PART II

POLICIES AND PROCEDURES
for
ADVANCED NURSE PRACTITIONER SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: October 1, 2024

TABLE OF CONTENTS

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.)
07/01/2024	None	There are no policy related updates/revisions for July 2024.	N/A	N/A
10/01/2024	Appendices S, U and V	Deleted Georgia Families, Georgia Families 360 and Non-Emergency Medical Transportation (NEMT) Appendices.	D	N/A
10/01/2024	Appendix X	Added comprehensive appendix which includes links to the websites providing information on Georgia Families, Georgia Families 360 and NEMT.	A	N/A

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

601. Enrollment

601.1. Conditions of Participation:

In addition to the general conditions of participation identified in the Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual, Section 105, providers in the Nurse Practitioner Services Program must meet certain conditions.

601.2. Licensure - Each nurse practitioner must maintain:

601.2.1. Current Registered Nurse License for the State of Georgia.

601.2.2. Current specialty certification by the appropriate certifying agent of the American Nurses Association as indicated below:

601.2.2.1. Pediatric Nurse Practitioner: Current certification through the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP).

601.2.2.2. Adult, Adult-Gerontology Primary Care, and Family Nurse Practitioners: Current certification through a certifying agent of the American Nurses Association, such as the American Nurses Credentialing Center (ANCC)

601.2.2.3. Effective July 1, 2022, DCH will facilitate the enrollment of Psychiatric Mental Health Nurse Practitioners (PMHNPs) in Georgia Medicaid and allow reimbursement for services provided to Georgia Medicaid members. (Rev. 04/2023)

601.2.2.3.1. PMHNPs will enroll under provider specialty code 218. The submission of an additional location application for specialty 218 is required if the provider has 2 or more certifications.

601.2.2.3.2. Current certification for the PMHNPs must be maintained through a certifying agent of the American Nurses Association such as the American Nurses Credentialing Center (ANCC).

601.2.2.4. Women's Health Nurse Practitioner (WHNP): Current certification through the National Certification Corporation (NCC)

601.2.2.5. Certified Registered Nurse Anesthetist; Current certification through the certifying agent of the American Association of Nurse Anesthetists (AANA).

601.2.2.6. If the rendering provider's specialty is (031) Certified Registered Nurse Anesthetist or (204) Physician Assistant Anesthetist the system bypasses the cut back logic of 90% for the above provider specialties only.

601.2.3. Current registration with the State Board of Nursing in the specialty certified.

602. Nurse Practitioner Requirements and Guidelines

Each enrolled nurse practitioner agrees to bill the Division for only those services that are performed by or under the supervision of the nurse practitioner. For purposes of this policy, only those necessary and appropriate medical services that meet the following conditions will qualify as services performed under the supervision of the practitioner:

602.1. The services must be performed by medical personnel who are authorized by law to perform the services and who are qualified by education, training, or experience.

602.2. Nurse practitioners may not bill for the services of independent contractors or other independent practitioners, e.g., audiologists, physical therapists, occupational therapists, speech pathologists, or any person covered by the provisions of 601.2 (e).

602.3. The nurse practitioner must periodically and regularly review the patient's medical records.

602.4. The nurse practitioner must be immediately available onsite at the time the services are delivered.

602.5. A nurse practitioner may not bill for services rendered by person(s) not approved to provide that service by the Division or applicable licensure, certification or other State or Federal Regulation. (Rev. 10/2014)

602.6. Nothing in the language in this section shall be construed to override more stringent limitations found in Chapter 900 of this Manual.

602.7. The provider must maintain an office, clinic, or other similar physical facility, which complies with local business and building license ordinances. (Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual, Chapter 100, for General Conditions of Participation.)

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

602.9. Indiscriminate billing under one nurse practitioner's name or provider number without regard to the specific circumstances of rendition of the services is specifically prohibited and will be grounds of disallowing reimbursement.

602.10. A nurse practitioner covering for another nurse practitioner will not be construed as a violation of this section if the covering nurse practitioner is on call and provides emergency or unscheduled services for a period of time not to exceed fourteen continuous days. The covering nurse practitioner must also be an enrolled Medicaid provider. Services performed by non-enrolled nurse practitioners are not covered or reimbursable under any circumstances.

602.11. The nurse practitioner agrees not to bill for adjunctive services provided in a nursing facility unless prescribed by the member's attending and prescribing physician. An "adjunctive service" is defined as any service provided by a physician or licensed practitioner other than the patient's primary care physician who is legally responsible for the medical care of the patient. The attending and prescribing physician's name must appear on the patient's chart.

602.12. The nurse practitioner agrees to bill the Division the lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date(s) of service, or the lowest price charged to other third-party payers for the procedure code most closely reflecting the service rendered. The nurse practitioner also agrees to maintain records on both Medicaid eligible and private paying patients for a minimum of five years to fully disclose compliance with this section. The nurse practitioner further agrees to furnish the Division, its authorized representatives, or contractual agents, with this information at no charge. (Rev. 10/2014)

602.13. The nurse practitioner agrees not to bill for any services performed by an independent laboratory or x ray facility. An independent laboratory or x ray facility is one that is independent of both the attending physician and consulting physician and of a hospital that meets at least the requirements to qualify as an emergency hospital. A laboratory or x-ray facility which is not located in a nurse practitioner's office or hospital is presumed to be independent unless written evidence establishes that it is owned by the billing nurse practitioner or a hospital which meets at least the definition of an emergency hospital.

602.14. The nurse practitioner agrees to cooperate with the appropriate policies of other Medicaid service programs, including but not limited to those described in Appendix C. (Rev. 10/2014)

602.15. The nurse practitioner agrees to notify the Division's Provider Unit in writing should any change in enrollment status occur such as: new address and/or telephone number; additional practice locations; dissolution of a group practice causing any change in our records; and voluntary termination from the Program. Each notice of change must include the date on which the change(s) is to become effective.

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

602.17. The nurse practitioner agrees to bill the Division only for procedures that are included in the nurse practitioner's written protocol and scope of practice.

602.18. The Division considers enrolled CRNAs and OB/GYN Nurse Practitioners to be advanced Nurse Practitioners and therefore governed by the rules and regulations of the Nurse Practitioner Program, as are Family, Pediatric, Adult and Gerontological Nurse Practitioners.

602.19. The CRNA shall not bill as a non-medically directed CRNA if being supervised by an employer physician who is billing for the supervision.

602.20. The nurse practitioner agrees not to bill the Division for services rendered as an employee of a Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC) or who is compensated by the clinic for services that are reimbursable under these programs.

602.21. The nurse practitioner agrees not to bill the Division for services rendered as an employee of a facility enrolled in the Community Mental Health Program or who is compensated by the Community Mental Health Provider for services provided.

603. Locum Tenens

Please refer to the Physicians Service Manual. (Rev. 10/2014)

Chapter 700: Special Eligibility Conditions

701. Eligibility Requirements

There are no special eligibility conditions for nurse practitioner diagnostic and treatment services. Other services available to members include, but are not limited to: Health Check (EPSDT) Services for members under age twenty-one (21), hearing aids, durable medical equipment, non-emergency transportation, refractive services, etc. Please refer to Appendix C for further information on these programs.

Chapter 800: Prior Approval - Hospital Pre-Certification

801. Services Requiring Prior Approval or Hospital Pre-Certification

Many procedures or services performed in the hospital or ambulatory surgical center setting require both prior approval and hospital pre-certification. The information provided in this Section provides guidance in determining when prior approval or pre-certification is needed. Services for members under the age of twenty-one years of age will require a hospital pre-certification or prior approval. The procedures for obtaining prior approval are located in Section 802. The procedures for obtaining hospital pre-certification are contained in Section 803. See Appendices E, L, and O in the Physician Services Manual for specific procedures. Appendices E, L, and O are subject to change without notice.

802. Prior Approval

As a condition of reimbursement, the Division requires certain services or procedures to be approved prior to the time of rendering. Prior approval pertains to medical necessity only; the patient must be Medicaid-eligible at the time the service is rendered. See Appendix E for a list of procedures requiring prior approval. (Rev. 10/2014)

The Division may require prior approval of all, or certain procedures performed by a specified physician or group of physicians based on findings or recommendation of the Division, its authorized representatives or agents, the Secretary of the U.S. Department of Health and Human Services or applicable State Examining Boards. This action may be invoked by the Georgia Department of Community Health Commissioner as an administrative recourse in lieu of, or in conjunction with, an adverse action described in Chapter 400. In such instances, the Division will serve written notice and the grounds for this action to the provider. (Rev. 10/2014)

Prior Approval for pregnancy related ultrasounds is required after the first ultrasound, or in some cases, prior to rendering the service. Refer to Appendices E, L, and O for detailed information regarding specific procedures that require prior approval before services are rendered. Physicians should seek prior approval on any service for which reimbursement might be questionable. The ordering physician is responsible for obtaining the Prior Approval. Failure to obtain prior approval shall result in denial of payment to all providers billing for services including the facility (Rev. 10/2014)

803. Procedures for Obtaining Prior Approval - Certain Services and Elective Surgeries

The provider is responsible for obtaining the prior authorization before rendering the service. Requests for prior approvals may be submitted online via the GAMMIS web-portal at www.mmis.georgia.gov. (Rev. 10/2014)

A request for prior approval must be submitted at least one week prior to the planned procedure. Procedures performed prior to receipt of an approved request may risk denial of reimbursement. Failure to obtain required prior authorization shall result in denial of reimbursement. (Rev. 10/2014)

Reimbursement is contingent on patient eligibility at the time services are rendered. All approved requests are effective for ninety days from the date of approval unless an extension is requested and approved. (Rev. 10/2014)

If an assistant surgeon is utilized, the assistant surgeon must also have a separate prior approval number and must use the separate prior approval number of the claim billed per Policies and Procedures for

Medicaid PeachCare for Kids Part 1 Manual. Reimbursement for services is contingent on the provider's enrollment in the Medicaid program, the patient's eligibility at the time services is rendered, and compliance with all other applicable policies and procedures. (Rev. 10/2014)

Prior approval is not required for obstetrics. (Rev. 10/2014)

804. Hospital Pre-Certification

All inpatient hospital admissions require pre-certification, except for routine deliveries. The admitting physician is responsible for obtaining the pre-certification of the hospital admission. The physician's failure to obtain the pre-certification number shall result in denial of payment to all providers billing for services, including the hospital and the attending physician. When a procedure requiring prior notification is performed in a hospital inpatient setting, hospital outpatient setting, or an ambulatory surgical center, the pre-certification number issued will be referred to as a pre-certification number not as a prior approval. Procedures performed in the office setting do not require pre-certification. (Rev. 10/2014)

A prior authorization may be required in addition to the pre-certification required for all inpatient admissions and certain outpatient services. (Rev. 10/2014)

A request for pre-certification should be initiated at least one week prior to the planned admission or procedure. Approval is valid for ninety days from the date of issuance. (Rev. 10/2014)

Hospital admissions exceeding ninety days require recertification within three calendar days prior to the ninetieth day of the continued stay. (Rev. 10/2014)

Failure to obtain recertification within the three calendar days of the ninetieth day will result in denial of the continued stay. No recertification will be granted for any part of the continuous stay if the request for recertification is received after the ninetieth (90th) day. The physician's failure to obtain the correct precertification number shall result in denial of payment. Precertification and recertification may be requested by contacting Gainwell Technologies PA/UM online via the web portal at www.mmis.georgia.gov or via telephone at 1(800) 766-4456. (Rev. 10/2014, 01/2021)

Emergency outpatient services, vaginal or C-section deliveries, and members who have Medicare Part A are not subject to hospital pre-certification. Appendix O provides detailed information regarding specific outpatient procedures that must be certified prior to the time rendered. Urgent outpatient procedures performed as a result of a condition which if not treated within 48 hours would result in significant deterioration of the member's health status must be certified within thirty calendar days of the date of the procedure. (Rev. 10/2014)

Failure to obtain the required certification will result in denial of reimbursement. (Rev. 10/2014)

805. Procedures for Obtaining Hospital Pre-Certification

Pre-certification is required for all inpatient hospital admissions (except for routine procedures performed in an outpatient hospital or ambulatory surgical center setting). Emergent admissions or surgical procedures and all hospital transfers must be certified within thirty calendar days of admission. Certification acknowledges only the medical necessity and appropriateness of the setting and does not guarantee reimbursement. (Rev. 10/2014)

Requests should be initiated at least one week prior to the planned admission or procedure. Approval is valid for ninety days from the date of issuance. Requests for pre-certifications may be submitted online via the Web portal at www.mmis.georgia.gov. (Rev. 10/2014)

In accordance with Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual, Section 202, when an individual is made retroactively eligible, requests for pre-certification must be received within six months from the month of determination of retroactive eligibility. Additionally, when members are eligible for both Medicare and Medicaid, and the Medicare benefits are exhausted, requests for certifications must be received within three months of the month of notification of exhaustion of benefits. For patients who are later determined to be retroactively eligible for Medicaid, GAINWELL TECHNOLOGIES must be contacted in advance for a reference number, which will be valid for ninety days. If the patient receives retroactive Medicaid eligibility, providers must continue the pre-certification and prior approval process, providing all required forms and documentation. Please note that obtaining a reference number prior to service provision does not guarantee approval for the requested services as the procedures still will be required to meet medical criteria. (Rev. 10/2014)

For determining timeliness of pre-certification update requests, if pre-certification has been obtained or is not required for an outpatient procedure, and during the procedure, it is determined that additional or a different procedure is necessary , the additional or different procedure should be considered an urgent procedure. The request for an update of the pre-certification file will be considered timely if received within thirty days of the date of the procedure. (Rev. 10/2014)

For determining timeliness of pre-certification update requests, if pre-certification has been obtained for an outpatient procedure and after the procedure has been performed, it is determined that inpatient services are necessary , the admission should be considered an emergency.

The request for an update of the pre-certification file will be considered timely if received within thirty days of the date of the admission. (Rev. 10/2014)

NOTE*** *Services that are primarily performed in an inpatient, outpatient, emergency, or ambulatory surgery setting will be Subject to a reduction in reimbursement. Please see Appendix K in the Physician's manual for services that are subject to the reduced reimbursement.*

806. Procedures for Obtaining Prior Approval for Pharmaceuticals

Approved injectable drugs listed on the Physicians' Administered Drug List (PADL) do not require pre-certification, unless indicated by the PA symbol. A request for injectable drugs must be submitted via the web portal at www.mmis.georgia.gov. The request must include applicable clinical information and the corresponding ICD-9 diagnosis code (ICD-10 diagnosis code), CPT or HCPCS code 11-digit National Drug Code (NDC) number. Requests that are incomplete may be delayed or denied for insufficient information. (Rev. 10/2014)

Failure to obtain a prior authorization shall result in denial of reimbursement. Providers should not obtain injectable drugs for administration in the office setting through outpatient pharmacy program and written prescriptions. For information regarding outpatient pharmacy prior approvals refer to the Pharmacy Services manual located at web portal at www.mmis.georgia.gov. (Rev. 10/2014)

807. Prior Approval: Office or Nursing Home Visits

807.1. Requests for prior approval for more than ten office or nursing home visits per calendar year for one member may be made if additional visits are medically necessary. Medically necessary visits include life threatening situations and situations involving serious acute or serious chronic illnesses. (Rev. 10/2014)

807.2. The attending physician must forward a Prior Approval Form DMA 81 containing:

807.2.1. The member's name and Medicaid number

807.2.2. The diagnoses of the member

807.2.3. Explanation of medical necessity for more than ten visits per year, and

807.2.4. The physician's signature (physician's stamps are not acceptable over a typed address) (Rev. 10/2014)

807.3. Approved requests are valid through December 31 of the approval year. The approval form must be retained in the provider's records for the length of time specified in the Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual. (Rev. 10/2014)

808. Procedures for Obtaining Pre-Certification for Transplants

Requests for approval of coverage of transplants should be submitted online via the web portal at www.mmis.georgia.gov. (Rev. 10/2014)

Prior approval and pre-certification accompanied by medical records must be received for review prior to rendering a transplant. Records must be current, and must include medical history, pertinent laboratory findings, x-ray and scan reports, social history and test results that exclude viremia, and justify the medical necessity of the transplant. (Rev. 10/2014)

Transplant procedures and related services must be approved prior to the time that services are rendered, regardless of age. These services cannot be approved retroactively. The member must be eligible at the time services are provided. (Rev. 10/2014)

If approval is given for the transplant procedure, a pre-certification number will be assigned. (Rev. 10/2014)

Chapter 900: Scope Of Services

901. General

The Advanced Nurse Practitioner Services Program provides reimbursement for a broad range of medical services, subject to the reimbursement limitations established in this manual. The Division has developed reimbursement limitations to ensure appropriate utilization of funds. These reimbursement limitations consist of the following:

901.1 prior approval requirements described in Chapter 800,

901.2 service limitations described in Chapter 900,

901.3 service restrictions described in Chapter 900

901.4 non covered procedures described in Section 900.

901.5 The Division will not reimburse an Advance Nurse Practitioner for any services, which is outside the legal scope (i.e., surgical first assist)

902. Coding of Claims

Provider coding of both diagnosis and procedures is required for all claims. The coding schemes acceptable by the Division are the ICD-9-CM & (ICD-10 CM) (International Classification of Diseases 9th & 10th Edition Clinical Modification) for diagnosis and the CPT (Current Procedural Terminology Edition) for procedures.

Certain codes from these coding schemes are not accepted by the Division, and certain modifications to the CPT coding scheme have been made. These are discussed in the sections that follow.

903. ICD-10-CM

Codes deleted from previous editions of the ICD are not accepted by the Division. The ICD -10-CM coding scheme consists of three volumes. Volumes I and II are needed by Advanced Nurse Practitioners. Categories of ICD 9 codes that begin with alphabetic character "E" (E800 E999) and the corresponding ICD- 10 codes range that begin with V81.2XXA - Y36.0105 are not accepted by the Division. The remaining special category of codes that begin with "V" or "Z" are acceptable only if the "V" code or "Z" code (ICD 10) codes describes the primary diagnosis. The provider must select the diagnosis codes that most closely describe the diagnosis of the patient.

In coding a diagnosis on a claim, the code must be placed on the claim form using the identical format (including the decimal point) as shown in the ICD 9 CM (examples: 402; 402.0; 402.00) and the ICD-10-CM codes, effective on and after October 1, 2015 (examples: I11, I11.0, and I11.9). Coding must be to the highest level.

904. CPT

The physician/ advanced nurse practitioner must select the procedure code that most closely describes the procedure performed. The following modifications and instructions apply to all physician claims. Professional services should be billed on the Health Insurance Claim Form (Centers for Medicare and Medicaid Services CMS 1500, version 02/12). Refer to Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual.

904.1. Codes deleted from previous editions of the CPT are not reimbursable.

904.2. Codes for "Unlisted Procedures" are not reimbursable.

904.3. Modifiers for clarifying circumstances are accepted by the Division, located at the end of this section. All modifiers are subject to post payment review.

904.4. Annual updates to the CPT are effective as soon as possible after the month of publication. This applies to deletions, additions, or revisions.

904.5. Physicians/advanced nurse practitioners will be notified of the effective date of these changes.

904.6. Other modifications to the CPT coding scheme were required by the Division to process claims for certain covered services. The special coding requirements and service limitations are discussed in the following section.

904.7. To check the status of a claim or require assistance with a billing problem, contact the Gainwell Technologies Provider Inquiry line at 1-800-766-4456.

904.8. For assistance with resolving denied claims with explanation of benefit (EOB) codes (e.g., timeliness or conflict with another claim), submit the completed DMA520 form with supporting documentation to:

GAINWELL TECHNOLOGIES
Provider Correspondence
P.O. Box 105200
Tucker, GA 30085-5200
800-766-4456 (Toll free)
Website: http://www.mmis.georgia.gov

904.9. For claims inquiries or appeals requiring clinical review for medical necessity, submit requests via the web portal (www.mmis.georgia.gov), under the link 'Prior Authorization/Provider Workspace/Provider Inquiry Form (DMA-520A)'.

904.9.1. Once the electronic inquiry is submitted, an inquiry number will be generated. The provider will have the ability to view the medical review decision via the web portal.

904.9.2. Only one DMA 520A form may be used per inquiry. All data fields must be completed.

904.9.3. Providers can electronically attach the supporting documentation at the time of the inquiry request or fax in the supporting documentation to the designated Alliant Health Solutions fax line numbers: 678- 527-3066 or 877-399-7142.

904.9.4. A copy of the DMA-520A form must be faxed with the supporting documentation, and the form must include the inquiry number obtained from the web submission. If the inquiry number is not provided on the DMA-520A form, or no supporting documentation is attached, the inquiry will be discarded.

904.9.5. Mailed DMA-520A provider inquiries and appeals will not be accepted and will be discarded.

904.9.6. Refer to Chapter 500, section 502, of the Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual for additional information.

905. General Claims Submission Policy for Ordering, Prescribing, or Referring - (OPR) Provider

905.1. The Patient Protection and Affordable Care Act (PPACA) 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. CMS expanded the claim editing requirements in § 1833(q) of the Social Security Act and the providers definitions in §1861-r and §1842(b)(18)C to align with the PPACA.

905.2. To comply with the PPACA, claims for services that are ordered, prescribed, or referred must indicate the ordering, prescribing, or referring (OPR) practitioner. The Division will utilize an enrolled OPR provider identification number verify Georgia Medicaid enrollment. Any OPR physician, or other eligible practitioner, who are not 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 rendering provider. If the NPI of the OPR Provider denoted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim will be denied.

905.3. Effective 1 April 2014, the Division will check claims for the NPI of all ordering, prescribing, and rendering providers in accordance with the OPR regulation. This edit will be informational until June 1, 2014. Effective June 1, 2014, inclusion of the ordering, prescribing and referring information will become mandatory. Claims that do not contain the required information will be denied.

905.4. For CMS-1500 claim form:

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

905.5. For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name.

Utilize the "ordering" provider field for claims that require a prescribing physician.

905.6. For claims transmitted via EDI:

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

905.7. The following resources are available for more information:

905.7.1. Access the Division's DCH-I newsletter and FAQs at: http://dch.georgia.gov/publications

905.7.2. Search to see if a provider is enrolled at: https://www.mmis.georgia.gov/portal/default.aspx

905.7.3. Choose the 'Provider Enrollment/Provider Contract Status' option. Enter Provider ID or NPI and provider's last name.

905.7.4. Access a provider listing at: https://www.mmis.georgia.gov/portal/default.aspx

(Rev. 04/2014)

906. Accepted Modifiers

22	**Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). This modifier should not be appended to an E/M service.
24	**Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period:** The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure.
25	**Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service:** The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.
26	**Professional Component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.
50	**Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier 50.
52	**Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier 52 signifying that the service is reduced.
54	**Surgical Care Only:** When one physician performs a surgical procedure, and another provides preoperative or postoperative management.
55	**Postoperative Management Only:** When one physician performed the post-operative management, and another physician performed the surgical procedure.
57	**Decision for Surgery:** An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding the modifier 57 to the appropriate level of E/M service.
58	**Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional: During the Postoperative Period:** The physician may need to indicate that the performance of a procedure or service during the postoperative period was a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure. The modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.
62	**Two Surgeons:** When two surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure, each surgeon should report his/her distinct operative work by adding the modifier 62 to the procedure.
78	**Unplanned Return to the Operating Room by the same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period:** Used to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier 78 to the related procedure.

80	**Assistant Surgeon:** Surgical assistant services may be identified by adding the modifier 80 to the usual procedure number.
AA	Anesthesia services rendered by an Anesthesiologist.
GT	Must be used in conjunction with the appropriate codes for Telemedicine following full implementation of HIPAA compliance (see “Telemedicine Consultations.”)
TC	**Technical Component:** Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances, the technical component charge is identified by adding modifier 'TC' to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving a qualified individual, CRNA’s or PAAA’s, by an anesthesiologist.
QX	Medically directed salaried employee of Anesthesiology.
QY	Medical direction of on anesthesia procedure involving a qualified individual [CRNA’s] or [PAAA’s] by anesthesiologist.
QZ	Non medically directed, self-employed.

907. Coding Modification and Service Limitations

The services or groups of services in this Section are covered with limitations. If a physician has medical justification for exceeding a service limitation, the medical justification should be documented and available to the Division upon request. Lack of documentation and justification will be grounds for denial or reduction of reimbursement, or recoupment of reimbursement.

908. Charts and Records

The physician must maintain legible, accurate, and complete charts and records to support and justify the services provided. A chart is a summary of essential medical information on an individual patient. A record is a date report supporting the claim submitted to the Division for services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. A record of service must be entered in chronological order by the practitioner who rendered the service.

908.1. For reimbursement purposes, such records shall be legible and shall include at a minimum, the following information:

908.1.1. Date of service

908.1.2. Patient’s name and date of birth

908.1.3. Name and title of person performing the service

908.1.4. Chief complaint or reason for such visit

908.1.5. Pertinent medical history

908.1.6. Pertinent findings on examination

908.1.7. Medications, equipment, or supplies prescribed or provided

908.1.8. Description of treatment (when applicable)

908.1.9. Recommendations for additional treatment, procedures, or consultations

908.1.10. X-rays, tests, and results

908.1.11. Plan of treatment, care, and outcome

908.1.12. The original handwritten personal signature, initial, or electronic signature of the person performing the service must be on the patient's medical records within three months of the date of service. This includes, but is not limited to, progress notes, radiological, and laboratory reports for each date of services billed to the Division. A signature on the super bill does not satisfy this requirement. Medical record entries without specified signature can result in recoupment of payment.

908.1.13. All medical records must be written in Standard English Language. Records must be available to the Division or its agents, and to the U.S. Division of Health and Human Services, upon request. Documentation must be timely, complete, and consistent with the bylaws and medical policies of the office or facility where the service is provided.

909. Anesthesia Services

The Division will reimburse CRNAs under the Advanced Nurse Practitioner Program for non-medically directed (Independent/Self Employed) services and medically directed services.

Reimbursement for anesthesia services includes the preoperative and post-operative visits, the administration of the anesthetic, and the administration of fluids or services "incident to" the anesthesia or surgery.

Two separate mechanisms for reimbursement of anesthesia are as follow:

909.1. Services by the Operating Surgeon

909.1.1. The Division will reimburse the operating surgeon for spinal or regional anesthesia only. The charge must be billed on a Physician / Practitioner Invoice (Centers for Medicare and Medicaid Services (CMS)-1500), " and the appropriate CPT code for the anesthesia service: 62310, 62311, 62318, or 62319.

909.1.2. Spinal or regional anesthesia will be reimbursed at the statewide maximum allowable reimbursement amount. In addition, reimbursement for obstetrical anesthesia provided by the attending physician is available only when the following standards are met:

909.1.2.1. The physician must remain on the premises when an epidural anesthesia is being done.

909.1.2.2. The physician should be credentialed by the hospital to perform this procedure; and

909.1.2.3. Re-dosing of the epidural must be done by a physician who is present. It cannot be done over a phone or if the physician is not present.

909.1.3. Reimbursement for local infiltration, digital block or topical anesthesia is included in the reimbursement for surgery. These charges are not separately reimbursable and should be included in the surgery fee.

909.2. Services by an Anesthesiologist/ CRNA

909.2.1. General Anesthesia for Surgery

Anesthesia for covered surgical procedures must be billed on the Center For Medicare & Medicaid Services Claim Form (CMS-1500 Claim Form), using the appropriate CPT Anesthesia code (code range 00100-01999) for the surgery performed and the appropriate modifier.

909.2.2. The accepted modifiers are listed below:

909.2.2.1. AA: Anesthesia services personally furnished by anesthesiologist

909.2.2.2. QK: Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individual(s), [CRNAs] or [PAAAs] by an anesthesiologist.

909.2.2.3. QY: Medical direction of one anesthesia procedure involving a qualified individual [CRNA] or [PAAA] by an anesthesiologist.

909.2.2.4. QX: Medically directed CRNAs

909.2.2.5. QZ: Non-medically directed CRNAs

All CRNAs must be enrolled in the Nurse Practitioner's Program to bill Medicaid for services rendered. Medically directed CRNAs must bill for services performed using the QX modifier.

If the surgical procedure is non-covered or denied, anesthesia for that service also is non-covered.

Physicians may no longer bill for the total services performed by their CRNA's or PAAA's; however, physicians may bill for the supervision component of the services provided by CRNA's or PAAA's, using the QK or QY modifiers.

The calculation of anesthesia time begins when the Qualified Anesthesia Practitioner begins to prepare the patient for the induction of anesthesia in the operating room or an equivalent area and ends when the Qualified Anesthesia Practitioner /CRNA is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.

Reimbursement for general anesthesia is calculated using the following formula:

AC = CF (BU + TU)
AC = Allowed Charge
CF = Conversion Factor
BU = Base Units
TU = Time Units

Allowed Charge is the maximum amount payable by the Division for anesthesia services. The amount paid is the lesser of the submitted charge or the amount calculated in the formula.

Conversion Factor is a single unit rate used to calculate reimbursement for all anesthesiology services. This figure is determined by the Division in accordance with federal regulations.

Base Units are assigned to establish the relative difficulty of each service. These numbers are derived from Relative Value Studies, which, in turn, are derived from charge patterns.

Time Units are calculated as the total time required for the service. One-time unit is fifteen minutes or any part thereof.

Claims for anesthesia services must be submitted using total time in minutes, with each 15 minutes or any part thereof, being equaled to one unit, on the CMS 1500 claims form.

Do not add base or physical status units as GAMMIS automatically adds the appropriate base and physical status units according to the CPT and physical status codes billed.

If special conditions are indicated on the claim, additional base units may be assigned by the Division in the calculation.

909.2.3. Concurrent Procedures: Medical Direction

909.2.3.1. The medical direction of four or less concurrent anesthesia procedures is reimbursable under physician services using the modifier QK if the following conditions are met:

909.2.3.1.1. The anesthesiologist is immediately available in all cases when medical direction is provided;

909.2.3.1.2. The anesthesiologist performs a pre anesthetic examination and evaluation;

909.2.3.1.3. The anesthesiologist prescribes the anesthesia plan;

909.2.3.1.4. The anesthesiologist personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence (if applicable);

909.2.3.1.5. The anesthesiologist ensures that any procedures in the anesthesia plan that the anesthesiologist does not perform are performed by a qualified individual;

909.2.3.1.6. The anesthesiologist monitors the course of anesthesia administration at frequent intervals;

909.2.3.1.7. The anesthesiologist remains physically present and available for immediate diagnosis and treatment of emergencies; and

909.2.3.1.8. The anesthesiologist provides indicated post anesthesia care.

909.2.3.2. Reimbursement is not available for direction of more than four concurrent anesthesia procedures. Anesthesia services provided by physician's assistants are not covered.

909.2.4. General Anesthesia for Routine Dental Procedures

Reimbursement of anesthesia for routine dental procedures must be billed using the most appropriate CPT anesthesia codes 00100-01999. Dental procedures without a CPT anesthesia codes designation may be billed using the Current Procedural Terminology code D9243 (intravenous moderate (conscious) sedation/analgesia- each 15-minute increment).

909.2.5. Regional or Spinal Analgesia for Pain Management

Services performed by an anesthesiologist for pain management are reimbursable only when medically necessary for intractable pain (e.g., advanced cancer). These services must be billed on the CMS 1500 using Type of Service '2.' Daily management of the epidural must be billed using procedure code 01996. (Rev. 10/2023)

909.2.6. Monitored Anesthesia Care (MAC)

When administered as anesthesia for medical or surgical procedures, monitored anesthesia must be billed on the CMS 1500 claim form using CDT code D9239 (Intravenous moderate conscious sedation/ analgesia- first 15 minutes) and D9243 (Intravenous conscious sedation/analgesia – each 15 minutes).

Reimbursement for MAC is calculated using the Flat Rate methodology. There are no base units assigned to CDT codes D9239 and D9243. MAC involves the intra-operative monitoring of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or the development of adverse physiological patient reaction to the surgical procedure by a physician or a qualified individual under the medical direction of a physician.

MAC also includes the pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated post-operative anesthesia care.

A physician personally furnishing or medically directing the MAC does not automatically mean the MAC is a covered service. The MAC must be reasonable and medically necessary under the given circumstances. (Rev. 01/2016)

909.2.7. Electroconvulsive Therapy (ECT)

Reimbursement of anesthesia services for Electroconvulsive Therapy (ECT) must be billed under procedure code 00104 on the CMS 1500 claim form, with the appropriate modifiers of AA, QK, QX, QY, or QZ.

909.2.8. Non-Invasive Imaging or Radiation Therapy

Reimbursement of anesthesia services for Non-Invasive Imaging or Radiation Therapy must be billed under procedure code 01922 on the CMS 1500 claim form, with the appropriate modifiers AA, QK, QX, QY, or QZ.

909.2.9. Services Other Than Surgery

Services other than anesthesia for surgery (services performed by an anesthesiologist that are not in conjunction with surgery, e.g., endotracheal intubation, nerve block, etc.), must be billed on the CMS 1500 Claim Form using Type of Service '2.' Specialized anesthesia services separate payment is allowed for Swan-Ganz and CVP lines placement by the anesthesiologist during anesthesia administration if the procedure is medically necessary and is not included in the global surgical fee for the surgery being performed.

909.2.10. Obstetric, Labor and Delivery

Obstetric Anesthesia Labor and Delivery epidural and caudal anesthesia are covered services with the appropriate modifiers of AA, QK, QX, QY, or QZ.

The following procedure codes must be used when billing for Labor and Delivery epidurals/caudal:

909.2.10.1. 01967: Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection or any necessary replacement of an epidural catheter during labor)

909.2.10.2. + 01968: Anesthesia for cesarean delivery following neuraxial labor analgesia/ anesthesia (List separately in addition to code for primary procedure performed) (Use 01968 in conjunction with code 01967)

909.2.10.3. 01969: Anesthesia for cesarean hysterectomy following Neuraxial labor analgesia/ anesthesia (List separately in addition to code for primary procedure performed) (Use 01969 in conjunction with code 01967)

909.2.11. Split Billing Primary and Add-On Codes

The Division makes an exception to the CPT coding guidelines and allows split billing of the primary (01967-AA) and add-on (01968 & 01969 QX) CPT anesthesia/epidural codes by the anesthesiologist and the CRNA and PAAA when performing the services for the same patient on the same date of service. The exception to add-on code billing is only applicable to anesthesia codes 01967, 01968, and 01969, and when billed with the appropriate modifiers.

909.2.11.1. 01960: Vaginal Delivery

909.2.11.2. 01961 Cesarean Section

909.2.11.3. Reimbursement is based on general anesthesia methodology.

909.2.11.4. Anesthesia reimbursement is limited to one anesthesia per labor and delivery regardless of the mode of anesthesia or the type of delivery. Anesthesia for sterilization procedures performed on the same date must be billed using the appropriate procedure code with modifier 78.

910. Antigen Therapy

For policy and billing guidance related to Antigen Therapy, please refer to Section titled Allergy Services of the Policies and Procedures for Physicians Services Manual. The manual can be found on the GAMMIS web-portal at www.mmis.georgia.gov, under the Provider Information, Provider Manuals tabs. (Rev. 01/2024)

911. Auxiliary Personnel

The Division has no provision for direct enrollment of or payment to auxiliary personnel employed by the nurse practitioner, such as nurses, non-physician anesthetists, unlicensed surgical assistants, or other aides. Physician's Assistant services are reimbursable only under criteria set forth in Chapter 600 of the Policies and Procedures for Physician Services manual.

Certified Pediatric, OB\GYN and Family Nurse Practitioners, and CRNAs are eligible for enrollment. Licensed physical, occupational, and speech pathology therapists are eligible for enrollment to provide services to members less than twenty-one years of age. Services provided by practitioners eligible for enrollment cannot be billed by the nurse practitioner. Nurse practitioners cannot be reimbursed for services provided by nurse practitioner extenders.

When the nurse practitioner employs auxiliary personnel to assist in rendering services to patients and bills the charges as part of the nurse practitioner's charge for the service, the Division may reimburse the nurse practitioner for such services if the following criteria are met:

911.1. The services are of kinds that are "commonly furnished" in the particular medical setting; and

911.2. The services are not traditionally reserved to nurse practitioner; services traditionally reserved to nurse practitioners include but are not limited to hospital, office, home or nursing home visits, etc.

Employed auxiliary personnel performing an incident to services may be part-time or full-time employees of the enrolled nurse practitioner. In order to satisfy the employment requirement, the auxiliary personnel must be considered an employee of the enrolled nurse practitioner. To satisfy the employment requirement, auxiliary personnel must be considered an employee of the enrolled physician, and the leased employees must be full-time and the terms of lease must render leased employees in all respects under control and supervision of enrolled physician. To satisfy the employee lease requirement, the applicable agreement, the term of the lease must be for a minimum of one year.

Services provided by auxiliary personnel not employed by the nurse practitioner are not covered. Even if the services are provided on nurse practitioner's order or included in the nurse practitioner's bill they are not covered as incidents to a nurse practitioner's service.

"Incident to" means the services are furnished as an integral, although incidental, part of the nurse practitioner's personal professional services in the course of diagnosis or treatment of an injury or illness. Such a service could be considered "incident to" when furnished during a course of treatment where the nurse practitioner performs an initial service and subsequent services of a frequency that reflect the nurse practitioner's active participation in and management of the course of treatment.

"Supervision by the nurse practitioner" does not mean the nurse practitioner must be present in the same room; however, the nurse practitioner must be present at the site of the services and be immediately available to provide assistance and direction throughout the time the services are performed.

"Commonly furnished" services are those customarily considered incident to the nurse practitioner's personal services in the particular medical setting.
(Rev. 10/2014)

912. Co-Payment

See Appendix P for details on co-payments.

913. Electrocardiograms (EKG)

CPT code 93014 is reimbursable when the physician who is interpreting an EKG performed in a rural area by a physician's assistant or a nurse practitioner, and no physician is immediately available at the rural clinic. The code should not be used to bill for services to a patient who is hospitalized and on a cardiac telemetry monitor. Additionally, the code should not be utilized to report transmissions of patient demand event monitoring devices.

CPT code 93268 should be used to report transmission, physician review, and interpretation of event recordings produced by a cardiac event recorder.
(Rev. 10/2014)

914. Family Planning Services

Please refer to the Family Planning Services Manual.
(Rev. 10/2014)

915. Office or Other Outpatient E/M Services

All levels of office and other outpatient E/M services as specified in the current CPT manual, including definitions and instructions, are incorporated herein by reference. In addition, the following limitations apply for members aged twenty-one years or older.

If a member is admitted to the hospital as an inpatient in the course of an appointment in another site of services (e.g., hospital emergency Division, physician's office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission and should not be billed separately.

Reimbursement for office E/M service is limited to ten (10) per member per calendar year, regardless of the number of physicians rendering care, unless prior approval has been obtained, or if the visit is an emergency. (See Chapter 800 for prior approval procedures.) Claims for emergency office E/M services must be clearly marked "EMERGENCY' and describe the emergent condition. Office records or notes must be submitted with all claims marked "EMERGENCY' to support medical necessity. All emergency claims must be forwarded to:

Prior Authorization & Pre- Certification
Alliant Health Solutions
PO Box 105329
Atlanta, Georgia 30348

915.1. Please see the Family Planning Manual for reimbursement of Family Planning E/M.

915.2. Only one office E/M per date of service is reimbursable to the same provider or provider group regardless of extenuating circumstances except in the case of providers of different specialty codes.

915.3. Office E/M services rendered after office hours, during night hours, Sundays and holidays, are included in the same maximum allowable as regular office E/M services.

915.4. The service was provided in a situation where a delay in treatment would endanger the health of the individual.

915.5. Documentation of service in the physician's office records is not sufficient for reimbursement of hospital E/M services.

915.6. Hospital E/M services to members waiting nursing home placement are not reimbursable unless the services are medically necessary.

915.7. Observation or inpatient hospital care codes 99234 through 99236 must be used for outpatient observation or hospital admission that begin and end on the same calendar date with a minimum of twelve hours.
(Rev. 01/2016)

916. Observation

Observation services are services by a hospital/physician, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an out-patient's condition, or to determine the need for a possible admission to the hospital as an inpatient. Such services are covered if provided per physician's order. Observation services usually do not exceed twenty-four hours. Some patients, however, may require 48 hours of outpatient observation services. In only rare and exceptional cases do outpatient observation services span more than 48 hours.

A person is considered a hospital inpatient if formally admitted and acute inpatient qualifying criteria designated by Division, such as InterQual7 are met. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released or admitted as an inpatient.

If a patient is retained on observation status for 48 hours without being admitted as an inpatient, further observation services will be denied as not reasonable and necessary for the diagnosis or treatment of a physical or mental condition. (See Chapter 100 of the Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual.) A maximum of 48 hours of observation may be reimbursed. If the 48-hour observation limit is exceeded and the patient does not meet the criteria for inpatient admission, the submitted claim may include the total number of units, but the facility will only receive reimbursement for the 48 hours or units. However, any services provided beyond the medically necessary time are non-covered.

Observation generally covered as an outpatient service. Observing the patient for up to 24 hours should be adequate in most cases. A physician who believes that exceptional circumstances in a particular case justify approval of more than 48 hours in an outpatient observation setting may submit a claim with documentation of the exceptional circumstances. The claim can be appealed for medical review. If, after medical review, the determination is made that continued observation beyond 48 hours was medically necessary, an observation status may be approved.

Outpatient observation is not covered in the following situations: complex cases requiring inpatient care, post-operative monitoring during the standard recovery period; routine preparation services furnished prior to diagnostic testing in the hospital outpatient Division and the recovery afterwards; and the observation billed concurrently with therapeutic services such as chemotherapy, physical therapy, and similar situations.

The outpatient status becomes inpatient when inpatient services are medically necessary. Inpatient services must be certified per Chapter 800. Certification must be obtained within thirty calendar days of the beginning date of this episode of care. To receive certification for the admission, documentation must be provided proving that the admission is medically and appropriate.

If the provider billed for inpatient services and later determines that the services should have been billed as an outpatient service, the provider has three months from the date of service to adjust the claim. Providers should not substitute outpatient services for medically appropriate inpatient admissions. An inpatient is not considered to have been discharged if placed in observation after an inpatient admission. If an inpatient stay is likely, outpatient observation should not be billed to the Division. The date of the inpatient admission is the calendar date the patient is formally admitted as an inpatient and will count as the first inpatient day.

Elective procedures where the anticipated stay is less than 24 hours is considered an observation stay if the primary reason for the stay is to monitor for possible complications. Services, such as complex surgery, require inpatient care, and may not be billed as outpatient. Request for updates to the pre-certification file and retroactive certification (except pediatrics as per current policy) of inpatient level of care that should have been anticipated will not be considered timely and will be denied.

The Division covers services that are medically appropriate and necessary. The services provided in the setting must be appropriate to specific medical needs of the member. (See Chapter 100 of the Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual.) The medical record must substantiate the medical necessity and appropriateness including appropriateness of the setting. When the outpatient observation setting is non-covered, all services provided in the outpatient observation setting are also non-covered. Services that are not reasonable or necessary for the diagnosis and treatment of patients but are

provided for the convenience of patients or physicians are not covered. (See Chapter 100 of the Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual.)

Level of care and setting determinations are based on patient assessment, medical condition and anticipated or actual treatment as documented in the request for approval. Peer review, in conjunction with inpatient/outpatient qualifying criteria such as InterQual, may be used by PAUM contractors to assess the patient's medical condition and to substantiate medical necessity for inpatient or outpatient status. s. Hospitals are required to conduct concurrent review and to keep the hospitalized patient until the same criteria indicate hospitalization is no longer necessary. The Division will notify providers in writing 30 days prior to the date of any changes in the criteria or version of criteria being used to certify inpatient admissions. Written notice will be provided on banner messages and on remittances. The same version of criteria will be used for any retrospective medical reviews as were used prospectively.

917. Injectable Drugs - Private Office

Procedure codes and descriptions for injectable drugs (other than allergy injections) are listed in the Physicians Injectable Drug List Manual (PIDL) unless otherwise specified, immunization drugs for members less than 19 years of age are covered under the EPSDT-Health Check for Kids Program.

Claims for injectable drugs and immunizations must include CPT or HCPCS code and must also have an NDC.

Medications listed in the PIDL do not require prior authorization (PA) unless otherwise indicated by PA.

The Division's maximum allowable reimbursement for approved drugs on the Physician's Injectable Drug List (PIDL) to the lesser of:

917.1. The provider's usual and customary charge; or,

917.2. Average Sales Price (ASP) plus 6% as defined July 1st of each year or upon the drug's initial availability in the marketplace, whichever is later; or,

917.3. Average Wholesale Price (AWP) minus 11% for injectable drugs that do not have ASP pricing, until ASP pricing becomes available and ASP plus 6% pricing can be utilized.

917.4. Drugs on the PIDL that are without an ASP rate are denoted by an inverted triangle (▼).

Administration fees are not separately reimbursable under the Physician Services Program for injectable drugs with the exception of chemotherapy administration codes 96401-96542 and certain vaccines.

918. Laboratory Procedures

Laboratory procedures are defined in the CPT in the ranges 80100 through 89399 and 80049 through 80092. Providers must select the procedure code that most closely describes the procedure performed.

918.1. Multi-channel Tests

Individual components of automated, multi-channel tests must be billed separately. These tests must be billed using codes in the ranges 80100 through 89399 and 80049 through 80092. Only one unit of the appropriate test may be billed for one date of service.

Additional instructions and reimbursement information are located in the Schedule of Maximum Allowable Payments for Clinical Laboratory and Anatomical Pathology Services. This schedule is applicable to laboratory procedures that are performed in a physician's office or in an independent laboratory. The Division has established the following limitations for reimbursement for laboratory services:

918.1.1. Providers billing for laboratory services must be in compliance with the final rules of the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) to receive Medicaid reimbursement. At a minimum, a certificate of waiver is required for tests as defined by the Centers for Medicare and Medicaid Services (CMS). For tests performed of moderate or higher complexity, the physician must meet the CLIA requirements for certification.

918.1.2. Providers who do not have a Certificate of Waiver or Registration on file with CMS will have claims denied for laboratory services. If erroneous payment has been made to providers without appropriate certification, the Division will initiate recovery procedures.

918.1.3. No more than twelve tests per fiscal year (July 1 - June 30) may be reimbursed for the purpose of family planning.

918.1.4. The Division will not reimburse nurse practitioners for laboratory procedures that are sent to state, public, or independent laboratories. Independent laboratories are enrolled separately in the Medicaid program and must bill the Division directly for their services. Reimbursement for the collection and handling code, 99000, and the specimen collection code 36415 is included in the E/M services code reimbursement and is not separately reimbursable.

918.1.5. The laboratory procedures shown below must be sent to the appropriate state laboratory with the member's name and Medicaid number for the test procedures to be performed without charge.

918.2. Neonatal Metabolic Screens

The following tests comprise the neonatal metabolic screen required by Georgia on all infants between 24 hours after birth or by the seventh day of life:

918.2.1. Methionine for Homocystinuria

918.2.2. Galactose; blood

918.2.3. Phenylalanine (PKU), blood; Guthrie

918.2.4. Thyroxine (T 4) neonatal

918.2.5. Tyrosine, blood

918.2.6. Leucine for Maple Syrup Urine Disease (MSUD)

918.2.7. 17-Hydroyprogesterone (CAH)

918.2.8. Sickle Cell

Specimens for the above battery of tests or metabolic screens on newborns must be sent on filter paper (DHR Form 3491) to the State laboratory in Atlanta only. The Division allows follow up tests on infants less than three months of age when the initial screening indicates necessity.

918.3. Hemoglobin Testing

The Division will not make payment for the following tests for sickle cell detection, confirmation or follow-up for infants and family members of infants suspected of sickle cell anemia or trait:

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

All blood specimens with a sickle cell indicator must be forwarded in an appropriate sickle cell outfit to the Waycross Regional Public Health Laboratory.

The Division will provide reimbursement for these hemoglobin tests for possible diagnosis other than sickle cell.

918.5. Syphilis Serology

The Division will not reimbursement for syphilis serology. Please refer to the independent Lab Services manual for a list of covered procedure codes for syphilis testing.

918.6. Tuberculosis Testing

The following procedures are for tuberculosis testing:

918.6.1. Tubercle Bacillus culture

918.6.2. Concentration plus isolation

918.6.3. Definitive identification

All sputum specimens with a tuberculosis indicator must be forwarded in the sputum outfit provided by the State to the State Laboratory in Atlanta only. Under no conditions will the Division reimburse for tuberculosis testing.

918.7. Salmonella and Shigella Testing

Stool culture is often used for the detection of salmonella or shigella. All stool cultures with a salmonella or shigella indicator must be forwarded in a stool culture outfit (provided by the State) to the State laboratory in Atlanta. Under no condition will the Division reimburse for salmonella or shigella testing.

918.8. HIV/AIDS Test Procedures

The Division reimburses for screening tests when ordered by the member physician or practitioner within the context of a healthcare setting and performed by an eligible Medicaid provider. Please refer to the Independent Lab Services manual for a list of covered procedure codes for HIV testing. The manual can be found on the GAMMIS web-portal at www.mmis.georgia.gov, under the Provider Information, Provider Manuals tabs.
(Rev. 10/2014)

918.9. Drug Testing

Qualitative drug screening testing detects the presence of a drug in the human body. Blood or urine samples may be used; however, urine is the preferred specimen for broad qualitative screening. Blood is relatively insensitive for many common drugs, including psychotropic agents, opioids, and stimulants. Detection of a drug or its metabolite in urine is evidence of prior use. It does not by itself indicate that the drug remains in the blood or continues to cause clinical effects.

Current methods of analysis for drugs include chromatography, immunoassay, chemical (“spot”) tests and spectrometry. A laboratory must possess a valid standard for every substance identified. Drugs or classes are commonly assayed by qualitative screen, followed by confirmation with a second method.

Drugs or classes of drugs commonly assayed by qualitative urine screen are as follows: Alcohols, Amphetamines, Barbiturates, Benzodiazepines, Cocaine and Metabolites, Methadone, Methaqualones, Opiates, Phencyclidines, Phenothiazines, Propoxyphenes, Tetrahydro cannabinoids, and Tricyclic Antidepressants. Confirmation of the qualitative result by a different, more specific, and or quantitative method may be necessary in the following situations:

918.9.1. When it is necessary to identify the specific drug in a class

918.9.2. When following decreasing levels during recovery from an overdose

918.9.3. To estimate the amount of timing of ingestion of a drug shown to be positive at an undetermined concentration

When ethanol use is suspected, a quantitative blood test (without a qualitative urine screen) is preferred. When other alcohols (e.g., methanol, isopropanol, ethylene glycol) are suspected to have been ingested, a quantitative screening test for volatile substances is preferred.

Laboratories and Physician offices performing and billing procedure codes 80100, 80102, G0431 & G0434 must be CLIA certified. While drug screens may vary, each sample is expected to be screened at a minimum for opiates, methadone, amphetamines, cocaine, benzodiazepines, THC, and the screen may include other drugs indicated by patient history when procedure code 80100 is used. Additionally, the following requirements are also applicable for the codes:

918.9.4. Procedure code 80100 must be used for the comprehensive drug screen and cannot be used in conjunction with procedure code G0434 on the same patient for the same date of service.

918.9.5. Procedure code 80102 is to be used only for confirmation of drug screens with positive findings.

918.9.6. Procedure code G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) must be used to report more complex testing methods, such as multi-channel chemistry analyzers, where a more complex instrumented device is required to perform some or all of the screening tests for the patient.

918.9.7. Procedure code G0434 (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) must be used to report very simple testing methods, such as dipsticks, cups, cassettes, and cards, that are interpreted visually, with the assistance of a scanner, or are read utilizing a moderately complex reader device outside the instrumented laboratory setting.

918.9.8. If multiple drugs are confirmed using a single analysis, only one unit of 80102 will be allowed. Urine testing may be performed by a laboratory on a weekly basis for the first three months of treatment. Unbundled codes and charges for each drug class performed on the same date of service will not be allowed.

The Division will not reimburse for more than twenty-five multiple drug screens per member per fiscal year using a combination of codes 80100, 80102, G0431 & G0434. Reimbursement will not be made for more than five quantitative drug screens to monitor prescribed medications without medical justification.

The State Laboratory locations and telephone numbers are listed below:

Atlanta Central Laboratory
Georgia Department of Public Health
1749 Clairmont Road
Decatur, Georgia 30033-4050
(404) 327-7900

Waycross Regional Laboratory
Georgia Department of Public Health
1101 Church Street
Waycross, Georgia 31501-3525
(912) 338 - 7050

Specimen outfits for testing to be done in the Regional Laboratories should be ordered directly from those laboratories at the above addresses; however, the outfits for the tests in the Atlanta Central Laboratory must be obtained from:

Laboratory Services and Supply
1790 Clairmont Road
Decatur, Georgia 30033-4050

Reimbursement for laboratory procedures performed in the physician's office is for the technical and professional components. Charges for such laboratory procedures must be billed using CPT codes ranging from 80002 through 89365.

919. Medicare Deductible/Coinsurance

If a member is eligible for both Medicaid and Medicare, all claims must be sent to the Medicare carrier first. Medicare upper limits of reimbursement will apply for all services covered by Medicare. Policies and procedures for billing these services and detailed coverage limitations are described in Chapter 300 of Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual and Chapter 1000 of this manual.

920. Newborn Care

Reimbursement is available for inpatient post-natal normal newborn care on eligible newborns. Services including the history and physical, along with the subsequent hospital care and discharge day management, are reimbursable for normal newborns when medically necessary. Applicable codes include:

920.1. 99238 – Hospital discharge day management. (Cannot be billed on the same date as 99432).

920.2. See Chapter 900 for Laboratory Neonatal Metabolic Screens.

Hospital services for all newborns must be billed under the newborn's Medicaid number and contain the diagnosis code reflective of the medical condition.

Preventive health screening of eligible children performed after the newborn examination is covered under the EPSDT-Health Check (EPSDT) Program only. Clinics or nurse practitioners enrolled in the EPSDT-Health Check (EPSDT).

Program as screening providers may receive reimbursement for screening services provided eligible children. Please see Section 701 and Appendix D for further information regarding the EPSDT-Health Check (EPSDT) Program.

921. Nursing Home Services

Please refer to the Nursing Facility Manual. The manual can be found on the GAMMIS web-portal at www.mmis.georgia.gov, under the Provider Information, Provider Manuals tabs.
(Rev. 10/2014)

922. Obstetrical Services

922.1. Initial Visit and Prenatal Profile

The Division provides reimbursement for the initial visit to determine pregnancy and the initial laboratory services (prenatal profile) separately from any other obstetrical care. Charges for these initial services should be billed immediately after the initial contact.

922.2. Antepartum, Delivery and Postpartum Care

922.2.1. Total Obstetrical Care

If a member is eligible for Medicaid for the entire duration of a pregnancy and is cared for by one practitioner or a group practice, the attending practitioner must bill the Division under the appropriate procedure code for total obstetrical care which includes antepartum care, delivery, and postpartum care.

For reimbursement, the attending practitioner should be designated in the member's chart and services billed under that practitioner's number.

Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery.

Medical problems complicating labor and delivery management may require additional resources and should be identified by utilizing the codes in the CPT medicine section in addition to codes for maternity care.

If during the course of delivery, the attending nurse practitioner requires the services of a consulting physician, pre-certification is not required if the consulting physician submits CPT codes for consultation only. However, if the consulting physician assumes care, or provides more services than strict consultation, pre-certification is required and should be obtained from the Gainwell Technologies.

Postpartum care includes hospital and office visits following vaginal or cesarean section delivery. For medical complications of pregnancy (e.g., cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, pre-term labor, premature rupture of membranes), see services in the Medicine section of the CPT.

For surgical complications of pregnancy (e.g., appendectomy, hernia, ovarian cyst, Bartholin cyst), see services in the surgery section.

Total obstetrical care cannot be billed for a delivery of less than 20 weeks gestation (by dates or ultrasound) of the CPT.

Procedure code 59025 (non-fetal stress test) cannot be billed for members with a gestation period of less than 34 weeks. A practitioner may bill one fetal non-stress test in 24 hours for members that are at or past 34 weeks gestation. If the member is on continuous monitoring, only an initial non-fetal stress test should be required. In a rare instance where more than one non-fetal stress test would be required, while the member is on continuous monitoring, there must be clearly documented evidence of medical necessity.

When a C-Section is performed and the attending is not part of the group practice authorized to perform C-Sections, the global package cannot be billed. The physician performing the C-Section must bill for that service and the attending must bill for the appropriate antepartum and postpartum care.

922.2.2. Lactation Consultation Services

Effective 07/01/2022, the Department of Community Health will cover lactation consultation services for post-partum and breastfeeding mothers. Please refer to the Policies and Procedures for Physicians Services Manual for policies and billing guidance related to Lactation Consultation Services.
(Rev. 10/2022)

922.2.3. Partial Obstetrical Care Due to Member Eligibility

If a member becomes eligible for Medicaid as a result of a live birth, no prenatal services (including laboratory) are reimbursable. If the member was ineligible for the nine-month period preceding delivery, the appropriate delivery only or delivery and postpartum care code must be billed. No charge is reimbursable for hospital admission, history and physical or normal hospital E/M services. Deliveries of less than 20 weeks gestation (by dates or ultrasound) cannot be billed as a delivery.

922.2.4. Partial Obstetrical Care Due to Involvement of More Than One Physician During Pregnancy

If a practitioner provides all or part of the antepartum care but does not perform delivery due to termination of pregnancy by abortion or referral to another physician for delivery, use the appropriate CPT code as explained below:

922.2.4.1. Antepartum care only consisting between 4 to 6 visits but not including delivery must be billed using procedure code 59425;

922.2.4.2. Antepartum care only consisting of 7 or more but not including delivery must be billed using procedure code 59426;

922.2.4.3. For the occasion when a patient is seen for only 1 to 3 antepartum care visits, see appropriate E/M code. E/M codes for antepartum services cannot exceed 3 visits.

922.3. Delivery Only Codes

Delivery only codes, 59409, 59612, 59514 and 59620 include the in hospital postpartum follow up care. Codes 59410, 59515, 59614 and 59622 can only be billed when the physician does not provide antepartum care but performs the delivery and follows the mother for the 60 days post-delivery for all the postpartum care. Procedure code 59871 cannot be billed on the same day as delivery.

If the same practitioner began routine antepartum care prior to the 28th week of gestation and continued care through the delivery and postpartum period, the practitioner must bill the appropriate code total obstetrical care.

If a practitioner who has not cared for the member during the prenatal period delivers the child, the practitioner should bill the appropriate delivery only or delivery and postpartum care procedure code. A delivery of less than 20 weeks gestation (by dates or ultrasound) cannot be billed as a delivery.

922.4. Out of State Deliveries

The Division will reimburse out of state providers for routine or emergent obstetrical deliveries.

922.5. First Trimester Incentive Payment

The Division provides incentive payment if the practitioner begins routine antepartum care in the first trimester of pregnancy (on or before 13 weeks gestation) and continues to provide normal prenatal care through the entire antepartum, delivery and postpartum periods.

For dates of service July 1997 and forward, in addition to all other requirements, it is required that voluntary HIV counseling and testing be offered and provided. Documentation shall be a part of the medical records. See Appendix Q for provider's guide to HIV pre-test and post-test counseling. Failure to document may result in repayment of the entire incentive payment.

To bill for this incentive, a 22 modifier must be added to code 59400 - Total Obstetrical Care - Vaginal Delivery or 59610 - Total Obstetrical Care, Vaginal Delivery, after previous C-section. Please note that these codes are mutually exclusive and only one can be billed per pregnancy

923. Tobacco Cessation Services for Medicaid Eligible Members

The Department covers tobacco cessation services specifically for pregnant women. The advance nurse practitioner may bill for this service in addition to billing the appropriate Evaluation and Management (E/M) office visit along with using CPT codes 99406 or 99407 only.

Two 12-week tobacco cessation treatment period will be allowed per pregnancy. A face-to-face counseling session is required for this service and must be documented in the pregnant member's medical record every 30 days during the 12-week treatment period which may begin during any trimester.

Pharmacotherapy medications are also covered but should be prescribed only after the risks have been discussed in the face-to-face counseling session. Please refer to the Pharmacy Services Manual for detailed information on the covered medications and Prior Authorization (PA) procedure.
(Rev. 10/2014)

924. Radiological Services

Codes for radiological services have three formats: professional component, technical component, and complete procedure. Not all procedures have all three components. In general, these components should be used as follows:

924.1. Professional Component (26 modifier)

Radiology services should be billed as professional component when:

924.1.1. The physician provides only the professional service for the procedure; or

924.1.2. The service is provided in a hospital; or

924.1.3. The technical portion of the service is performed by someone other than the physician's salaried employee.

924.2. Technical Component (TC modifier)

Radiology services should be billed as technical component when the physician is providing the technical portion of the service only. This component has very limited application under current Medicaid policy.

924.3. Complete Procedure

To bill for complete radiological procedures which include charges for actually processing and developing the x ray (technical component), and evaluating the x ray (professional component), submit the codes as defined in the CPT without a modifier.

When billing for multiple identical radiology services performed on the same date of service, charges must be placed on only one line of the claim form with the number of X-rays taken being placed in the "unit" space. For example, three single view chest X-rays performed on the same date of service would be billed as three units of procedure code 71045, at $10.00 per unit to equal $30.00 for the line charge.

To bill for identical bilateral procedures where there is not an all-inclusive code, bill the procedure code with a 50 modifier on one line indicating one unit of service. Use of the 50 modifier will ensure correct payment for both procedures using the one code. However, if there is an all-inclusive procedure code for a bilateral procedure, the one charge for such procedure will be reimbursed at the lower of 100% of the allowed amount of the submitted charge.

924.4. Computerized Tomography - (CAT scans)

The Division reimburses for all medically necessary CAT scans.

924.5. Other Radiological Services

Other Radiology procedures including some specific pregnancy ultrasounds, CTs, MRIs, and PET scans (refer to Appendix O for specific codes)

924.6. Pregnancy Related Ultrasounds

Prior Approval for certain pregnancy related ultrasounds is required after the first ultrasound or in some cases, prior to rendering the service. Refer to Appendix O for detailed information regarding specific procedures that require prior approval before services are rendered . Physicians should seek Prior Approval on any service for which reimbursement might be questionable. The ordering physician is responsible for obtaining the Prior Approval. The physician's failure to obtain Prior Approval will result in denial of payment to all providers billing for services including the facility.

924.7. Magnetic Resonance Imaging (MRI)

The Division covers medically necessary MRI when CT scans or SPECT procedures are not definitive or appropriate. Only one MRI per day will be paid without submission of documentation for medical necessity. Reimbursement for follow-up visits by the radiologist is included in the reimbursement for the MRI.

Please note that only enrolled Medicaid providers may be reimbursed for MRI procedures.

CT Scans or MRIs, which do not require contrast or are of a lower acuity, may be done under the general supervision of the physician. CT Scans/MRIs that require contrast or are at an increased level of acuity must be performed under the direct supervision of the physician.

924.8. Mammography

All mammography exams must be performed at a state certified facility, and the results must be interpreted by a physician certified by the American Board of Radiology, or the American Osteopathic Board of Radiology, or certified as qualified to interpret the results of mammography exams as determined by the Secretary of Health and Human Services. Contact the office below with questions on obtaining certification:

Healthcare Facility Regulation Division
Georgia Department of Community Health
2 Martin Luther King Street, S.E.
East Tower, 17th Floor
Atlanta, Georgia 30334
(404) 657-5866

The Division must have an update and valid copy of your certification. Please fax new certification to GAINWELL TECHNOLOGIES at 1-866-483-1044 or 1-866-483-1045 or forward to:

Prior Authorization & Pre-Certification
Alliant Health Solutions
PO Box 105200
Atlanta, Georgia 30348
800-766-4456 (Toll free)

When billing for mammography on the CMS 1500 claim form, enter the radiology center's 6-digit certification number on field 24a, with the preceding EW qualifier. Please refer to Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual for billing instructions. (Rev. 04/2023, 07/2023)

925. Reduced Services (52 Modifier)

Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's election. Use of the 52 modifier signifies that service rendered has been reduced. Reimbursement will be reduced accordingly. Example: When the CPT states that all codes in a section are for a bilateral procedure, the 52 modifier must be used to report the service if only a unilateral service was provided. Please see the current CPT manual for specific instructions on use of this modifier with specific codes. Failure to use the 52 modifier appropriately will result in recoupment of payment. Failure to use the 52 modifier when indicated shall be identified as an overpayment subject to recovery. (Rev. 10/2014)

926. Site of Service Differential

Services that are primarily performed in office settings will be subject to a reimbursement reduction when performed in an inpatient, outpatient, emergency, or ambulatory surgery setting. The reduced reimbursement is calculated as part of RBRVS and is updated annually. Appendix J lists the services that are subject to the reduced reimbursement.

927. Supplies and Materials

Office medical supplies, except for drugs and certain supplies associated with performing the procedures will be considered to be a practice expense which is included in the payment for the service to which they are incidental. No additional reimbursement will be made.

928. Surgery

Reimbursement for surgical procedures is based on the global fee concept under which a single fee is billed and paid for all necessary services normally furnished by the surgeon before, during, and after the procedure. Four modifiers (24, 25, 78 and 79) have been added to identify a service or procedure furnished during a global period that is not normally a part of the global fee. For example, a service unrelated to the condition requiring surgery or for treating the underlying condition and not for normal recovery from the surgery, may be payable outside of the global fee.

928.1. Major Surgery

The initial evaluation or consultation by the surgeon will be paid separately from the global surgery package. The pre-operative period will include all pre-operative visits, in or out of the hospital, by the surgeon beginning the day before the surgery.

Modifier 57 is to be used with the evaluation and management code for the visit or consultation the day the decision for surgery is made. Modifier 57 cannot be used with minor surgeries.

The global surgery fee will include all additional medical or surgical services required of the surgeon because of complications that do not require additional trips to the operating room. All medically necessary return trips to the operating room, for any reason and without regard to "fault," will be separately billed and paid at a reduced rate.

The payment level for re-operations to deal with complications will be set at the value of the intra-operative services being performed if there is a CPT code to describe these services. Codes exist to describe re-operations for complications for various body areas. If no code exists, the payment level may not exceed 50 percent of the value of the intra-operative services originally performed. (See also description of CPT modifier 78.)

A standard 90-day post-operative period will include all services by the primary surgeon during this period unless the service is for a problem unrelated to the diagnosis for which the surgery is performed or is for an added course of treatment other than normal recovery from the surgery. (See also description of CPT modifiers 24 and 79). Immunosuppressive therapy following transplant surgery is not included in the global fee and will be paid separately. The global fee will include services such as dressing changes, local incision care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, and nasogastric and rectal tubes; and change and removal of tracheostomy tubes.

Procedures with a 90-day post-operative follow-up period which are incident to major global surgery policy are listed at CMS Palmetto, located at https://www.palmettogba.com/ (Rev. 07/2022)

928.2. Minor Surgery and Non-Incisional Procedures

Minor surgeries, some of which are designated by a "star" following the procedure code number, are not paid using a global surgery policy. (Rev. 10/2014)

In addition, the surgery section of the CPT also includes diagnostic and therapeutic endoscopic procedures that are frequently performed by non-surgeons and may or may not involve actual surgery.

For minor surgeries and endoscopic procedures, no payment generally will be made for a visit on the same day in addition to the surgical procedure or endoscopy procedure unless a separately identifiable service is furnished (see also description of CPT modifier 25). For example, a visit could properly be billed in addition to payment for suturing a scalp wound if a full neurological examination is made for a patient with head trauma. But billing for a visit would not be appropriate if the evaluation consisted only of identifying the need for sutures and confirming allergy and immunization status. There will be no post-operative period for endoscopic procedures performed through an existing body orifice. Procedures requiring an incision for insertion of a scope (for example, a laparoscopic cholecystectomy) will be subject to either the major or minor surgical policy, whichever is appropriate.

Minor surgeries will have post-operative periods of 0 or 10 days. Those with 10 days will have all post-operative services related to recovery from the surgery during this period included in the fee for the surgery. Services furnished during this period for treatment of the underlying condition will be paid for separately (see also description of CPT modifier 24). Minor surgeries with a 10-day post-operative period are listed in the current "Federal Register."

928.3. Bilateral Procedures (Modifier 50)

If identical bilateral procedures are performed at the same operative session, the first will be reimbursed at the lower of 100% of the allowed amount or the submitted charge, while the second will be reimbursed at the lower of 50% of the allowed amount or the submitted charge. To bill for identical bilateral procedures where there is not an all-inclusive code, bill the procedure code with a 50 modifier on one line indicating one unit of service. Use of the 50 modifier will ensure correct payment for both procedures using the one code. However, if there is an all-inclusive procedure code for a bilateral procedure, the one charge for such procedure will be reimbursed at the lower of 100% of the allowed amount or the submitted charge.

928.4. Multiple Procedures

If multiple surgical procedures that add significant time or complexity to the procedure are performed at the same operative session, each of the clearly identified and defined procedures shall be reimbursed in the following manner:

928.4.1. The first or major procedure: the lower of 100% of the maximum allowed amount or the submitted charge.

928.4.2. The second through the fifth procedure: the lower of 50% of the maximum allowed amount or the submitted charge.

928.4.3. The subsequent procedures: the lower of 25% of the maximum allowed amount or the submitted charge.

Each individual surgical procedure for which reimbursement is being requested must be coded on separate lines on the claim form with an associated charge for each procedure. For the reimbursement methodology to be quickly and accurately applied, separate procedures must be arrayed from major to minor on the CMS 1500 claim form in field 24.

928.5. Incidental Procedures

Additional charges for incidental procedures performed at the time of a surgical operation are not covered unless substantiated by medical documentation. Such incidental procedures would include an incidental appendectomy, incidental excision of scars, and lysis of adhesions. A diseased appendix surgically removed at the same time as another surgery will be reimbursed under the multiple surgery reimbursement policy.

928.6. Surgical Team

Surgical services furnished by several physicians are reimbursed as if only one physician furnished all of the services in the global package, and the multiple surgery regulations apply.

928.7. Co-Surgeons - (Modifier 62)

Co-surgeons will be reimbursed one-half of 125% of the global fee and payment (equally divided between the two surgeons). No payment will be made for an assistant-at-surgery in these cases.

928.8. Surgical Assistant

A surgical assistant may be required for the management of specific surgical procedures. The upper limit of reimbursement for a nurse practitioner is 16% of the maximum allowable for the surgical procedure. The services of an assistant nurse practitioner are not anticipated for non-critical surgical procedures such as routine appendectomy, herniorrhaphy or sterilization.

Reimbursement will not be made for an assistant-at-surgery if the following conditions exist:

928.8.1. Medicare does not reimburse assistants for the specified surgery; or

928.8.2. A resident was available to assist; or

928.8.3. An assistant-at-surgery was not medically necessary.

Claims for appropriate assistant nurse practitioner charges must be billed by the enrolled nurse practitioner who is assisting the surgery. The “type of service” code “8”, "Assistant at Surgery" must be placed on the claim form and the procedure code must be the one billed by the primary surgeon.

If the surgeon is assisted by a Physician's Assistant whose supervising physician is not enrolled for PA services, or a non-physician who is not separately enrolled as a certified Nurse Midwife, or an Advanced Nurse Practitioner, the charge for such service is not separately reimbursable but may be included in the surgeon's fee for the procedure.

928.9. Surgery & Follow Up Care by Different Physicians (Modifiers 54 & 55)

The total of all allowances for all practitioners who furnish parts of the services included in a global fee (and who bill using one of the modifiers 54 and 55) must not exceed the total amount of the reimbursement that would have been paid to a single practitioner under the global fee for the procedure. Each physician will be paid directly for the portion of the global surgery services furnished, providing all parties utilize the respective modifiers appropriately. It is expected that the surgeon always furnishes the usual and necessary pre and intra-operative services and also, with few exceptions, in-hospital post-operative services. It is recognized that there are cases when the surgeon turns over the out-of-hospital recovery care to another health care provider. Reimbursement will be adjusted to accommodate these cases and will be made in accordance with the weighted percentages for post-operative care as published in the November 25, 1991, Federal Register.

In referring a patient to another health care provider, the surgeon agrees to accept the reduced reimbursement for the surgery. The surgeon must file the surgical procedure code with the 54 modifier. The follow-up care cannot be reimbursed until the surgery has been paid. The physician that is providing the follow-up care must bill the surgery procedure code once using the 55 modifier. If the surgery is non-covered for any reason, the follow-up care is also non-covered.

Follow-up care must be completed (either 10- or 90-day global period) before the service is billed. Only the surgical code used by the operating physician with a modifier of 55 can be billed. Individual office visits are not reimbursable for follow-up surgical care.

Failure to use the 54 modifier on the claim prevents payment to the provider rendering post-operative care. Please refer to the Ambulatory Surgery Manual for additional information.

928.10. Ambulatory Surgical Center Services

Certified freestanding ambulatory surgery centers are eligible to enroll in the Division's Ambulatory Surgical Center (ASC) Program. ASCs are limited to providing surgical procedures that would otherwise be covered if performed in a hospital. Selected surgical procedures performed in an ASC setting may require preadmission certification or prior approval. The precertification or prior approval information must be obtained by the physician and given to the ASC prior to the performance of the surgical procedure. Physicians should contact local ASCs to obtain information regarding coverage and policies prior to scheduling surgical procedures.

929. Children's Intervention Services (Formerly Therapy Services)

The CIS program is comprised of six intervention services that must be provided by licensed and enrolled practitioners, for members less than twenty-one years of age. The six services are: audiology, nursing, occupational therapy, physical therapy, counseling provided by licensed clinical social workers, and speech-language pathology. Qualified providers must be currently licensed as audiologists, clinical social workers, occupational therapists, physical therapists, registered nurses, or speech-language pathologists. Services provided though the CIS program must be billed under the provider number of the enrolled professional personally performing the service.
(Rev. 10/2014)

930. Vaccines for Children Program (VFC)

Vaccines given to Medicaid eligible children are covered only in accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). Certain immunization drugs for members 19-21 years of age are covered under the Physician Services Program. For further clarification regarding specific CPT immunization codes covered under the EPSDT-Health Check program, in conjunction with Vaccines for Children (VFC), refer to the EPSDT-Health Check Services Manual Appendix E, and the Physician Services Manual, Appendix B and B1.

Administration:
Reimbursement for immunization drugs supplied by VFC and administered to children ages birth to 18 years of age, under the EPSDT-Health Check Program is not covered. Reimbursement is limited to the administration of the vaccine only.

Please refer to the EPSDT-Health Check Program Manual. The manual can be found on the GAMMIS web-portal at www.mmis.georgia.gov under the Provider Information, Provider Manuals tabs.
(Rev. 10/2014)

931. Service Restrictions

931.1. Sterilization and Hysterectomies

In compliance with (42 CFR 441.250), the Division may reimburse for sterilizations and hysterectomies only if the following requirements are met:

931.1.1. Sterilizations

931.1.1.1. The individual is at least twenty-one years old at the time consent is obtained;

931.1.1.2. The individual is not mentally incompetent.

931.1.1.3. The individual voluntarily gave informed consent in accordance with the provisions of this Section, and a properly executed "Informed Consent for Voluntary Sterilization" form (DMA 69) is submitted with the claim.

931.1.1.4. At least thirty days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least seventy-two hours have passed since the person gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least thirty days before the expected date of delivery (the expected date of delivery must be provided on the consent form);

931.1.1.5. Interpreters are provided when language barriers exist; and arrangements are made to effectively communicate the required information to an individual who is blind, deaf, or otherwise handicapped; and

931.1.1.6. The individual was not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

931.1.1.7. See note at the end of DMA Forms section regarding documentation requirements for claims reimbursement.

931.1.2. Hysterectomies

931.1.2.1. The hysterectomy was performed for medical necessity and not for the purpose of family planning, sterilization, hygiene, or mental retardation;

931.1.2.2. The individual is informed prior to the hysterectomy that she will be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy.);

931.1.2.3. The individual and the attending physician sign the “Patient’s Acknowledgement of Prior Receipt of Hysterectomy Information” form DMA 276 or DMA 276 either before or after the surgery is performed (the individual is not required to sign in the cases of prior sterility or emergency hysterectomy); and

931.1.2.4. The properly executed “Patient’s Acknowledgement of Prior Receipt of Hysterectomy Information” is attached to the claim form submitted to the Division.

931.1.2.5. See note at the end of the DMA Forms regarding documentation requirements for claims reimbursement.

931.2. Abortions

In accordance with federal regulations and recent Congressionally enacted revision to the Hyde Amendment, the Division will reimburse for abortions performed on Medicaid eligible patients, if the life of the mother would be endangered if the fetus were carried to term, or if the mother was a victim of rape or incest. Form DMA-311 applies to surgical and non-surgical abortion procedures, such as the use of mifepristone 200 mg (RU486) when used for abortion purposes.

A "Certification of Necessity for Abortion" (Form DMA 311) certifying the above situation must be properly executed and attached to the claim form when submitted to the Division.

931.3. Supply of Forms

A supply of the "Informed Consent for Voluntary Sterilization" (DMA 69), the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" (DMA 276), the "Certification of Necessity for abortion" (DMA 311) and "Prior Approval for Medical Services (DMA 81) forms may be obtained from the Division's fiscal agent. These forms are the only forms accepted by the Georgia Division of Medical Assistance in the reimbursement of sterilizations, hysterectomies, abortions, and prior approved medical services.

The Division and the Medicaid program cannot reimburse for sterilization, hysterectomies, or abortions without documentation required in 42 CFR 441.206 and 42 CFR 441.256. The Division does not accept documentation for informed consent completed or altered after the service was rendered.

931.4. Colorectal Cancer Screening

The Division will cover colorectal cancer screening test/procedures for the early detection of colorectal cancer. Coverage of the colorectal cancer-screening test includes the following procedures:

931.4.1. Screening fecal-occult blood test,

931.4.2. Screening flexible sigmoidoscopy,

931.4.3. Screening colonoscopy for high risk individuals, and

931.4.4. Screening barium enema as an alternative to a screening flexible sigmoidoscopy or screening colonoscopy

The following new HCPCS codes have been established for these services:

931.4.5. G0104: colorectal cancer screening; flexible sigmoidoscopy

931.4.6. G0105: Colorectal cancer screening; colonoscopy on an individual at high risk;

931.4.7. G0106: Colorectal cancer screening; barium enema as an alternative to G0104: screening sigmoidoscopy

931.4.8. G0107: Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations

931.4.9. G0120: Colorectal cancer screening; as an alternative to G0105, screening colonoscopy

Limitations:

Screening flexible sigmoidoscopies (G0104) are covered at a frequency of once every 48 months for members age 50 and over. If during the course of this procedure a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed rather than code G0104. This screening must be performed by a Doctor of Medicine or osteopathy.

Screening colonoscopies (G0105) are covered at a frequency of every 24 months for members at high risk for colorectal cancer. If during the course of this procedure a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed rather than code G0105. A Doctor of Medicine or osteopathy must perform this screening.

High risk for colorectal cancer means an individual with one or more of the following:

931.4.10. A close relative (sibling, parent or child) who has had colorectal cancer or an adenomatous polyposis; or

931.4.11. A family history of familial adenomatous polyposis; or

931.4.12. A family history of hereditary nonpolyposis colorectal cancer; or

931.4.13. A personal history of adenomatous polyps; or

931.4.14. A personal history of colorectal cancer; or

931.4.15. Inflammatory bowel disease, including Crohn's Disease and Ulcerative Colitis.

Screening barium enema examinations (G0106 and G0120) are covered as an alternative to either a screening sigmoidoscopy or a screening colonoscopy, respectively. The same frequency parameters specified for screening sigmoidoscopy and colonoscopy applies.

Screening fecal-occult blood test is covered at a frequency of once every 12 months for members age 50 and over.

HCPCS code G0105 must receive pre-certification. Please follow the guidelines as outlined in Chapter 800.

932. Non-Covered Services

The services and procedures listed below are non-covered by the Division under the Advanced Nurse

Practitioner program. This list is representative of non-covered services and procedures and is not meant to be exhaustive. Providers must bill with the most applicable evaluation and management code.

932.1. Cosmetic surgery or mammoplasties for aesthetic purposes;

932.2. Immunization Injections for members aged twenty one or older;

932.3. Preventive health care. (Recipients under age twenty one may receive this care through the EPSDT-Health Check screening process. Refer to Appendix C for information on the EPSDT-Health Check Program);

932.4. Therapeutic Injections except those contained in the Division's Physicians' Injectable Drug List;

932.5. Acupuncture;

932.6. Sub-convulsive electric shock treatment, biofeedback, hypnotherapy, sleep therapy and all services listed in the CPT under "Other Psychiatric Therapy;"

932.7. All procedures listed in the CPT as "unlisted procedure";

932.8. Educational supplies, medical testimony, special reports, travel by the practitioner, no show or canceled appointments, additional allowances for services provided after office hours or between 10:00 p.m. and 8:00 a.m. or on Sundays or holidays, calls, visits or consultations by telephone and other related services;

932.9. Routine lab and x-ray services required on hospital admissions;

932.10. Biofeedback or hypnotherapy;

932.11. Services provided free of charge to Medicaid members by County Health Divisions or State Laboratories, e.g., metabolic screens for members less than one year of age, etc.

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

932.13. Services or procedures performed without regard to the policies contained in this policy manual;

932.14. Services normally provided free of charge to indigent patients, e.g., free clinics;

932.15. Hospital visits to members awaiting placement in a nursing facility, unless medically necessary;

932.16. Hospital visits if the hospital admission and/or length of stay are disallowed by the hospital Utilization Review staff or the Division;

932.17. Radiological procedures performed by a portable x ray service;

932.18. Services provided in a State owned facility;

932.19. Drugs used in the physician's office or dispensed by the physician except those injectables authorized on the Physicians' Injectable Drug List;

932.20. Tubal anastomosis;

932.21. ESRD Dialysis Services for Medicaid Only members;

932.22. Hospital admissions and daily visits for maintenance dialysis;

932.23. Office visits for maintenance dialysis;

932.24. Insertion or removal of catheters or shunt declotting for dialysis patients enrolled in the Dialysis Services Program;

932.25. Penile prosthesis;

932.26. Procedure code 90862 - psychiatric pharmacologic management;

932.27. Services provided to Georgia Better Health Care members without authorization from their case manager;

932.28. Substance Abuse Clinic Services; and

932.29. Vaccines for members less than nineteen (19) years of age that are available through the Vaccines for Children program (VFC).

932.30. Sensitivity training, encounter groups, or workshops;

932.31. Sexual competency training;

932.32. Education testing and diagnosis;

932.33. Marriage or guidance counseling;

932.34. Psychiatric services rendered through, by or in mobile units and/or facilities other than the physician's office, nursing facility, or acute care hospital (non-psychiatric). A mobile unit shall not constitute a physician's office for psychiatric services.

932.35. Psychiatric services provided to patients in Therapeutic Residential Treatment programs.

932.36. Chiropractic Services (not applicable to Chiropractic Services covered by Medicare as a primary carrier)

932.37. Surgical first assist services are not allowed in the advance nurse practitioner program.

932.38. The Division of Medical Assistance does not directly reimburse psychological services rendered to individuals enrolled in the Therapeutic Residential Intervention Services Program (TRIS) /Multi-Agency Team for Children (MATCH). TRIS services include Intensive Residential Treatment, Intermediate Residential Treatment, Therapeutic Foster Care, and Therapeutic Residential Wilderness Camps.

932.39. The Division of Medical Assistance does not provide reimbursement for psychological, family therapy, group therapy, or somatotherapy services rendered by other health care professionals, including but not limited to medical social workers, psychiatric nurses, physician assistants or other physician extenders, regardless to the place of service. See also Part II Policy and Procedure Manual for Physician Services, Chapter 900.

The common practice of allowing other health care workers to provide interview (90801) and testing (96100) services is not being construed as a violation.

To appeal non-covered medically necessary services, call 1-800-766-4456, or email a request via the Web Portal (www.mmis.georgia.gov), and select “Contact Us”.
(Rev. 10/2014, 07/2022)

Chapter 1000: Basis For Reimbursement

1001. Reimbursement Methodology

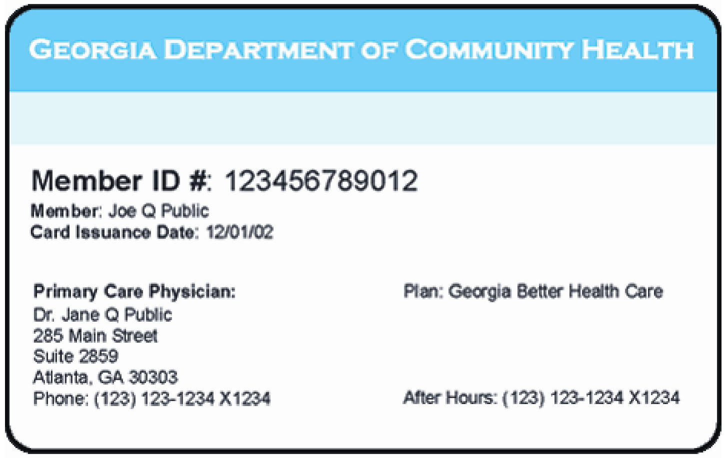
The Division will pay the lower of the nurse practitioner's lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date(s) of service, the lowest price charged to other third party payers, or 90% of the statewide maximum allowable reimbursement which is 84.645% of the 2000 Resource Based Relative Value Scale(RBRVS) as specified by Medicare for Georgia Area 1(Atlanta). All procedure codes recognized and adopted after the 2000 RBRVS are subject to the same level of reimbursement.

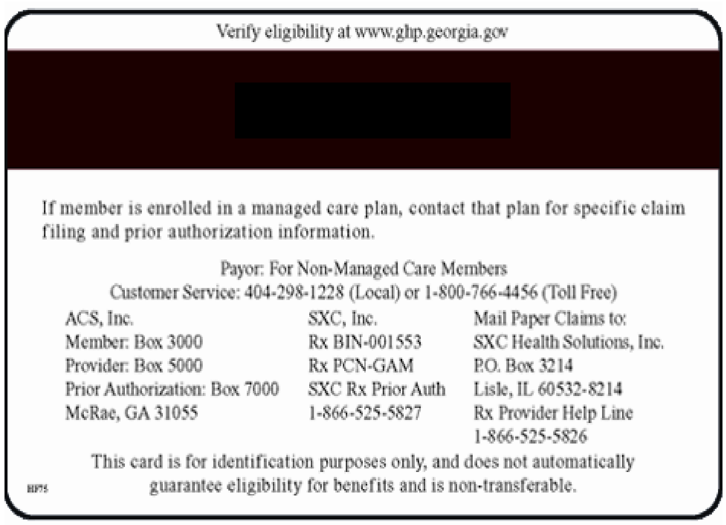
The Division's Schedule of Maximum Allowable Payments (by procedure code) is available at www.mmis.georgia.gov.

This is not a fee schedule. As required in Chapter 600, physicians must bill the lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date(s) of service, or the lowest price charged to other third party payers for the procedure code most closely reflecting the services rendered.

Appendix A
Medical Assistance Eligibility Certification

This card replaces former member ID cards for both FFS Medicaid and PeachCare for Kids Plans.





Note: Providers are required to verify member eligibility prior to rendering service before each.

Appendix B

Vaccines For Children (VFC) Program

A. General

This federal vaccine program provides free vaccines to be used for all children under nineteen (19) years old except those who have insurance that covers immunizations. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) created the funding for this program called Vaccines for Children (VFC). This program will simply expand upon the current Georgia Free Vaccine program.

The Georgia VFC program will supply vaccines for the following:

i. Children enrolled in Medicaid or qualified through a Medicaid waiver;
ii. Children who do not have health insurance;
iii. Children who are American Indian or Alaskan Native;
iv. Children who have health insurance, but vaccines are not a covered benefit; and
v. Children enrolled in PeachCare for Kids.

The State Department of Public Health will be responsible for enrolling physicians, physician's assistants, nurse practitioners and nurse midwives into the program and processing the vaccine orders.

All physicians, physician's assistants, nurse midwives and nurse practitioners who provide immunization services must enroll in the Vaccines for Children program and provide immunizations to Medicaid eligible children whose ages are birth through eighteen (18) years of age.

B. Enrollment

vi. Providers who render immunizations to Medicaid children must be enrolled in the VFC program. The following are requirements for enrollment in the VFC program:

vii. Providers must complete the Provider Enrollment Form, the Provider Profile and Vaccine Order Form and return to the below address:

Georgia Immunization Program
P. O. Box 949
Atlanta, Georgia 30301-0949
(404) 657-5013 or 1-800-848-3868

viii. Providers in Group Practices need only complete one Enrollment Form. However, a copy of the license of each provider must be attached to the Enrollment Form. A Provider Profile must be completed for each location (separate office, clinic, etc.) where immunizations are given.

ix. Individual providers must attach a copy of their license to the enrollment form.

Questions regarding enrollment, vaccine orders and record keeping should be directed to the Georgia Immunization program.

For a complete list of procedure codes to bill for Immunizations (ages birth up to 19 years), Tuberculin Skin Tests and Blood Lead Tests, please refer to the EPSDT-Health Check Services program manual. Bill only EPSDT-Health Check Program procedure codes on the same claim form. Bill other Medicaid program (i.e., Physician Services Program, etc.) procedure codes on a separate CMS-1500 Claim Form.

Appendix C

Information Related To Other Medicaid Programs

A. Ambulance Program

Ambulance providers enrolled in the Medical Assistance Program are required to be licensed by the state and have crews trained for emergencies. In addition to stating the patient's diagnosis, the physician must certify in writing that the physical condition of the patient necessitated ambulance transportation. The ambulance provider must have the physician's written and signed prescription in order to be reimbursed.

Ambulance providers are required to obtain prior approval from the Division for non-emergency transportation of patients from institution to institution when the trip is over 150 miles one way (hospital to hospital; hospital to nursing home; home to nursing home). This type of transportation also requires the physician's written and signed certification of the patient's physical condition that requires transportation by ambulance stretcher van.

B. Community Care Services Program (CCSP)

The CCSP program area provides services for members that allow the individual to be cared for in the home or a day care center as an alternative to institutional care. The services provided may or may not be medical in nature. However, the member's medical condition must be such that, without the services provided, the member would be confined to a hospital or nursing home. Therefore, the medical necessity for services is the physician's statement that the member's medical condition justifies the CCSP care. The below are program areas that fall under CCSP:

i. ADH (Adult Day Health)

ii. HDS (Home Delivered Services)

iii. PSS (Personal Support Services)

iv. ERS (Emergency Response System)

v. ALS (Alternative Living Services)

vi. RC (Respite Care)

vii. HDM (Home Delivered Meals)

After the physician approves the initial need for these home-based services, the physician must also authorize the continuing medical need for these services. The document that evidences this continuing need for care is the Medical Plan of Treatment (MPOT) that must be obtained from the physician as often as the patient's condition dictates, or at least, every 60 days.

The physician must review the MPOT for accuracy in treatment authorized and sign and date in the spaces so provided. Without the physician's signature and the date on which it was signed, the Division is unable to certify that medically necessary services were ordered prior to the date services were rendered. Therefore, reimbursement to these providers may be denied by the Division for failure to demonstrate the continuing need for services.

The Division encourages the physician to regard any document presented for his signature which concerns medical treatment to a member as the physician's authorization for the services therein stated.

C. Durable Medical Equipment (DME) Program

All DME must be prescribed by the attending physician. The physician's prescription stating the patient's name, age, diagnosis, type and description of the equipment, medical justification for the equipment, prognosis, and length of time the equipment will be needed should be given to the member. The member should take the prescription to a DME supplier enrolled in the Medical Assistance Program. The DME supplier will submit the physician's request to the Division since prior approval from the Division of Medical Assistance is required for the reimbursement of the certain durable medical equipment. Covered DME necessary to enable a member to leave the hospital may be rented "short term" for two months while the prior approval is being reviewed.

D. Home Health Care and Model Waiver Services

Home Health and Model Waiver Services are similar to the CCSP program in that, without the care provided, the member would be confined to an institutional setting. However, the care provided is skilled nursing care or care rendered under the supervision of a Registered Nurse. It is very important that the Home Health or Model Waiver provider obtain authorization from the attending physician to provide treatment as often as the patient's condition dictates, or at least every sixty (60) days. The document that evidences this continuing need for care is the Medical Plan of Treatment (MPOT), Plan of Treatment, or Plan of Care. The physician must review the document for accuracy in treatment authorized and sign and date in the spaces so provided. Without the physician's signature and the date on which it was signed, the Division is unable to certify that medically necessary services were ordered prior to the date services were rendered. Therefore, reimbursement to these providers may be denied by the Division for failure to demonstrate the continuing need for services. The Division encourages the physician to regard any document presented for his signature that concerns medical treatment to a member as the physician's authorization for the services therein stated.

E. Non-Emergency Transportation Broker System

The Medicaid Non-Emergency Medical Transportation (NEMT) program provides transportation through a NEMT Broker system. Five NEMT regions have been established in the State—North Atlanta, Central, East and Southwest. The Department has contracted with a Broker in each of the five NEMT regions to administer and provide non-emergency medical transportation for eligible Medicaid members. The Brokers are reimbursed a monthly capitation rate for each Medicaid member residing within their region.

Medicaid members who need access to medical care or services covered by Medicaid and have no other means of transportation must contact the Broker servicing their county to arrange for appropriate transportation. Non-emergency medical transportation is provided only in the absence of other transportation.

Each Broker is required to maintain toll free telephone access for transportation scheduling services Monday thru Friday from 7:00 a.m. to 6:00 p.m.

Contractors for the non-emergency medical transportation (NEMT) services broker program are ModivCare (formerly Logisticare) and Verida (formerly Southeastrans). Refer to Appendix S, Table S for the contact information and coverage area for each broker.
(Rev. 07/2022)

F. Orthotics And Prosthetics (O&P) Program

Before the Medicaid-enrolled prosthetic supplier can provide services to amputee members, the O&P supplier must receive a prescription from the physician.

G. Pharmacy Program

The Division provides reimbursement to enrolled pharmacists for certain physician prescribed drugs. Coverage is limited to those drugs supplied by manufacturers or suppliers who have agreed to rebate a portion of their product's cost to the state. Please refer to the Policies and Procedures Manual for Pharmacy Services, for exceptions to this policy.

H. Emergency Prescriptions

Please refer to the Policies and Procedures Manual for Pharmacy Services, for exceptions to this policy.

I. Hearing Aid Services

The Division provides reimbursement for hearing aids through the Orthotics and Prosthetics Program. 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.

J. EPSDT- Health Check Services (Children's Preventive Health Care)

EPSDT-Health Check Services are available only to members who are under the age of twenty-one (21). Physicians have the option to render screening services, as well as diagnostic and treatment services to eligible EPSDT-Health Check patients or to render only diagnostic and treatment services. Physicians who desire to render screening, diagnostic and treatment services must be enrolled with the Division to provide Physician Services as well as EPSDT-Health Check Services and should secure a copy of the Policies and Procedures Manual for EPSDT-Health Check Services. All EPSDT-Health Check services, except immunizations, must be authorized or performed by the member's primary care physician (PCP) in order for those services to be reimbursed. (Rev. 07/2022)

K. Reconstructive/Restorative Surgery

Coverage is extended for EPSDT-Health Check screened members for reconstructive/restorative surgery necessary to correct or repair either 1) the effects of an accidental injury, or 2) a congenital defect. This type of surgery requires prior approval (see Chapter 800).

L. Eyeglasses And Contact Lenses

For vision services, please refer to the Policies and Procedures Manual for Vision Care Services, which is available from the fiscal agent.

M. Children's Intervention Services - (for members under 21)

All services must be prescribed by the attending physician. The physician's prescription for services and the plan of care developed in consultation with a Medicaid enrolled therapist must be furnished to the therapist. The plan relates the type, amount, frequency, and duration of the services that are to be furnished and indicate the diagnosis, goals and anticipated length of treatment. The six services are: audiology, nursing, occupational therapy, physical therapy, counseling provided by licensed clinical social workers and speech language pathology. The plan must be established before treatment is begun. The plan must be signed by the physician and incorporated into the patient's medical records.

N. Adult Protective Services Targeted Case Management

Adult Protective Services Case Management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for Medicaid eligible members aged 18 and over who are experiencing or at risk of abuse, neglect, or institutionalization, or have been placed by Probate Court as wards of the Director of County Departments of Family and Children Services.

These services must consist of at least one of the following activities:

i. Developing and implementing an individualized service plan

ii. Locating needed service providers and making the necessary linkages

iii. Monitoring the member and service providers to determine adequacy of services

iv. Reassessing the member to determine needed services in the event of a crisis

O. Adults With Aids Targeted Case Management

Under this case management program, enrolled providers are reimbursed for identifying, coordinating, and reviewing the delivery of appropriate services for Medicaid eligible adults with AIDS who need assistance with acute problem solving. These members are 21 years of age and older, have been diagnosed as having AIDS, and are at the greatest risk of hospitalization. Individual case managers must serve between 40 and 60 clients.

P. Ambulatory Surgical Center Services

Ambulatory Surgical Centers provide services to patients who are not admitted to the center for surgery and are not expected to stay overnight following the procedure. The covered services include the below:

i. Surgery

ii. Nursing services, services of technical personnel, and other related services

iii. Use of operating and recovery rooms, patient preparation areas and waiting rooms

iv. Drugs, biologicals, surgical dressings, supplies, splints, carts, appliances, and equipment

v. Administrative services

vi. Blood and blood products

vii. Intraocular lenses, corneal tissue implants, and vascular portal implants

viii. Birthing Centers

Services in this program are limited to normal vaginal delivery when services are provided to “low risk” Medicaid members of child-bearing age.

Q. At-Risk Of Incarceration Case Management Services

At-Risk of Incarceration Case Management is a set of interrelated activities for Medicaid eligible emotionally disturbed or substance abusing children and youth under 21 years of age who are at-risk of incarceration. These interrelated activities include:

i. Establishing an individualized service plan

ii. Locating needed service providers and making necessary linkages

iii. Monitoring the child and service providers to determine the adequacy of service

iv. Reassessing the child to determine services in the event of a crisis

These eligible children or youth have been referred to or placed in a therapeutic residential treatment facility or nonresidential intensive supervision program as an alternative to a secure confinement facility.

Enrollment for this program is coordinated with the Department of Children and Youth Services.

R. Childbirth Education Classes (Non-Hospital Based)

These classes are designed to educate Medicaid-eligible pregnant women regarding the birth experience and to equip them with the tools to prepare for a healthier pregnancy, birth, and postpartum period.

i. A series of six child-birth preparation classes provide information concern pregnancy, proper prenatal care, what to expect during labor and delivery, and information on breast feeding.

ii. The Medicaid-reimbursed childbirth education program consists of two components:

iii. Two classes, Newborn Care and Newborn Feeding. The Newborn Care class provides information on basic newborn care. The Newborn Feeding class is designed to provide information about newborn feeding, e.g., bottle-feeding, breast-feeding, and general nutrition.

To qualify for enrollment, Childbirth Education providers must be licensed registered nurses, certified nurse practitioners, certified nurse midwives, physician's assistants, or physicians. Except for physicians and nurse midwives, childbirth education providers must be certified as a childbirth educator by a national or state recognized association and have one year of experience providing childbirth education classes.

S. Child Protective Services Targeted Case Management

Child Protective Services Case Management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for Medicaid eligible members from birth through age 17 who have been placed in Foster Care or are receiving Child Protective Services necessary to protect them from abuse, neglect, or exploitation.

These services must consist of at least one of the following activities:

i. Developing and implementing an individualized service plan

ii. Locating needed service providers and making the necessary linkages

iii. Monitoring the child and service providers to determine adequacy of services

iv. Reassessing the child to determine needed services in the event of a crisis

Enrollment for this program is coordinated with the Department of Human Resources.

T. Dedicated Case Management

Dedicated Case Management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for Medicaid eligible members who are emotionally or mentally disturbed, drug or alcohol abusers, mentally retarded, or developmentally disabled.

These services must consist of at least one of the following activities:

i. Developing and implementing an individualized service plan

ii. Locating needed service providers and making the necessary linkages

iii. Monitoring the member and service providers to determine adequacy of services

iv. Reassessing the member to determine needed services in the event of a crisis

Enrollment for this program is coordinated with the Department of Human Resources.

U. Dental Services

Dental services are defined as any diagnostic, preventive, or corrective procedures administered by or under the direct supervision of a licensed dentist. These services may include:

i. Treating teeth and associated structures of the oral cavity

ii. Treating disease, injury, or impairment, which may affect the oral or general health of the individual

iii. Topical Fluoride Varnish (D1206) can be administered by the Pediatrician or his PA to eligible members from 1 month old to the last month of their 13th birthday.

Under the Georgia Medicaid Program, there are two separate components of dental coverage: the EPSDT-Health Check Program for children through the end of the birth month of their 21st year and the Adult Dental Program for adults aged 21 or older. Services provided under the EPSDT-Health Check Program are available either as the result of the EPSDT-Health Check screening process or as a result of a request or need by the Medicaid member.

V. Diagnostic, Screening And Preventive Services

The Diagnostic, Screening and Preventive Services (DSPS) Program reimburses a broad range of diagnostic, screening, and preventive services. These services are provided at an office, clinic, school-based clinic, or similar facility in Georgia. At a minimum, the following services must be provided:

i. Antepartum and postpartum care

ii. Newborn follow-up services

iii. Immunizations for adults

iv. Diagnosis and treatment of sexually transmitted diseases

v. Hepatitis B Management

vi. Hypertension diagnosis and treatment

vii. Follow-up and management of tuberculosis

viii. Nutritional counseling

The services listed above must be provided directly and may not be subcontracted.

Enrolled DSPS providers must also be providers of EPSDT-Health Check, Family Planning, Pregnancy-Related, and Perinatal Case Management Services.

W. Dialysis

This program provides for services and procedures designed to promote and maintain the functions of the kidney and related organs.

X. Early Intervention Case Management (Service Coordination Services)

Early Intervention Case Management is an active, ongoing process consisting of specific activities aimed at assisting parents of developmentally delayed infants and toddlers in gaining access to services. These linking activities consist of:

i. Participating in developing and reviewing the Individualized Family Service Plan (IFSP)

ii. Coordinating and facilitating the provision of medically necessary services identified in the IFSP

iii. Assisting families of eligible children in gaining access to services and identifying and utilizing available service providers

iv. Developing a transition plan to pre-school or community services by the child's third birthday

Children from birth to age three may be determined eligible for this program if they meet the Department of Human Resources' definition of developmental delay, which specifies delay in one or more of the following five areas:

v. Cognitive development

vi. Physical development, including vision and hearing

vii. Communication development

viii. Social or emotional development

ix. Adaptive development

Y. Family Planning

Family Planning services are services provided to eligible members who are sexually active and wish to prevent pregnancies, plan the number of pregnancies, or plan the spacing between pregnancies and confirmation of pregnancy. Enrollment is this program is limited to public Health Clinics. Family Planning Services may also be provided under the Physician, Nurse Midwife, or Nurse Practitioner programs.

Z. Federally Qualified Health Center (FQHC)

A federally qualified health center must provide a full range of primary diagnostic and therapeutic services and supplies commonly provided by a physician's office. These services are aimed at residents living in areas that have a shortage of primary health care services. These centers are not-for-profit medical practices, reaching out to meet community health care needs and accountable to the community through a local governing body of consumers and community leaders.

Some of the services required to be provided include:

i. Medical history, physical examination and assessment of health status

ii. Evaluation and diagnostic services (radiological and laboratory services)

iii. Services and supplies supporting physician and physician extender services (e.g., pharmaceuticals, vaccines, clinical psychologist, and social worker services)

AA. Hospice

This program includes services furnished primarily in a member's home by a certified hospice to a terminally ill member. An individual is considered terminally ill if the medical prognosis is a life expectancy of six months or less.

The hospice must:

i. Be currently licensed

ii. Meet the standards of Medicare participation

iii. Have written policies and procedures on advance directives

BB. Inpatient/Outpatient Hospital Services

Participating hospitals are reimbursed for covered services provided to eligible Medicaid members. These hospitals must:

i. Be currently licensed

ii. Meet the standards for Medicare participation

iii. Operate a utilization review program

iv. Have written policies and procedures on advance directives

In addition, "Hill-Burton" hospitals are required to comply with Hill-Burton regulations.

CC. Independent Care Waivered Services

A waiver from the Health Care Financing Administration authorizes Medicaid coverage of services to eligible severely physically disabled individuals who are medically stable but are in a hospital or nursing facility or are at-risk of being placed in one of those facilities.

The services available under this program include:

i. Case management

ii. Homemaker

iii. Personal care services

iv. Environmental modification

v. Skilled nursing

vi. Transportation

vii. Specialized medical equipment and supplies

viii. Personal emergency response systems

ix. Companion services

x. Counseling

xi. Occupational therapy

DD. Independent Laboratory

This program provides reimbursement for most pathological and clinical laboratory tests.

EE. Medicare Only

Chiropractors, dialysis facilities, speech therapists, physical therapists, licensed clinical social workers and rehabilitation facilities may enroll as Georgia Medicaid providers only to service patients who are Medicare/Medicaid eligible. For these members, Medicaid will pay the co-insurance and deductible portion of the Medicare bill. Medicaid will not reimburse providers enrolled as "Medicare Only" for any other services.

FF. Mental Retardation Waiver Program

The Mental Retardation Waiver Program (MRWP) is a home and community-based service waiver provided to eligible individuals with mental retardation/development disabilities (MR/DD) who reside in their own home and/or are at risk of institutional placement.

The following covered services offer alternatives to institutional care:

i. Service coordination

ii. Residential training and supervision

iii. Personal support services

iv. Respite care services

v. Day habilitation services

vi. Supported employment services

vii. Personal emergency response service

viii. Specialized medical equipment and supplies:

1. Assistive Technologies

2. Adaptive equipment

3. Vehicle adaptations
4. Environmental modifications
5. Protective chucks
6. Diapers
7. Food supplements
8. Home based services
9. Skilled nursing care
10. Home health aide services
11. Physical, speech, and occupational therapies

Enrollment for this program is coordinated with the Department of Human Resources.

GG. Nurse-Midwifery Services

This program covers services provided by enrolled Certified Nurse-Midwives rendering care to eligible Medicaid members.

Covered services in this program include, but are not limited to prenatal care, labor, delivery, postpartum care, newborn care, and other services permitted under applicable state and federal regulations.

National certification as a nurse midwife and a current Georgia nurse's license is required for enrollment in this program. nurse's license is required for enrollment in this program. certification as a nurse midwife and a current Georgia nurse's license is required for enrollment in this program.

HH. Nursing Facility Services

This program includes services provided by an institution (nursing facility or an intermediate care facility for the mentally retarded) furnishing health-related care and services on a regular basis to individuals who do not require the degree of care and treatment that a hospital is designed to provide.

The nursing facility must have:

i. License number and effective date to operate a nursing facility or an intermediate care facility for the mentally retarded

ii. Verification that the entire facility is certified to participate in the Medicaid program

iii. Have written policies and procedures on advance directives

iv. Certification that the facility is in compliance with the requirements for participation

II. Oral And Maxillofacial Surgery Services

The Oral and Maxillofacial Surgery Services Program reimburses for a broad range of surgical services that are covered for all eligible Medicaid members. Oral surgeons can enroll to become providers under this program.

JJ. Perinatal Case Management

Perinatal Case Management is a set of interrelated activities for coordinating and monitoring appropriate services for pregnant women.

The purpose of these services is to:

i. Assist Medicaid-eligible pregnant women in gaining access to needed medical, nutritional, social, educational, and other services

ii. Encourage using cost-effective medical care through referrals to appropriate providers

iii. Discourage over-utilizing costly services

Qualified providers must be licensed registered nurses or licensed Masters prepared social workers who have experience in maternal and child health. Providers must receive special training by the Georgia Department of Human Resources, Division of Public Health. Doctors' offices and agencies may enroll if they have qualified staff to perform the services. The nurse or social worker may be supported by paraprofessional staff members who have one year of human service delivery experience or documented college level course work in health or human services.

The eligible providers must be capable of offering the following four services covered under this program:

iv. A comprehensive new patient visit (maximum of one per pregnancy)

v. Brief and extended follow-up visits (maximum of eight visits per pregnancy)

vi. A postpartum follow-up visit (maximum of one per pregnancy)

KK. Physician Services

The Physician Services Program reimburses for a broad range of medical services. Covered services are provided by qualified enrolled physicians to eligible Medicaid members. The standard scope of diagnostic and treatment services provided by physicians is included. Physicians enrolling in the physician program must also enroll their Georgia certified physician assistants and physician assistants for anesthesiology in this program.

NOTE: Ophthalmologists who render refractive services must enroll in both the Physician Services and Vision Care Services Programs.

LL. Podiatry

The Podiatry Services Program reimburses for diagnosis, medical, surgical, mechanical manipulative, and electrical treatment services limited to ailments of the human foot or leg.

MM. Pregnancy-Related Services

Pregnancy-Related Services are provided to Medicaid-eligible women and their infants beginning at the postpartum period and terminating when the infant reaches one year of age.

The Pregnancy-Related Services program provides for two types of visits. The Division will reimburse for two postpartum home visits and two child related preventive health inter-periodic home visits. The goal of the program is to help reduce infant mortality and maternal and infant morbidity.

The two postpartum visits must occur within the first 28 days after maternal discharge. The purpose of the visits is to identify early signs of illness and infection.

The first preventive health inter-periodic visit should occur between the infant's sixth and seventh months of life and the second visit between the infant's eleventh and twelfth months of life. The purpose of the visits is to teach the mother temperature taking skills, to assess developmental milestones and to provide the mother with instructions on environmental safety and accident prevention.

Qualified providers of Pregnancy-Related Services must be licensed registered nurses, certified nurse practitioners, certified nurse midwives, physician's assistants, or physicians. Except for physicians, certified nurse practitioners and certified nurse midwives, providers must have experience in at least two of the following areas: obstetrical care; prenatal care; postpartum care; or adult or pediatric preventive physical assessment and screening. (Rev. 07/2022)

NN. Psychological Services

Psychological services are defined as services applying recognized principles, methods, and procedures of the science and profession of psychology, such as, but not limited to:

i. Evaluating and treating mental and nervous disorders

ii. Administering and interpreting tests of mental abilities, aptitudes, and personality characteristics for such purposes as psychological diagnosis and classification.

Psychological services are available to Medicaid members through the end of their birth month of their 21st year. Medicaid reimbursement is limited to no more than 24 hours per member per calendar year without prior approval. Evaluation and testing services are limited to five hours per calendar year without prior approval.

OO. Rehabilitation Services

Rehabilitation as defined by federal regulation has limited covered in the Physician Services program. Short-term rehabilitation services, i.e., physical therapy, occupational therapy and speech therapy, may be covered in alternative programs such as but may not be limited to Children Intervention Services, Home Health Care, and other Waivered Services—see the specific program manual for coverage parameters.

Certain physical therapy services rendered to members 21 years of age and older may be covered under the Physician Services program if billed by the physician when the service is provided by their salaried employee, as specified in Chapters 600 and 900. For rehabilitation services for children less than 21 years is also outlined in Chapter 600, related to Children Intervention Services (CIS).

Physical therapy services for members over 21 years of age, covered if immediately following an acute illness, injury or impairment and when the following conditions are met:

i. Physical therapy services must be furnished under a written treatment plan established by the physician. This plan must identify the rehabilitation potential, set realistic goals and measure progress. The plan must contain the type of modalities and procedures, frequency of visits, estimated duration, diagnosis, functional goals and recovery potential.

ii. The physician must initially certify and recertify every 30 days that continued therapy is necessary. Recertification must include an estimate of how much longer the service will be needed and the diagnosis and date of onset of the acute illness, injury or impairment that is being treated.

iii. The services must be of such a level of complexity and sophistication, or the member's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified therapist.

iv. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state.

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

PP. Rural Health Clinic

Rural health clinics provide outpatient services in rural areas by a physician, nurse practitioner, physician assistant, or certified nurse midwife, under the supervision of a physician. A rural health clinic must provide, either directly or by referral, a full range of

primary diagnostic and therapeutic services and supplies commonly provided by a physician's office. The services of these clinics are aimed at Medicare and Medicaid members living in areas that have a shortage of primary health care services and health professionals.

QQ. Swing-Bed Services

This program provides for rural hospitals with less than 100 hospital beds that can be used for either nursing facility beds or acute levels of care until a bed is available in a nursing facility. Hospitals that enroll in this program should meet the requirements listed under Hospital Services of this package.

RR. Therapeutic Residential Intervention Services (TRIS)

Therapeutic Residential Intervention services are those services provided to Medicaid-eligible members under age 21 who are in need of mental health treatment services for dysfunctional behaviors and psychiatric conditions that prevent residency with the family or in a setting less restrictive than therapeutic residential care.

The State Multi-Agency Team for Children (MATCH) must determine if members are in need of services.

Enrollment for this program is coordinated with the Department of Human Resources.

Appendix D
EPSDT-Health Check

The EPSDT-Health Check program is Georgia Medicaid's well-child or preventive health care program for children birth to twenty-one (21) years of age.

It is the early and periodic screening, (EPS) component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT is the result of a 1967 Amendment to Title XIX of the Social Security Act, which directed attention to the importance of preventive health services for children. The Medicaid manual for the EPSDT-Health Check program covers the screening (EPS) policies and procedures for well-child check-ups. The screening services consists of a comprehensive unclothed physical examination, a comprehensive health and developmental history, developmental assessment, anticipatory guidance, measurements, age appropriate vision and hearing tests, certain laboratory procedures and lead risk assessment. The EPSDT-Health Check program also reimburses for the Administration of Immunizations given to children up to age nineteen (19) years. All EPSDT-Health Check services, except immunizations, must be authorized by or performed by the member's primary care case manager or physician (PCP) in order for those services to be reimbursed.

The policies and procedures for the diagnosis and treatment (DT) services may be found in the related Medicaid program policies and procedures manuals (i.e., Physician Services Program, etc.). Physicians who choose to render screening, diagnostic and treatment services must be enrolled in the EPSDT-Health Check program to receive reimbursement for the screening services and must be enrolled in the Physician Services program in order to receive reimbursement for diagnostic and treatment services. (Rev. 07/2022)

Appendix E
Sterilizations

A. DMA 69 - Informed Consent for Voluntary Sterilization Form

The Division will make reimbursement only for those sterilization procedures that meet the criteria established in Chapter 900 of this Manual. This form must be properly completed on both sides by the member and the attending physician.

Some important points in obtaining and submitting a properly executed Form DMA 69 are listed below.

i. The Physician's Statement

1. The applicable paragraph (1 or 2) must be designated.

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

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

   If Paragraph 2 is designated, the applicable box must be checked, and the information requested must be filled in.

   If the box indicating "Premature delivery" is checked, the individual's date of expected delivery must be given on the line provided.

   If the box indicating "Emergency abdominal surgery" is checked, the circumstances of the emergency surgery must be described on the line provided.

2. The physician must sign and date the consent form after the surgery is performed.

3. The physician must sign the consent form. Signature stamps are not acceptable.

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

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

iv. The only consent form acceptable to the Division is: "Informed Consent for Voluntary Sterilization" (DMA 69). No other form can be used.

v. A 30-day wait does not apply to the hysterectomy acknowledgement form. (See Appendix F).

vi. The sterilization informed consent form may not be used for hysterectomy procedures. Medically necessary hysterectomy procedures require the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" (DMA 276).

A copy of the properly executed "Informed Consent for Voluntary Sterilization" must be attached to the physician's claim form when submitted to the Division for payment. In addition, a copy of the consent form must accompany any other claims for services rendered in conjunction with the sterilization (e.g., hospital, anesthesiology, etc.). Therefore, the attending physician is responsible for providing a copy of the properly executed consent form to each Medicaid provider associated with the case.

A copy of the DMA 69 - Informed Consent for Voluntary Sterilization can be found on the GAMMIS web-portal at www.mmis.georgia.gov under the Provider Information, Forms for Providers tabs.

Appendix F
Hysterectomies

The Division will make reimbursement only for those hysterectomy procedures that meet the criteria established in Section 904.1 (b) of this manual.

Section I. Member's Statement

The member or her representative must sign and date this form on the spaces provided unless the member was sterile prior to the hysterectomy, or the hysterectomy was an emergency.

Section II. Physician's Statement

The physician must sign and date this form on all hysterectomies performed. If the member was sterile prior to the hysterectomy, the physician must indicate this condition beside #1 and state the reason for prior sterility. If the hysterectomy was an emergency, the physician must indicate this condition beside #2 and attach the discharge summary and operative record.

In addition, a copy of the acknowledgement form must accompany any other claims for services rendered in conjunction with the hysterectomy (i.e., hospital, anesthesiology, etc.). Therefore, the attending physician is responsible for providing a copy of the properly signed acknowledgement form to each Medicaid provider associated with the case.

A copy of the DMA 276 - Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" Form DMA 276 can be found on the GAMMIS web-portal at www.mmis.georgia.gov under the Provider Information, Forms for Providers tabs.

Appendix G
Abortions

The Division will make reimbursement only for those abortions that meet the criteria established in Chapter 900 of this Manual.

A "Certificate of Necessity for Abortion" form (DMA 311) must be properly completed and signed for all abortions. A copy of the form must be attached to the physician's claim when submitted to the Division for payment. In addition, a copy of the form must accompany any other claim for services rendered in conjunction with the abortion (i.e., hospital, anesthesiology, etc.). Therefore, the attending physician is responsible for providing a copy of the properly executed certification form to each Medicaid provider associated with the case.

A copy of the DMA 311 - Certificate of Necessity for Abortion can be found on the GAMMIS web-portal at www.mmis.georgia.gov under the Provider Information, Forms for Providers tabs.

Appendix H
Vaccines Covered In The Physician And Advanced Nurse Practitioner Service Programs

For vaccines covered under the Physicians and Nurse Practitioner Services Programs, please refer to the Provider's Administered Drug List (PADL) Manual. The PADL manual can be found on the GAMMIS web-portal at www.mmis.georgia.gov under the Provider Information, Provider Manuals tabs.
(Rev. 10/2022)

Appendix I
Newborn Medicaid Certification - Temporary Enrollment

A process is in place to expedite the enrollment of Medicaid eligible newborns. This process enables authorized providers to immediately obtain a temporary Medicaid number for a newborn infant, born to a Medicaid eligible mother with a Medicaid number ending with a P or S only.

Any Physician, Nurse Midwife, Nurse Practitioner, EPSDT-Health Check Provider, Pharmacy, Hospital, Health Department, Durable Medical Equipment Provider, or Birthing Center enrolled as a Georgia Medicaid Provider is authorized to obtain a temporary Medicaid number for these newborn infants. The authorized provider must complete a Newborn Medicaid Certification form, DMA-550, and contact Gainwell Technologies (GAINWELL TECHNOLOGIES) Inquiry Unit at 1-800-766-4456 or to obtain the temporary Medicaid number. Calls may be made between 8:00 a.m. and 9:00 p.m. Monday through Friday and between 9:00 a.m. and 3:00 p.m. on weekends.

The Newborn Medicaid Certification Form (DMA 550) will serve as a temporary Medicaid card pending issuance of a permanent card. The temporary card will be valid for a thirty-day period, beginning with the date of issuance of the number for the newborn Medicaid certification.

A copy of the DMA 550 form can be found on the GAMMIS web-portal at www.mmis.georgia.gov, under the Provider Information, Provider Forms tabs.

Appendix J

Procedure Codes Subject To Site Of Service Differential

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
10004	11401	11730	12041	15115	15570	17111	19350
10005	11402	11732	12042	15116	15572	17250	19355
10030	11403	11740	12044	15120	15574	17260	19396
10035	11404	11750	12045	15121	15576	17261	20100
10036	11406	11755	12046	15130	15600	17262	20101
10040	11420	11760	12047	15131	15610	17263	20102
10060	11421	11762	12051	15135	15620	17264	20103
10061	11422	11765	12052	15136	15630	17266	20200
10080	11423	11770	12053	15150	15650	17270	20205
10081	11424	11771	12054	15151	15730	17271	20206
10120	11426	11772	12055	15152	15731	17272	20220
10121	11440	11900	12056	15155	15740	17273	20225
10140	11441	11901	12057	15156	15760	17274	20500
10160	11442	11920	13100	15157	15775	17276	20501
10180	11443	11921	13101	15170	15776	17280	20520
11000	11444	11922	13102	15171	15780	17281	20525
11001	11446	11950	13120	15175	15781	17282	20550
11010	11450	11951	13121	15176	15782	17283	20551
11011	11451	11952	13122	15200	15783	17284	20552
11012	11462	11954	13131	15201	15786	17286	20553
11042	11463	11971	13132	15220	15787	17306	20600
11043	11470	11976	13133	15221	15788	17307	20604
11044	11471	11980	13151	15240	15789	17310	20605
11045	11600	12001	13152	15241	15792	17311	20606
11046	11601	12002	13153	15260	15820	+17312	20610
11047	11602	12004	14000	15261	15821	+17314	20611
11055	11603	12005	14001	15300	15822	17340	20612
11056	11604	12006	14020	15301	15823	17360	20615
11057	11606	12007	14021	15320	15837	19000	20650
11200	11620	12011	14040	15321	15839	19001	20665
11201	11621	12013	14041	15330	15851	19020	20670
11300	11622	12014	14060	15331	15852	19030	20694
11301	11623	12015	14061	15335	15860	19100	20900
11302	11624	12016	14300	15336	16000	19101	20910
11303	11626	12017	15002	15340	16020	19110	20922
11305	11640	12018	+15003	15341	16025	19112	20974
11306	11641	12020	15004	15360	16030	19120	20979
11307	11642	12021	+15005	15361	17000	19125	20983
11308	11643	12031	15040	15365	17003	19290	21025
11310	11644	12032	15050	15366	17004	19291	21026
11311	11646	12034	15100	15401	17106	19295	21029
11312	11719	12035	15101	15420	17107	19296	21030
11313	11720	12036	15110	15421	17108	19298	21031
11400	11721	12037	15111	15430	17110	19300	21032

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
21034	21461	24065	26641	27613	28054	28238	28515
21034	21462	24066	26645	27614	28060	28240	28525
21040	21480	24075	26670	27618	28062	28250	28530
21076	21485	24200	26675	27619	28070	28260	28531
21077	21497	24201	26700	27630	28072	28261	28540
21079	21501	24220	26705	27648	28080	28262	28546
21080	21550	24362	26705	27656	28086	28270	28555
21081	21555	24500	26720	27658	28088	28272	28570
21082	21700	24500	26725	27659	28090	28280	28575
21083	21720	24505	26740	27664	28092	28285	28576
21084	21820	24530	26742	27665	28092	28286	28585
21085	21920	24535	26750	27685	28100	28288	28600
21086	21925	24560	26755	27686	28103	28289	28606
21087	21930	24565	26770	27730	28104	28292	28630
21100	22010	24576	26775	27732	28107	28296	28635
21110	22015	24577	26991	27740	28108	28297	28636
21116	22310	24600	27040	27742	28110	28298	28645
21120	22505	24640	27047	27750	28111	28299	28660
21121	22510	24650	27086	27752	28112	28300	28665
21125	22511	24655	27093	27760	28113	28302	28666
21127	22512	24670	27095	27762	28114	28304	28675
21208	22513	24675	27096	27780	28116	28305	28740
21209	23000	25065	27194	27781	28118	28306	28750
21210	23030	25246	27200	27786	28119	28307	28755
21215	23031	25500	27220	27788	28120	28308	28760
21235	23065	25505	27230	27808	28122	28310	28820
21245	23066	25520	27246	27810	28124	28312	28825
21246	23075	25530	****27278**	27816	28126	28313	28890
21248	23330	25535	27301	27818	28140	28315	29000
21249	23350	25560	27323	27824	28150	28322	29010
21270	23500	25565	27327	27825	28153	28340	29015
21300	23505	25600	27372	27830	28160	28341	29035
21310	23520	25605	27500	28001	28173	28344	29040
21315	23525	25622	27501	28002	28175	28345	29044
21320	23540	25624	27508	28003	28190	28400	29046
21337	23545	25630	27516	28008	28192	28405	29049
21345	23570	25635	27517	28010	28193	28430	29055
21355	23575	25650	27520	28011	28200	28435	29058
21400	23600	25675	27530	28020	28202	28450	29065
21401	23605	26010	27532	28022	28208	28455	29075
21421	23620	26011	27538	28024	28210	28470	29085
21440	23625	26055	27550	28035	28220	28475	29105
21445	23650	26070	27560	28043	28222	28490	29125
21450	23665	26160	27603	28045	28225	28495	29126
21451	23675	26432	27604	28046	28230	28496	29130
21452	23930	26600	27605	28050	28232	28505	29131
21453	23931	26605	27606	28052	28234	28510	29200

Cpt Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
29220	30906	32504	36836	40812	42320	44213	46050
29240	31000	32960	36837	40814	42325	44227	46080
29260	31002	32994	36860	40816	42326	44385	46083
29280	31020	33507	37184	40819	42330	44386	46200
29305	31030	33548	37185	40820	42335	44388	46210
29325	31231	33741	37186	40830	42340	44389	46211
29345	31233	33745	37187	40844	42400	44390	46220
29355	31235	33746	37188	41000	42405	44391	46221
29358	31237	33768	37220	41005	42450	44392	46230
29365	31238	33880	37221	41006	42550	44393	46250
29405	**31242	33881	37222	41007	42600	44394	46255
29425	****31243**	33883	37223	41008	42650	45005	46270
29435	31295	33884	37224	41009	42660	45100	46275
29440	31296	33886	37225	41015	42665	45108	46285
29445	31297	33889	37226	41016	42700	45150	46320
29450	31298	33891	37227	41017	42720	45300	46500
29505	31502	33925	37230	41018	42800	45303	46505
29515	31505	33926	37231	41100	42802	45305	46600
29520	31510	33967	37232	41105	42804	45307	46604
29530	31511	33995	37233	41108	42806	45308	46606
29540	31512	33997	37234	41110	42808	45309	46608
29550	31515	36000	37235	41112	42809	45315	46610
29580	31525	36005	37252	41113	42810	45317	46611
29700	31570	36400	37253	41115	42975	45320	46612
29705	31575	36405	37609	41250	43200	45330	46614
29710	31576	36406	37718	41251	43201	45331	46615
29720	31577	36410	37722	41252	43202	45332	46710
29730	31578	36425	37785	41800	43235	45333	46712
29740	31579	36430	38220	41806	43236	45335	46900
29750	31612	36450	38221	41822	43239	45338	46910
29850	31615	36465	38222	41823	43245	45340	46916
30000	31622	36466	38300	41825	43290	45378	46917
30020	31623	36470	38305	41826	43291	45379	46922
30100	31624	36471	38500	41827	43450	45380	46924
30110	31625	36475	38505	41828	43754	45381	46935
30117	31628	36476	38790	41830	43755	45382	46936
30124	31634	36478	40490	41874	43756	45384	46937
30200	31652	36479	40500	42000	43757	45385	46938
30210	31653	36482	40510	42100	43770	45395	46940
30220	31654	36483	40520	42104	43771	45397	46942
30300	31700	36489	40530	42106	43772	45400	46945
30560	31717	36510	40650	42107	43773	45402	46946
30468	31720	36522	40652	42140	43774	45520	47000
30469	31730	36533	40654	42160	43886	45905	47383
30580	31825	36535	40800	42180	43887	45910	47531
30801	32400	36536	40801	42182	43888	45915	47532
30802	32408	36537	40804	42280	44180	45990	47533
30901	32421	36593	40805	42281	44186	46020	47534
30903	32422	36598	40808	42300	44187	46030	47535
30905	32503	36600	40810	42310	44188	46040	47536

Cpt Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
47537	51102	53601	56821	59015	64463	65220	67228
47538	51600	53620	57020	59160	64470	65222	67345
47539	51605	53621	57061	59200	64472	65270	67500
47540	51610	53660	57065	59300	64479	65272	67505
47541	51700	53661	57100	59412	64480	65275	67515
47542	51701	53850	57105	59425	64483	65286	**67516**
47543	51702	53852	57135	59426	64484	65400	67700
47544	51703	54000	57150	59430	64486	65410	67710
48102	51705	54001	57156	59812	64487	65420	67800
49080	51710	54015	57160	59820	64488	65426	67801
49081	51715	54050	57170	59821	64489	65430	67805
49180	51600	54055	57180	59840	64505	65435	67810
49185	51605	54056	57295	59841	64508	65436	67820
46934	51720	54057	57410	59871	64510	65450	67825
49418	52000	54065	57415	60000	64520	65600	67830
49505	52005	54100	57421	60300	64530	65772	67840
50250	52010	54105	57452	60100	64550	65778	67850
50382	52204	54115	57454	61001	64553	65779	67875
50384	52234	54150	57455	61020	64555	65785	67880
50387	52235	54160	57456	61026	64560	65800	67882
50389	52240	54200	57460	61070	64561	65815	67700
50391	52265	54220	57461	62263	64585	65855	67900
50430	52270	54230	57465	62264	**64596**	65860	67903
50431	52275	54231	57500	62270	**64597**	66020	67904
50432	52276	54235	57505	62272	**64598**	66030	67906
50433	52281	54450	57510	62280	64600	66130	67908
50434	52282	54500	57511	62281	64605	66250	67909
50435	52283	54700	57513	62282	64611	66625	67914
50551	**52284**	54800	57520	62284	64612	66700	67915
50553	52285	55000	57522	62290	64616	66710	67916
50555	52310	55100	57558	62291	64617	66720	67917
50557	52315	55250	57800	62302	64620	66761	67921
50561	52270	55700	58100	62303	64622	66762	67922
50590	52317	55870	58110	62304	64623	66770	67923
50592	52330	55874	58120	62305	64626	66821	67924
50606	52332	55876	58301	64400	64627	67025	67930
50684	52441	55880	58321	64405	64630	67027	67935
50686	52442	56405	58322	64408	64640	67028	67938
50690	52647	56420	58323	64415	64642	67031	67950
50693	53000	56440	58340	64417	64643	67101	67961
50694	53020	56441	58350	64418	64644	67105	67966
50695	52442	56501	58356	64420	64645	67110	68020
50705	53025	56515	58555	64421	64646	67120	68040
50951	53040	56605	58558	64425	64650	67141	68100
50953	53060	56606	58565	64430	64653	67145	68110
50955	53200	56700	**58580**	64435	64680	67208	68115
50957	53260	56440	58800	64445	64721	67210	68200
50961	53265	56720	58970	64450	65125	67220	68330
51100	53270	56740	58976	64461	65205	67221	68340
51101	53600	56820	59000	64462	65210	67227	68360

Cpt Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
68400	80502	**93153	95973	99203	99482	
68420	85097	93242	95975	99204		
68510	86077	93244	95978	99205		
68530	86078	93246	95979	99211		
68705	86079	93248	96101	99212		
68760	88321	93313	96102	99213		
68761	88329	93316	96103	99214		
68770	88333	93319	96116	99215		
68801	88334	93720	96118	99242		
68810	89135	93721	96119	99243		
68815	90901	93722	96120	99244		
68840	91013	93797	96401	99245		
68841	91022	93798	96402	99291		
68850	91117	94619	96405	99292		
69000	92002	94625	96406	99300		
69005	92004	94626	96409	99301		
69020	92012	94640	96411	99302		
69100	92014	94660	96413	99303		
69105	92019	94664	96415	99304		
69110	92020	94667	96416	99305		
69145	92070	94668	96417	99306		
69200	92120	95010	96440	99307		
69210	92130	95015	96446	99308		
69220	92140	95056	96450	99309		
69222	92229	95065	96521	99310		
69405	92230	95075	96522	99341		
69410	92260	95145	96523	99342		
69420	92287	95146	96542	99344		
69421	92315	95147	**96547	99345		
69424	92316	95148	**96548	99347		
69433	92317	95149	96570	99348		
69540	92330	95165	96571	99349		
69610	92335	95170	97012	99350		
69620	92504	95806	97018	+99417		
69705	92506	95830	97022	99424		
69706	92507	95851	97024	+99425		
71271	92508	95852	**97551	99426		
**75580	92511	95857	98940	+99427		
76145	92652	95865	98941	99436		
76376	92653	95866	98942	+99437		
76377	92950	95873	98980	+99439		
76883	92960	95874	+98981	99447		
**76984	**93150	95970	99170	99448		
77423	**93151	95971	99183	99449		
80500	**93152	95972	99202	99481		

**Denotes new 2024 HCPCS codes. Strike-throughs denote deleted codes. *Please See the Site of Service Fee Schedule for NEW Codes

Rev. 01/2024

Appendix K
Radiology Prior Authorization

Code	Description
70450	CT Head/Brain wo Dye
70460	CT Head/Brain w Dye
70470	CT Head/Brain wo & w Dye
70551	MRI Brain wo Dye
70552	MRI Brain w Dye
70553	MRI Brain wo & w Dye
71271	CT Thorax Lung Cancer Screen
72148	MRI Lumbar Spine wo Dye
72149	MRI Lumbar Spine w Dye
72158	MRI Lumbar Spine wo & w Dye
72192	CT Pelvis wo Dye
72193	CT Pelvis w Dye
72194	CT Pelvis wo & w Dye
74150	CT Abdomen wo Dye
74160	CT Abdomen w Dye
74170	CT Abdomen wo & w Dye
74176	CT Abdomen & Pelvis wo Contrast
74177	CT Abdomen & Pelvis w Contrast
74178	CT Abdomen & Pelvis 1+ Section/Regns
**75880	Vein X-Ray Eye Socket
76145	Dose Evaluation for Radiation Exposure
76805	OB US>/=14 weeks, Single Fetus
76810	OB US>/=14 weeks, Addl Fetus
76815	OB US, Limited, Fetus(s)
76816	OB US, Follow-up, per Fetus
**76984	DX INTRAOP THORACIC AORTA US
**76987	DX INTRAOP EPICAR CAR US CHD
**76988	DX NTROP EPCR US CHD IMG ACQ
**76989	DX INTRAOP EPCAR US CHD I&R
77089	TXS DXA CAL w I/R FX Risk
77090	TBS Techl Prep and Transmiss of Data
77091	TBS Techl Calculation Only
77092	TBS I/R FX Risk QHP
78608	PET Brain Imaging
78811	PET Tumor Imaging Limited Area
78812	PET Tumor Imaging Skull to Thigh
78813	PET Tumor Imaging Whole Body
78814	PET w/CT Imaging Limited Area
78815	PET with CT Imaging Skull to Thigh
78816	PET with CT Imaging Whole Body
76883	PET US Nerves in Extremity

**Denotes New 2024 HCPCS Codes Rev. 01/2024

Appendix L
HCPCS V- Codes

The Department of Community Health no longer publishes "V" codes available for utilization within Georgia Medicaid.

Utilization must be based upon correct coding guidelines and follow program policy.

Appendix M
Outpatient, Ambulatory Surgical Center (ASC) And Hospital Procedures Requiring Prior Approval And/Or Precertification

The following CPT/HCPCS codes represent the procedures and services that must be prior approved (PA) and/or pre-certified before services are rendered in an outpatient setting, ambulatory surgical center, or hospital, except in emergencies. Emergency services must be reported and reviewed retrospectively within 30-days.

All services requiring prior approval and/or pre-certification applies to all eligible members, regardless of age.

Note: Prior approval (PA) for certain procedures may be completed telephonically, while others are limited to written or web portal submission only. For further information, contact the Gainwell Technologies at (800) 766-4456 (Toll free).

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
11446	15220	15773	19306	****22837**	25607	27059	27681
11750	15240	15778	19307	****22838**	25608	27197	27685
14001	15260	15840	20975	22853	25609	27198	27686
14020	15271	15841	21011	22854	26055	****27278**	27687
14021	15272	15842	21012	22856	26060	27325	27690
14041	15273	15845	21013	22859	26111	27326	27691
14060	15274	17260	21014	22861	26113	27337	27692
14061	15275	17261	21016	22864	26118	27339	27700
14300	15276	17262	21032	22867	26160	27345	27702
14301	15300	17263	21552	22868	26350	27366	27703
14302	15320	17264	21554	22869	26352	27420	27705
14350	15330	17266	21558	22870	26356	27422	27707
15002	15420	17270	21931	22900	26358	27424	27709
15003	15430	17271	21932	22901	26370	27425	27712
15004	15570	17272	21933	22903	26372	27430	27715
15005	15572	17273	21936	22904	26373	27435	27745
15040	15574	17274	22520	22905	26390	27605	28008
15050	15576	17276	22521	23071	26392	27606	28035
15100	15600	17280	22523	23073	26410	27612	28039
15110	15610	17281	22524	23078	26412	27616	28041
15115	15620	17282	22532	23473	26418	27620	28045
15130	15630	17283	22533	23474	26420	27630	28047
15135	15758	17284	22534	24071	26426	27632	28055
15150	15760	17286	22548	24073	26428	27634	28062
15152	15769	17311	22551	24079	26432	27635	28072
15155	15650	17312	22552	24370	26433	27637	28080
15170	15740	17314	22586	24371	26434	27638	28086
15175	15770	17315	22633	25078	27043	27656	28088
15200	15771	19305	****22836**	25606	27045	27680	28090

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
28092	29881	31661	35634	42950	44186	52000	53410
28102	29882	32408	35637	42975	44187	52001	53420
28103	29883	32482	35638	43200	44188	52005	53425
28107	29884	32553	36147	43217	44204	52007	53430
28110	29885	32554	36148	43220	44205	52010	53431
28111	29886	32555	36221	43226	44206	52204	53440
28112	29887	32556	36222	43231	44208	52214	53444
28113	29888	32557	36223	43232	44227	52224	53445
28114	29889	32561	36224	43235	44360	52234	53447
28116	29914	32562	36225	43237	44361	52235	53448
28118	29915	32701	36226	43238	44364	52240	53449
28119	29916	33202	36227	43239	44369	52250	53450
28120	30115	33254	36228	43240	44705	52260	53460
28122	30117	33255	36456	43241	45171	52270	53855
28124	30118	33256	36474	43242	45172	52275	54161
28126	30125	****33276**	36836	43247	45378	52276	54520
28171	30150	****33287**	36837	43249	45380	52277	54522
28173	30160	****33288**	37197	43251	45383	52281	54530
28175	30468	33741	37211	43252	45385	52283	54535
28200	31020	33745	37212	43257	45387	****52284**	54865
28202	31030	33746	37213	43258	45391	52285	55040
28208	31032	33782	37214	43260	45392	52287	55041
28210	31070	33783	37220	43262	45395	52290	55060
28220	31200	33894	37221	43263	45397	52300	55175
28222	31201	33897	37223	43264	45400	52305	55180
28225	31205	33981	37224	43265	45402	52310	55500
28226	****31242**	33982	37225	43280	45500	52315	55540
28230	****31243**	33983	37226	43281	45505	52317	58559
28232	31276	33990	37227	43282	45520	52318	55605
28240	31551	33991	37228	43284	45560	52320	55650
28288	31552	33992	37234	43285	46505	52330	55867
28291	31553	33993	37235	43290	46707	52332	58560
28295	31554	33995	37246	43291	47560	52340	58561
28340	31572	33997	37247	43325	47561	52341	58562
28341	31573	34718	37248	43327	47562	52342	58563
28344	31574	35302	37249	43328	49321	52343	****58580**
28360	31591	35303	37761	43332	49322	52347	58660
28810	31592	35304	37780	43333	49402	52351	58661
28820	31620	35305	37785	43334	49411	52352	58662
28825	31622	35306	38243	43335	50382	52400	58672
29581	31626	35506	40510	43336	50387	52450	58673
29870	31627	35535	40650	43337	50945	52500	58880
29871	31647	35537	40652	43338	50947	52601	60212
29874	31648	35538	40654	43360	50948	52630	60220
29875	31649	35539	41006	43361	51727	52640	60225
29876	31651	35540	41007	43497	51728	52647	60240
29877	31652	35570	41009	44157	51729	52648	60260
29879	31653	35632	41530	44158	51990	53400	60270
29880	31660	35633	42145	44180	51992	53405	60271

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
60500	63252	66852	74261	93248			**Denotes new 2024 HCPCS codes. Strike-throughs denote deleted codes. *Please See the Site of Service Fee Schedule for NEW Codes
60502	63265	66920	74262	93451			
60505	63266	66930	74263	93452			
60512	63267	66940	75565	93453			
60521	63270	66982	75571	93454			
61586	63271	66983	75572	93455			
61600	63272	66984	75573	93456			
61736	63273	66985	75574	93457			
61737	63275	66986	**75580	93458			
61797	63276	66989	75591	93459			
61798	63277	66991	76145	93460			
61799	63278	67311	76706	93461			
61800	63280	67312	76801	93503			
**61889	63281	67320	76802	93505			
**61891	63282	67331	**76984	93510			
62320	64410	67332	**76987	93511			
62321	64415	67346	**76988	93514			
63222	64417	**67516	**76989	93536			
63223	64420	67808	**76984	93580			
62324	64421	67880	**76984	93750			
62325	64430	67882	77089	94011			
62326	64449	67901	77090	94012			
62327	64475	67902	77091	94013			
62380	64476	67903	77092	94619			
63001	64490	67904	78452	95719			
63003	64491	67906	78453	95721			
63005	64569	67908	78608	95722			
63011	64582	67909	78811	95723			
63012	64583	67914	78812	95724			
63015	64584	69716	78813	95725			
63016	64611	69728	78814	95726			
63017	64612	69729	78815	95803			
63045	64628	69730	78816	95905			
63046	+64629	70450	90670	96000			
63047	64653	70460	90674	96001			
+63052	**64596	70470	91110	96001			
+63053	**64598	70551	92065	96567			
63170	64681	70552	92229	96570			
63185	65710	70553	92242	96570			
63190	65730	71271	92540	96571			
63191	65750	72148	92550	99151			
63194	65780	72149	92570	99152			
63195	65781	72158	**92622	99153			
63196	65782	72192	92652	99155			
63197	66820	72193	92653	99156			
63198	66821	72194	**93150	99157			
63199	66830	74150	93242	99231			
63250	66840	74160	93244	99417			
63251	66850	74170	93246				Rev. 01/2024

Appendix N
Physician's Certification Of Medical Evaluation Of Hearing Loss

Medical Clearance for Hearing Aid Referral

____

Date

____

Patient's Name

The above patient has been medically evaluated and may be considered a candidate for a hearing aid.

____

Date Of Evaluation

____

Physician's Signature

____

Physician's Name

____

Address

Appendix O
Drugs With Therapy Limitations Or Quantity Level Limits

For specific information regarding services, coverage, and limitations under the Pharmacy program, please see the Pharmacy Services manual, the Medicaid Preferred Drug List, and relevant Banner Messages available online at www.mmis.georgia.gov. Paper copies of the manual or Drug List may be obtained from the Division's Fiscal Agent by contacting the Gainwell Technologies at or 800-766-4456.

Appendix P
Copayments For Certain Services

A. General Copayment Information

The Division is implementing a tiered member co-payment scale as described in 42CFR447.54 on all evaluation and management procedure codes (99202 – 99499) including the ophthalmological services procedure codes (92002 – 92014) used by physicians or physicians' assistants.

i. The tiered co-payment amounts are as follows:

State's Payment	Maximum Co-Payment
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

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

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

1. Pregnant women
2. Nursing facility residents
3. Hospice care members
4. Members under 21
5. Women who have been screened for breast and cervical cancer under the Centers Disease Control and Prevention breast and cervical cancer early detection program established under title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42 U.S.C. 300n) and need treatment for breast or cervical cancer.) Categories of Service 245 and 800.

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

6. Emergency services,
7. Family Planning services
8. Waiver services
9. Dialysis services

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

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

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

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

GAINWELL TECHNOLOGIES will automatically deduct the co-payment amount from the provider's payment for claims processed with dates of service July 1, 2005, and after. Do not deduct the co-payment from your submitted charges. The application of the co-payment will be identified on the remittance advice. A new explanation of benefit (EOB) code will indicate payment has been reduced due to the application of co-payment.

Pharmacy Services

For copayments related to Pharmacy services, please refer to the Pharmacy manual which can be found on the GAMMIS web-portal at www.mmis.georgia.gov under the Provider Information, Provider Manuals tabs.

Appendix Q
Provider's Guide To HIV Pre-Test And Post-Test Counseling

All providers who provide prenatal care to pregnant women in their first trimester (before 13 weeks) are required to include voluntary HIV AIDS counseling and testing as a fundamental component of comprehensive prenatal care in order to receive the "$100.00 incentive pay".

A. HIV Pre-Test Counseling

i. During pre-testing HIV testing, providers should discuss with pregnant women the below:

1. prior history of HIV counseling and testing
2. nature of AIDS and HIV-related illness
3. benefits of early diagnosis and medical intervention
4. HIV transmission and risk reduction behaviors
5. Benefits of early diagnosis for preventing perinatal transmission and for treatment of newborn

B. Informed Consent For HIV Blood Test

ii. Before administering the HIV Blood Test, providers should ensure the below procedures are performed:

6. Obtain written informed consent, prior to ordering test, from patient or person authorized to consent
7. Provide the patient with a copy of the consent form or document containing all pertinent information
8. Consider patient's ability, regardless of age, to comprehend the nature and consequences of HIV blood testing. If the patient's ability to understand is temporarily impaired, defer testing
9. Explain test and procedures:
   - (a) purpose of the test
   - (b) meaning of test results
   - (c) testing is voluntary
   - (d) consent may be withdrawn at any time
10. Explain protections of confidential HIV-related information and conditions of authorized disclosures

11. A licensed physician or other person authorized by law to order a laboratory test must sign all orders for HIV blood testing and certify the receipt of informed consent

12. Schedule appointment for delivery of test results and post-test counseling (allow sufficient time for completion of confirmatory testing).

C. Communicate Test Results And Provide Post-Test Counseling

**Deliver test results to patient or authorized proxy in person.

iii. For Patients With NEGATIVE Test Results:

1. discuss meaning of the test results

2. discuss possibility of HIV exposure during past six months and need to consider retesting

3. emphasize that a negative test result does not imply immunity to future infection

4. reinforce personal risk reduction strategies

iv. For Patients With POSITIVE Test Results:

5. discuss the meaning of the test results

6. discuss availability of medical care including prophylaxis for opportunistic infections and antiretroviral therapy

7. discuss and recommend use of ZVD, consistent with clinical practice guideline, to reduce risks of maternal-child transmission; discuss risk of HIV transmission through breastfeeding

8. discuss partner/contact notification; offer assistance

9. encourage referral of partners and children for HIV testing

10. provide counseling or refer to counseling:

    (a) for coping with the emotional consequences of test results

    (b) for behavior change to prevent transmission of HIV infection

11. provide or refer to needed medical support and services

DOCUMENT THE PROVISION OF PRE/POST TEST COUNSELING AND THE TEST RESULTS IN THE PATIENT'S RECORD.

D. Maternal-Child HIV Transmission Prevention Counseling

Counseling should explain the benefits of early diagnosis for preventing perinatal transmission and for treatment of the newborn.

v. Before Prescribing Any Regimen:

12. discuss with HIV-infected patient risks and benefits of antepartum, intrapartum and postpartum use of ZDV therapy to reduce the risk of maternal-child HIV transmission

13. discuss patient concerns

14. obtain ZDV use history

Written request for copies should be forwarded to:

GAINWELL TECHNOLOGIES

Provider Enrollment Unit

P. O. Box 88030

Atlanta, GA 30356

OR

Phone your request to:

1 (800) 766-4456

Choose option (#4)

Appendix R
Statement Of Participation

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

Written request for copies should be forwarded to:

GAINWELL TECHNOLOGIES

Provider Enrollment Unit

P. O. Box 88030

Atlanta, GA 30356

OR

Phone your request to:

1 (800) 766-4456

Choose option (#4)

Appendix S
Gainwell Technologies Contact Information

A. Member Information

Members should be instructed to call Gainwell for any member-related questions or concerns. Gainwell can be reached at 1-866-211-0950.

B. Provider Information

i. Providers should call Gainwell at 1-800-766-4456 for any provider issues or concerns and access the GABBY - Virtual Agent (formerly known as IVRS).

Please listen to the following prompts and select the appropriate option:

1. Member Eligibility and Service Limits
2. Claim Status
3. Payment Information
4. Provider Enrollment
5. Prior Authorization
6. Multi-Factor Authentication (MFA), Web-Portal Access
7. All Other Information
    - (a) Pharmacy Benefits
    - (b) Web portal
    - (c) Nurse Aide
    - (d) HIPPA 12

ii. For questions or concerns regarding the below topics, contact 1-877-261-8785:

8. Web Portal Password Resets
9. Provider Pin Activations
10. Electronic claim file submissions
11. Claim Rejects
12. Web Portal Navigation/Registration
13. Identifying and troubleshooting technical issues
14. Enrollment of trading partners

Appendix T
National Provider Identifier (NPI) Requirements

A. NPI General Information

The National Provider Identifier (NPI) has been adopted by the U.S. Department of Health and Human Services to meet the HIPAA health care provider identification mandate. It is a 10-digit number assigned to health care providers. Once a provider has an NPI, it will not change regardless of job or location changes. It replaces all existing health care provider identifiers including numbers assigned by Medicare, Medicaid, Blue Cross, etc. on standard HIPAA transactions. It will be the number used to identify providers nationally.

i. Who needs an NPI?

All Medicaid providers, both individuals and organizations, who are eligible to receive an NPI, are required to have an NPI. This includes the below:

1. All Medicaid healthcare providers and
2. All CMO healthcare providers.

The NPI will be required on electronic claims.

Medicaid providers who are not eligible to receive an NPI will maintain their current Medicaid Provider ID. A table showing the types of Medicaid providers and whether they are required to get and use an NPI is included at the end of this Appendix.

ii. When do I need to use my (National Provider Identifier) NPI with Georgia Medicaid?

3. Applying to be a Medicaid Provider
4. On all electronic claim submissions including claims submitted via WINASAP.

iii. When do I need to use my Medicaid Provider Number?

You will need to use your Medicaid Provider Number in the following circumstances.

5. Paper claims submission (CMS 1500)
6. Resubmission of electronic claims on paper
7. Submission of web claims
8. IVR System inquiries
    (a) Provider authentication
    (b) All claim inquiries

(c) All other inquiries

9. Telephone inquiries

(d) Provider authentication

(e) All claim inquiries

(f) All other inquiries

10. Prior authorizations

(g) Requests

(h) Inquiries

11. Referrals

(i) Request

(j) Inquiries

12. Medicaid forms

iv. When do I need both my NPI and my Medicaid Provider Number?

13. Adding a location to my Provider record

14. Changing my Provider information

15. Written inquiries and correspondence

16. E-mail and 'Contact Us' inquiries

Refer to the Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual for additional information about NPI requirements. The manual can be found on the GAMMIS web-portal at www.mmis.georgia.gov under the Provider Information, Provider Manuals tabs.

Appendix U
Provider Preventable Conditions, Never Events, And Hospital Acquired Conditions

Based on the Centers for Medicare and Medicaid Services (CMS) directive, Georgia Medicaid implemented its final rule outlined in 42 CFR 447.26, regarding PROVIDER PREVENTABLE CONDITIONS (PPCs), NEVER EVENTS (NEs), and HOSPITAL ACQUIRED CONDITIONS (HACs) acquired in ALL hospital settings and other non-inpatient health care settings.

HACs are defined as diagnoses determined by either the state and/or Medicare to be reasonably preventable, i.e., Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following a total knee replacement or hip replacement surgery, and PPCs, i.e., the wrong body part and surgical invasive procedures performed by a practitioner or provider to the wrong patient that should never happen in an admission to treat a medical condition. CMS specifically in Section 2702 of the Patient Protection and Affordable Care Act, prohibits payment to providers for Other Provider-Preventable Conditions (OPPPCs) as specified in 42 CFR 434, 438, and 447 of the Federal Register, page 32816.

The Hospital Services Manual in Section 1102(e) outlines the Department's policies and procedures on HACs as identified by Medicare' federal regulations published in October 2010. The Georgia Medicaid Management System (GAMMIS) was configured on July 1, 2011 with the HACs edits. The Department of Community Health will not reimburse inpatient facilities (if applicable) or enrolled Medicaid practitioners/providers for treatment of any HACs and/or PPCs identified through the claims adjudication and/or medical records review process. NEs in Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners and providers regardless of the healthcare setting are required to report NEs. Refer to the Reimbursement sections of the Hospital Services and Physician Services Policies and Procedures Manuals for additional information.

Claims will be subject to retrospective review in accordance with CMS' directive and the State Plan Amendment, Appendix 4.19. When a claim's review indicates an increase of payment to the provider for an identified PPC, HAC, or NE, the amount for the event or provider preventable condition will be excluded from the provider's total payment.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

Appendix V
PeachCare for Kids Co-Payments
(For children ages 6 and over)

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

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

Appendix W
New 1500 CMS Claim Form

HEALTH INSURANCE CLAIM FORM

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

PICA　　　　PICA

CARRIER

SAMPLE

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? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED ____ DATE ____

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

SIGNED ____

PATIENT AND INSURED INFORMATION

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org　　***PLEASE PRINT OR TYPE***　　APPROVED OMB-0938-1197 FORM 1500 (02-12)

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/GAINWELL:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?)
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)." Removed the arrow and text in the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier." **FOR DCH/GAINWELL: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date)**.
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091

FLD Location	NEW Change
	(Report End [Relinquished Care Date); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/GAINWELL:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/GAINWELL:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. **(Do not bill ICD 10 code sets before October 1, 2015.)**
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. **FOR DCH/GAINWELL**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

Appendix X
General Information - Georgia Families, Georgia Families 360, Non-Emergency Medical Transportation

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

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.asp