspend up to 30 days after submission in search of the E/M claim. If no record of an E/M claim is found within 30 days after submission of the LEA provider's originating site claim, reimbursement to the LEA provider will be denied. It is the responsibility of the LEA provider to contact the provider who rendered the distant site service to determine if the E/M visit was billed. The telehealth originating facility fee is reimbursed at the current DEFAULT rate.

Children's Intervention School Services (CISS)

Local Education Agencies (LEAs) may enroll in the Health Check Program (COS 600) to serve as telehealth originating sites only. The originating site is the actual location at which an eligible Medicaid member is receiving services via the telecommunications system. To enroll as a Health Check provider, the LEA will be required to submit a signed copy of the Attestation Form "For the Provision of Telehealth Services by Georgia's Local Education Agencies (LEAs)" which indicates that the LEA will comply with the telehealth requirements.

The Attestation Form is located on the MMIS web portal under the “Provider information, Forms, Enrollment” tab. Please complete the form and fax it with the coversheet located under the “Provider Information, Forms” tab to Gainwell Technologies Provider Enrollment at 1-866-483- 1044. See section 603.21 in the CISS manual for claiming information.

LEAs can enroll in the Health Check Program (COS 600) to serve as telehealth originating sites only. As a Health Check provider, the LEA serving as a telehealth originating site will be allowed to bill only the telehealth originating site facility fee *Children’s Intervention School Services VI-7 (procedure code Q3014).* The LEA should report procedure code Q3014 along with the EP and GT modifiers, Place of Service (POS) 03, and the appropriate ICD-10 diagnosis code(s). The diagnosis code(s) should be the same diagnosis code(s) listed on the distant site (rendering) provider’s claim. The rendering provider serving as the telehealth distant site should report the evaluation and management (E/M) office visit code (992xx) along with the GT modifier (including any other applicable modifiers), the appropriate POS, and the ICD-10 diagnosis code(s). LEAs are reimbursed for procedure code Q3014 under the Health Check Program (COS 600). It is the responsibility of the LEA to contact the provider who rendered the distant site service to determine if the E/M visit was billed.

Speech Language Pathology Services

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

Speech and Audiology Reimbursable Codes
Table J

Code	Service Description	Billing Note
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual.	Use POS 02
92521	Evaluation of Speech Fluency	Use POS 02
92522	Speech sound production evaluation	Use POS 02
92523	Speech sound production evaluation with language evaluation	Use POS 02
92524	Behavioral and qualitative analysis of voice and resonance	Use POS 02
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual. Two or more individuals	Use POS 02
97110	Therapeutic Exercise to Develop Strength, Endurance, range of motion, and flexibility, each 15 minutes	Use POS 02
97112	Therapeutic Procedure to re-educate brain-to-nerve- to-muscle function, each 15 minutes	Use POS 02

97161	Evaluation of physical therapy, typically 20 minutes	Use POS 02
97162	Evaluation of Physical Therapy, Typically 30 minutes	Use POS 02
97163	Evaluation of Physical Therapy, Typically 45 Minutes	Use POS 02
97164	Re-evaluation of Physical therapy, typically 20 minutes	Use POS 02
97530	Therapeutic activities to improve function, with one- on-one contact between patient and provider, each 15 minutes	Use POS 02
97532 DISCONTINUED Use code 97127	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact."	Use POS 02
97542	Wheelchair management, each 15 minutes	Use POS 02
97763	Management and/or training in use of orthotics (supports, braces, or splints) for arms, legs, and/or trunk, per 15 minutes	Use POS 02
97762 DISCONTINUED Use code 97763	Under Orthotic Management and Training and Prosthetic Training	Use POS 02
92567	Tympanometry (impedance testing)	Use POS 02
92568	Acoustic Reflex Testing	Use POS 02
92587	Distortion product evoked auditory test emissions	Use POS 02

Telehealth and Physician Services

Telehealth and Physician Services

The Department of Community Health's (DCH) Telehealth and Telehealth policies are slated to improve and increase access and efficiency to health care services by enabling medical services to be delivered via telehealth methods in Georgia. Telehealth services are not an expansion of Georgia Medicaid covered services; but, an option for the delivery of certain covered services. Telehealth will allow DCH to meet the needs of members and providers, while complying with all applicable federal and state statutes and regulations. The quality of health care services delivered must be maintained regardless of the mode of delivery.

Telehealth is the use of medical information exchange from one site to another via electronic communications to improve patients' health status. It is the use of two-way, real time interactive communication equipment to exchange the patient information from one site to another via an electronic communication system. This includes audio and video telecommunication equipment. Closely associated with telehealth is the term "telehealth," which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Telehealth is the use of telecommunication technologies for clinical care (telehealth), patient teachings and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.

The intent of our telehealth services policy is to improve access to essential healthcare services that may not otherwise be available for Medicaid eligible members. Telehealth is not a separate medical specialty. Products and services related to telehealth are often part of a larger investment by health care institutions in either information technology or the delivery of clinical care. When a provider, licensed in the state of Georgia, determines that medical care can be provided via electronic communication with no loss in the quality or efficacy of the member's care, telehealth services can be performed. The use of a telecommunications system may substitute for an in-person encounter for professional office visits, pharmacologic management, limited office psychiatric services, limited radiological services and a limited number of other physician fee schedule services.

An interactive telecommunications system is required as a condition of payment. The originating site's system, at a minimum, must have the capability of allowing the distant site provider to visually examine the patient's entire body including body orifices (such as ear canals, nose, and throat). The distant site provider should also have the capability to hear heart tones and lung sounds clearly (using a stethoscope) if medically necessary and currently within the provider's scope of practice. The telecommunication system must be secure and adequate to protect the confidentiality and integrity of the information transmitted.

Appendix A

Telehealth Member Consent Form

Prior to an initial telehealth service, the practitioner who delivers the service to a GA Medicaid Member shall ensure that the telehealth member consent form is provided to the member and signed. It should be delivered in a manner which the member can understand, using reasonable accommodations when necessary, that:

1. S/he retains the option to refuse the telehealth service at any time without affecting the right to future care or treatment and without risking the loss or withdraw of any program benefit to which the member would otherwise be entitled.

2. Available alternative options will be presented to the member (including in-person services).

3. The dissemination of any client identifiable images or information form the telehealth consultation to anyone, including researchers, will not occur without the written consent of the member.

4. S/he has the right to be informed of the parties who will be present at each end of the telehealth consultation and s/he has the right to exclude anyone from either site.

5. S/he has the right to see an appropriately trained staff or employee in- person immediately after the telehealth consultation if an urgent need arises.

Telehealth Member Consent Form

PATIENT NAME: _____
DATE OFBIRTH: _____
GA MED ID#: _____

1. **PURPOSE**: The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with the following procedure(s) and/or service(s):

_____

2. **NATURE OF TELEHEALTH CONSULT**: During the telehealth consultation:
3. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
4. A physical examination of you may take place.
5. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
6. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)
7. **MEDICAL INFORMATION & RECORDS**: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.
8. **CONFIDENTIALITY**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telehealth consultation.
9. **RIGHTS:** You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
10. **DISPUTES**: You agree that any dispute arriving from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.
11. **RISKS, CONSEQUENCES & BENEFITS**: You have been advised of all the potential risks, consequences, and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature:_____Date: _____

If signed by someone other than the patient, indicate relationship:_____

Witness Signature:_____Date: _____

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.It is important to note that GF is a full-risk program; this means that the three CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The three licensed CMOs:

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

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

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe

Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

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

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

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

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

Members can visit the Georgia Families Web site at www.georgia-families.com or call

1-800-GA-ENROLL (1- 888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

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

Included Categories of Eligibility (COE):

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

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

	897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled

215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled

233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver

255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged

305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind

429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO

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

HEALTH CARE PROVIDERS

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

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

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

Registering immunizations with GRITS:

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

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

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

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

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

Participating in a Georgia Families' health plan:
Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:
For members who are in Georgia Families, you should file claims with the member's health plan.

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

Credentialing

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed. Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program. This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

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

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

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

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

Billing the health plans for services provided:
For members who are in Georgia Families, you should file claims with the member's health plan.

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

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

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

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

How often can a patient change his/her PCP?

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

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

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

PHARMACY

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

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

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

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

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

If a patient does not have an identification card:

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

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

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

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

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

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

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

Who to call to request a PA:

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

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