PART II

POLICIES AND PROCEDURES
for
NURSE MIDWIFERY SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: October 1, 2024

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Policy Revision Record
[from 2024 to Current[1]]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
10/01/2024	Appendices I, M and N	Deleted Georgia Families, Georgia Families 360 and Non-Emergency Medical Transportation (NEMT) Appendices.	D	N/A
10/01/2024	Appendix P	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 2024 to current. For revisions prior to 2024, please see prior versions of the policy.

601. Enrollment

In addition to the general conditions of participation identified Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual, Section 105, providers in the nurse-midwife program must meet the following condition:

601.1 Each nurse-midwife must maintain a current license as a registered nurse and be currently certified as a nurse midwife by the American College of Nurse Midwives (ACNW).

601.2. A copy of the national certification must be on file with the Department.

602. Nurse Midwifery Requirements and Guidelines

602.1. Each enrolled nurse-midwife shall bill the Department for only for those services that are rendered by or under the supervision of the nurse-midwife. Only necessary and appropriate medical services, that meet the following conditions will qualify as services performed under the direct supervision of the nurse-midwife practitioner:

602.1.1. 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,

602.1.2. The person performing the services must be a salaried employee of the provider group, or of the group practice as defined below; a nurse-midwife 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) below;

602.1.3. The nurse-midwife must periodically and regularly review the patient's medical records;

602.1.4. The nurse-midwife must be immediately available on the site at the time the services are delivered;

602.1.5. A nurse-midwife may not bill for services rendered by a person not approved to provide that service by Medicaid policy, or by applicable licensure, certification, or other State or Federal Regulation; and

602.1.6. Chapter 900 shall control over language in this section.

602.2. In a group practice, each nurse-midwife must enroll separately and bill for services rendered under the rendering provider's own provider number. 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-midwives in a group practice are not covered.

602.3. Indiscriminate billing under one nurse-midwife's name or provider number without regard to the specific circumstances of rendition of the services is prohibited and is grounds for disallowing reimbursement or for recoupment of reimbursement.

602.4. A nurse-midwife covering for another will not be construed as a violation of this section when the covering nurse-midwife is on call and provides emergency or unscheduled services for a period of time not to exceed fourteen continuous days. The covering nurse-midwife must also be a Georgia Medicaid enrolled nurse-midwife.

602.5. The nurse midwife shall bill the Division the lowest price regularly and routinely offered to any group of the general public for the same service or item on the same date of service or the lowest price charged to other third party payers for the procedure code most closely reflecting the service rendered. The nurse midwife shall maintain records on both Medicaid eligible and private paying patients for a minimum of five years to fully ensure compliance. The nurse midwife shall provide the Division, its authorized representatives or contractual agents, with information requested regarding fees at no charge.

602.6. The nurse midwife shall not bill any services performed by an independent laboratory or freestanding diagnostic facility. A freestanding diagnostic facility is a facility that is independent of both the attending nurse midwife and the consulting nurse midwife, of a hospital which meets at least the requirements to qualify as an emergency hospital.

602.7. A laboratory, x-ray, or freestanding diagnostic facility that is not located in a physician's office or hospital (example: independent diagnostic facility) is presumed to be independent unless written evidence establishes that it is owned by the billing physician or a hospital and at a minimum meets the definition of an emergency hospital.

602.8. Services performed by a nurse midwife in an independent facility shall not be reimbursed through the nurse midwife program unless any one of the following conditions applies:

602.8.1. Any documented ownership in the practice;

602.8.2. Any documented cost associated with a lease of the radiology or diagnostic equipment;

602.8.3. Any documented contractual agreement for radiological or diagnostic services between the physician rendering professional services and owners of the equipment; or

602.8.4. Any documented concession agreement allocating costs of the equipment or practice to the physician. Example: An employer--employee relationship when the physician is a full-time employee of the facility that owns and operates the equipment and performs radiology services as part of an employment agreement may satisfy this requirement.

602.9. At least one of the above criteria must be met in order for the provider to bill the technical or global components of a procedure. Regardless of the above criteria, the professional component, indicated by use of the 26 can be billed if the nurse midwife is enrolled in the proper Medicaid category of service to deliver these services.

602.10. The nurse midwife agrees to cooperate with the appropriate guidelines of other Medicaid service programs adjunctive to Physician Services.

602.11. The nurse midwife shall immediately notify the Division's Provider Enrollment Unit in writing of any changes in enrollment status that occur, including but not limited toa new address or telephone number; additional practice locations; change in payee; closure of any individual practice; dissolution of a group practice causing any change in the Division's records; and voluntary termination from the Program. Each notice of change must include the date when the change became effective.

602.12. The nurse-midwife shall bill the Division for the procedure code that best describes the level and complexity of the service rendered and shall not bill under separate procedure codes for services that are included under a single procedure code.

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

602.14. The nurse midwife 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 if the nurse midwife is compensated by the clinic for services that are reimbursable under these programs.

(Rev. 10/2014)

603. Locum Tenens

603.1. Locum Tenens nurse-midwives are substitute nurse-midwives who take over regular nurse-midwives' professional practices when the regular nurse-midwife is absent. The regular nurse-midwife can bill for the services provided by the locum tenens nurse-midwife when the regular nurse-midwife is unavailable to provide the service. The following conditions apply:

603.2. Medicaid members have arranged or seek to receive the services from the regular nurse-midwife.

603.3. The regular nurse-midwife pays the locum tenens nurse-midwife for services provided on a per diem or similar fee-for-time basis.

603.4. The locum tenens nurse-midwife does not provide the visit services to Medicaid patients for a period of time exceeding sixty consecutive days within a twelve month period.

603.5. The locum tenens nurse-midwife must be an enrolled Medicaid provider. The locum tenens nurse-midwife must have a valid Georgia Medicaid provider number. The regular nurse-midwife must place the locum tenens nurse-midwife's provider number on the CMS1500 claim form on field 24J.

603.6. Services provided by locum tenens nurse-midwife must be identified in the member's medical record held by the regular nurse-midwife and must be available for inspection.

603.7. Reimbursements shall be limited to services the regular nurse-midwife is entitled to submit. Anyone who falsely certifies any of the above requirements may be subject to civil and criminal penalties for fraud.

603.8. The explanations and limitations contained in Chapter 900 apply.

603.9. A nurse-midwife covering for another physician shall not be construed as a violation of this Chapter. Here, the regular nurse-midwife must identify the services as substitute nurse-midwife services. (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 Precertification

801. Procedures for Obtaining Hospital Precertification

Precertification is required for all inpatient hospital admissions (except for routine deliveries for pregnant women and services for members under twenty-one years of age) and selected services performed in an outpatient hospital or ambulatory surgical care setting. (Please see Appendix D for a complete listing of the outpatient services which require precertification.)

Emergent admissions or emergent surgical procedures as well as 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 payment.

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. To obtain precertification, please contact the Division's medical peer review vendor at:

Alliant Health Solutions
Medicaid Precertification Department
P.O. Box 105200
Atlanta, Georgia 30348
Facsimile: 1-866-483-1044 (Available 24 hours)

For patients whom the provider believes may later be determined retroactively eligible for Medicaid, GHP must be contacted in advance for a reference number that will be good for ninety days. If the patient does, in fact, later receive retroactive Medicaid eligibility, providers must continue the precertification 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.

Written request must be submitted on the Medicaid Precertification Form available from HP PA/UM.

When precertification has been obtained or in instances where precertification is not required for an outpatient procedure and during the procedure, it is determined that additional or a different procedure is necessary (for determining timeliness or precertification update requests), the additional or different procedure should be considered an urgent procedure. The request for an update of the precertification file should be considered timely if received within thirty days of the date of the procedure.

When precertification has been obtained for an outpatient procedure and after the procedure has been performed, it is determined that inpatient services are necessary (for determining timeliness of precertification update requests), the admission should be considered an emergency. The nurse-midwife's request for an update of the precertification file should be considered timely if received within thirty days of the date of the admission.

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

802. Prior Approval: Additional Office/Nursing Home Visits Per Year (Members 21 Years and Older)

Requests for prior approval for more than ten (10) office or nursing home visits per year for any one member may be made only if additional visits are medically justified. Medically justified visits include life threatening situations and situations involving serious acute or serious chronic illness.
The attending nurse-midwife must forward a Prior Approval Form DMA-81 (6 87), which contains:

802.1. the member's name and Medicaid number;

802.2. the diagnoses of the member;

802.3. the medical necessity for more than ten (10) visits per year; and

802.4. the nurse-midwife's signature over the typed name and address of the physician.

The completed form must be mailed to:

Alliant Health Solutions
Prior Authorization Department
P.O. Box 105200
Atlanta, Georgia 30348

Approved requests are valid through December of the of the approval year. Prior approval is not required for obstetrical office visits. The approval forms must be retained in the nurse-midwife's records for a minimum of three years. It is not necessary to attach it to the claim form.

Chapter 900: Scope of Services

901. General

Nurse-Midwife services are those services rendered by a Certified Nurse Midwife in the management and care of pregnant women and newborns throughout the maternity cycle which includes pregnancy, labor, birth, the immediate six week postpartum period and services that midwives are authorized to perform under state law that are outside the maternity cycle. The Division does not reimburse for expanded services (i.e. surgical first assist).

902. Coding of Claims

All claims for nurse midwife services must be completed as instructed in the billing manual found in the Part 1 Policies and Procedures for Medicaid/Peachcare for Kids manual . Both diagnosis and procedure coding are required on all claims. The coding schemes accepted by the Division are the ICD-10- CM (International Classification of Diseases - 10th Edition - Clinical Modification) for diagnosis and the CPT (Current Procedural Terminology) for procedures. Copies of the CPT and ICD-10- CM) codebooks are available for purchase from the following organizations:

CPT
American Medical Association
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

ICD-10- CM
Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

The Division does not accept certain codes from these coding schemes as discussed in the sections below:

902.1. ICD-10- CM

The Division does not accept codes deleted from previous editions of the ICD- codes. The (ICD-10-CM) coding scheme consists of three (3) volumes. Nurse-midwives need only Volumes I and II. Further, the special categories of codes that begin with alphabetic characters "V" & “Y” (V81.2XXA – Y36.0105) are not accepted by the Division. The remaining special category of codes that begins with “V” or “Z” are acceptable only if the "V" code are “Z” codes (ICD-10) which describes the primary diagnosis. In coding the diagnosis on the claim, the code must be placed on the claim form using the identical format (including the decimal point) as shown in the ICD-10- CM example (I11.0, I11.9).

902.2. CPT

The nurse-midwife must select the procedure code(s), which most nearly describes the procedure(s) performed. The following modifications and instructions apply to all nurse-midwife claims (CMS-1500):

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

902.2.2. Codes for "Unlisted Procedures" are not accepted by the Division. All modifiers are subject to post payment review.

902.2.3. Modifiers for clarifying circumstances are accepted by the Division. The appropriate "Type and Place of Service" codes, listed on the back of the CMS-1500 claim form, must be used.

902.2.4. Updates to the CPT are effective as soon as possible after publication. This applies to deletions, additions and revisions. Nurse-midwives will be notified as to the effective date of these changes. It is the nurse-midwife's responsibility to maintain an up-to-date CPT publication.

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

902.2.6. Georgia Medicaid uses NCCI standard payment methodologies. NCCI Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures.

902.2.7. NCCI editing also includes Medically Unlikely Edits (MUE's) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

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

903. Accepted Modifiers

26 – Professional Component: of laboratory, radiology, and certain medical procedures.

TC – Technical Component: Is valid for a limited number of codes

GT – To be used in conjunction with the appropriate codes for Telemedicine following full implementation of HIPAA compliance (see "Telemedicine Consultations.")

904. Claims Submission for Ordering, Prescribing, or Referring (OPR) Providers

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

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

For the NEW CMS-1500 claim form:

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

For claims entered via the web:

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

For claims transmitted via EDI:

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

905. Coding Modifications and Service Limitations

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

905.1. Charts and Records

The nurse midwife must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. Chart means a summary of essential medical information on an individual patient. Record means dated reports supporting

claims submitted to the Division for services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service shall be entered in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible and shall include the following, but are not limited to the following:

905.1.1. Date(s) of service,

905.1.2. Patient's name and date of birth,

905.1.3. Name and title of person performing the service,

905.1.4. Chief complaint or reason for each visit,

905.1.5. Pertinent medical history,

905.1.6. Pertinent findings on examination,

905.1.7. Medications and or equipment or supplies prescribed or provided,

905.1.8. Descriptions of treatment (when applicable),

905.1.9. Recommendations for additional treatments, procedures, or consultations,

905.1.10. X-rays, tests, and results,

905.1.11. Plan of treatment, care, and outcome,

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

Electronic signature is defined as "an electronic or digital method executed or adopted by a party with the intent to be bound by or to authenticate a record, which is unique to the person using it, is capable of verification, is under the sole control of the person using it and is linked to the data in such a manner that if the data are changed the signature is invalidated." O.C.G.A. §10-12-3. (1) (1997).

905.1.13. 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. Department of Health and Human Services upon request. Documentation must be timely, complete, and consistent with the by-laws and medical policies of the office or facility where the service is provided.

906. Covered Services

The following services are covered under the Nurse Midwife Program.

906.1. Antigen Therapy

For policy and billing guidance related to Antigen Therapy, please refer to Chapter 900 (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)

906.2. Family Planning Services

The Division receives a higher percentage of federal funds for family planning procedures. Therefore, the Division has established a coding mechanism to identify these procedures. Nurse midwives who provide family planning services are requested to enter the letters "FP" in the "diagnosis code" space and to enter an "FP" in block 24H, the Family Planning/EPSDT block on the CMS-1500.

Please see the Family Planning Services Manual for additional information.
(Rev. 10/2014)

906.3. 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:

906.3.1. When the member is admitted to the hospital as an inpatient in the course of an appointment in another site of services (e.g., hospital emergency department, 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.

906.3.2. Reimbursement for office E/M services 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.

906.3.3. Office records or notes must be submitted with all claims marked “EMERGENCY’ to support medical necessity. All emergency claims must be forwarded to:

906.3.4. Initial hospital care using codes 99221 through 99223 is reimbursable only to the admitting physician or nurse-midwife. Only one unit of any one of these codes is reimbursable per admission.

906.3.5. Hospital, emergency room, observation, NICU, consultations or critical care E/M Services on the same date of service are not separately reimbursable to the same nurse-midwife or group of nurse-midwives of the same specialty. Only one charge per specialty for the most appropriate level of care may be reimbursed for one date of service.

906.3.6. E/M Services and psychiatric services on the same date of service by the same provider or provider group must be billed using either 90805 or 90817 as appropriate. Please note these codes also include the psychiatric services.

906.3.7. Charges for office E/M services and subsequent hospital admission, history and physical or hospital visit on the same date of service by the same nurse-midwife are not separately reimbursable. Only one charge for either service may be reimbursed.

906.3.8. Hospital E/M services must be documented in the hospital records on the date of each visit. Documentation of hospital visits in the nurse-midwife's office records will not be sufficient for reimbursement of hospital E/M services.

906.3.9. 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. 10/2016)

907. Injectable Drugs

Procedure codes and descriptions for injectable drugs (other than allergy injections) are listed in the Division's Physicians' Injectable Drug List, which may be obtained from the Division's fiscal agent. Injectable drugs can only be billed with approved HCPCS or CPT codes. Allergy injections must be coded from the CPT.

The Division's reimbursement for approved injectable drugs is limited to the lower of acquisition cost, submitted charges, or the AWP minus 11%. Additional limitations are listed in the aforementioned Injectable Drug List and are incorporated herein by reference.

Administration fees are not separately reimbursable under the Nurse-Midwife Program for injectable drugs with the exception of chemotherapy administration codes 96400-96414.

908. Laboratory Services

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

908.1. Multichannel Tests

Individual components of automated, multichannel 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.

Specific instruction and reimbursement information is presented 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 practitioner's office or in an independent laboratory. The Division has established the following limitations for reimbursement for laboratory services:

908.1.1. Nurse-Midwife 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 nurse-midwife must meet the CLIA requirements for certification.

908.1.2. Providers who do not have a Certificate of Waiver or registration on file with the (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.

908.1.3. Independent laboratories are enrolled separately in the Medicaid program, and therefore, must bill the Division directly for their services. Reimbursement for the collection and handling code 99000 and the routine specimen code 36415 are included in the E/M Services code reimbursement and are not separately reimbursable.

908.1.4. The Division will not reimburse nurse midwives for laboratory procedures which are required to be performed by independent, State or public laboratories. Nurse midwives must send specimens to the applicable laboratory and must provide the laboratory with the member's name and Medicaid number for the test procedures to be performed. The following procedures are to be sent to the State Laboratory System:

908.1.4.1. 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:

908.1.4.1.1. Methionine for Homocystinuria

908.1.4.1.2. Galactose; blood

908.1.4.1.3. Phenylalanine (PKU), blood; Guthrie

908.1.4.1.4. Thyroxine (T 4) neonatal

908.1.4.1.5. Tyrosine, blood

908.1.4.1.6. Leucine for Maple Syrup Urine Disease (MSUD)

908.1.4.1.7. 17-Hydroyprogesterone (CAH)

908.1.4.1.8. 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.

908.1.4.2. 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:

908.1.4.2.1. 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.

908.1.4.3. 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.

908.1.4.4. Tuberculosis Testing

The following procedures are for tuberculosis testing:

908.1.4.4.1. Tubercle Bacillus culture

908.1.4.4.2. Concentration plus isolation

908.1.4.4.3. 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.

908.1.4.5. 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.

908.1.4.6. 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. (Rev. 10/2014)

908.1.4.7. 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:

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

908.1.4.7.2. When following decreasing levels during recovery from an overdose

908.1.4.7.3. 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:

908.1.4.7.4. 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.

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

908.1.4.7.6. 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.

908.1.4.7.7. 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.

908.1.4.7.8. 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.

909. 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:

909.1. 99431 – History and Examination
909.2. 99433 – Subsequent hospital care
909.3. 99238 – Hospital discharge day management
909.4. 99238 cannot be billed on the same date as 99432. See Chapter 900 for Neonatal test requirements.

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 Program only. Clinics or physicians enrolled in the EPSDT - Health Check Program as screening providers may receive reimbursement for screening services provided eligible children.

Newborn circumcisions and routine newborn care provided in the hospital setting must be billed under the newborn's name and Medicaid number. In cases of multiple births, newborn circumcisions and routine newborn care must be billed under each baby's own name and Medicaid number. All other physician services provided newborns must be billed through the standard procedure, i.e., under the newborn's own name and Medicaid number.

Please refer to Policies and Procedures for Medicaid PeachCare for Kids Part I Manual for billing instructions, for information regarding Medicaid eligibility for newborns.

910. Obstetrical Services

910.1. 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.

910.2. Antepartum, Delivery and Postpartum Care

910.2.1. 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 observation of an attending physician, the designated physician initially caring for the member will be reimbursed.

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

When a Cesarean 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.

If an OB patient is admitted for a non-delivery related diagnosis in observation status and at the end of 48 hours admission is required and criteria is met, contact GHP for precertification.
Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Any other visits or services within this time period should be coded separately.

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. The Department does not reimburse for expanded services (e.g., surgical first assist).

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 mid-wife 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).

910.2.2. 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. (10/2022)

910.2.3. 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.

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

If a nurse mid-wife 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:

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

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

910.2.4.3. or 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.

910.2.4.4. The nurse-midwife may bill delivery only, or for delivery and postpartum care, depending on the services rendered.

910.3. Delivery only codes, 59409, 59612 and 59620 include the in-hospital postpartum follow up care. Codes 59410, 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.

910.4. If the same practitioner began routine antepartum care prior to the 28th week of gestation and practitioner must bill the appropriate code for total obstetrical care.

910.5. 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.

910.6. Out of State Deliveries

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

910.7. 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 pay, 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.

911. Radiology 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:

911.1. Professional Component (26 modifier)

Radiology services should be billed as professional component when:

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

911.1.2. The service is provided in a hospital; or

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

911.2. 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.

911.3. 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.

911.4. CAT Scans and MRIs

911.4.1. Computerized Tomography - (CAT scans)

The Division reimburses for all medically necessary CAT scans.
Certain Radiology procedures including some specific pregnancy ultrasounds, CTs, MRIs, and PET scans (refer to Appendix O for specific codes); 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 in the Physicians Manual 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.

911.4.2. 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.

912. Abortions

In accordance with federal regulations and recent Congressionally enacted revisions to the Hyde Amendment, the Division will reimburse for abortions performed on Medicaid-eligible patients, only 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.

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. 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.

912.1. DMA 69, 81, 276 and 311 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.

Medicaid funds are unavailable for sterilization, hysterectomies, or abortions performed without the documentation required by federal regulations (See 42 CFR 441.206 and 441.256). As such, claims for payment submitted without the required documentation or

with incomplete or inaccurate documentation will be denied. The Division does not accept documentation meant to satisfy informed consent requirements that has been completed or altered after the service was performed.

913. Non- Covered Services

The following services are non-covered in the Nurse Midwife Program.

913.1. Out of State Deliveries

The Division does not reimburse non enrolled, out of state nurse midwives or physicians for "term" deliveries. This policy disallows reimbursement for obstetrical care rendered to members who travel to other states to bear their children for reasons not related to medical necessity. This policy has no impact on enrolled nurse midwives or physicians in Georgia or bordering states. However, if an obstetrical patient is considering such travel or is seeking referral to an out of state health care provider for delivery, the patient should be informed that the delivery will be at her expense.

913.2. Assisting Physicians During Delivery

The Division will not reimburse a nurse midwife for assisting a physician during a vaginal delivery, whether the vaginal delivery is routine or difficult. The Division will not reimburse a nurse midwife for assisting a physician in the event of a cesarean section.

913.3. Scope of Practice

The Division will not reimburse a nurse midwife for any service, which is outside the legal scope of nurse midwife services (i.e., surgical first assist).

913.4. Ultrasound

Diagnostic ultrasound in obstetrical care is non covered for normal pregnancies.

913.5. Administrative Costs

The Division will not reimburse for educational supplies, medical testimony, special reports, travel, no show or canceled appointments, calls, visits or consultations by telephone.

In addition, no additional allowances are covered for services provided after office hours or during other inconvenient times.

913.6. Appeal

Non-covered medically necessary services for members under twenty-one (21) years of age may be appealed to:

Georgia Department of Community Health
P.O. Box 38446
Atlanta, Georgia 30334

913.7. Additional Non-Covered Services

The services and procedures listed below are also non covered by the Division under the Nurse-Midwife program. This list is representative of non- covered services and procedures and is not meant to be exhaustive:

913.7.1. cosmetic surgery or mammoplasties for aesthetic purposes;

913.7.2. immunization Injections for members aged twenty one or older;

913.7.3. Preventive Health Care. (Recipients under age twenty one may receive this care through the EPSDT-Health Check screening process. Refer to Appendix H for information on the EPSDT-Health Check Program); (Rev. 07/2022)

913.7.4. therapeutic Injections except those contained in the Division's Physicians' Injectable Drug List;

913.7.5. acupuncture;

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

913.7.7. all procedures listed in the CPT as "unlisted procedure";

913.7.8. 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;

913.7.9. biofeedback or hypnotherapy;

913.7.10. hospital Discharge Summaries;

913.7.11. services provided free of charge to Medicaid members by County Health Departments or State Laboratories, e.g., metabolic screens for members under one year of age, etc.;

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

913.7.13. services or procedures performed without regard to the policies contained in this policy manual;

913.7.14. services normally provided free of charge to indigent patients, e.g., free

clinics;

913.7.15. hospital visits to members awaiting placement in a nursing home, unless medically necessary;

913.7.16. hospital visits if the hospital admission or length of stay are disallowed by the hospital Utilization Review staff or the Division;

913.7.17. radiologic procedures performed by a portable x ray service;

913.7.18. services provided in a State owned facility;

913.7.19. drugs used in the physician's office or dispensed by the physician except those injectables authorized on the Division's Injectable Drug List;

913.7.20. tubal anastomosis;

913.7.21. ESRD Dialysis Services for Medicaid Only members;

913.7.22. hospital admissions and daily visits for maintenance dialysis;

913.7.23. office visits for maintenance dialysis;

913.7.24. insertion or removal of catheters or shunt de-clotting for dialysis patients enrolled in the Dialysis Services Program;

913.7.25. penile prosthesis;

913.7.26. procedure code 90862 - psychiatric pharmacologic management;

913.7.27. preventive services provided to EPSDT-Health Check members without authorization from their case manager; (Rev. 07/2022)

913.7.28. Substance Abuse Clinic Services; and

913.7.29. Vaccines for members less than nineteen years of age that are available through the VFC program.

913.7.30. sensitivity training, encounter groups, or workshops;

913.7.31. sexual competency training;

913.7.32. education testing and diagnosis;

913.7.33. marriage or guidance counseling;

913.7.34. 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;

913.7.35. psychiatric services provided to patients in Therapeutic Residential Treatment Program.

Non-covered medically necessary services for members under twenty-one years of age may be appealed to:

Medical Review
Alliant Health Solutions
P.O. Box 105200
Tucker, Georgia 30085-5200

Chapter 1000: Basis For Reimbursement

1001. Reimbursement Methodology

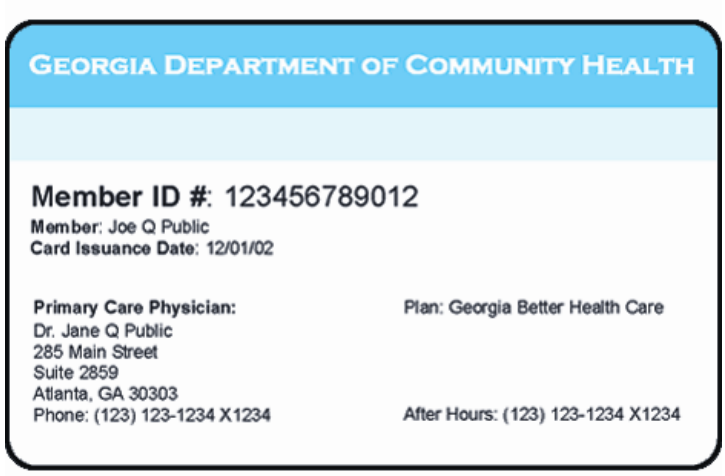
The Division will pay the lower of the nurse midwife's lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date of service, the lowest price charged to other third party payers, or the statewide maximum allowable reimbursement amount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

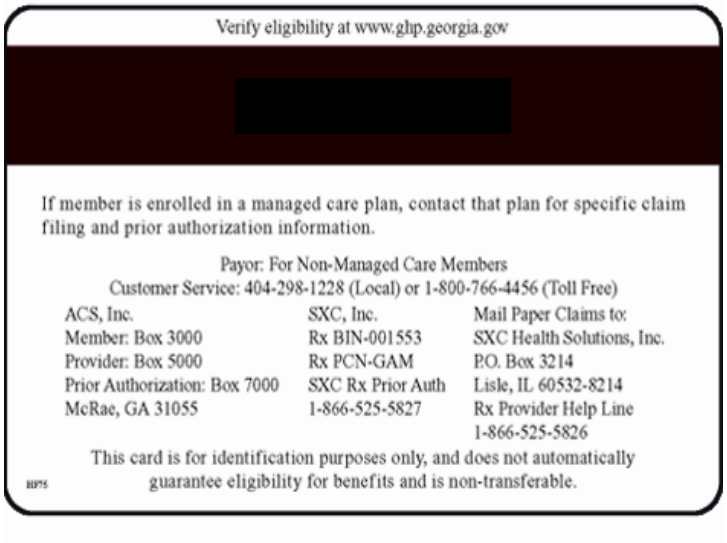
The Division's Schedule of Maximum Allowable Payment for Nurse Midwives is available at www.mmis.georgia.gov.

This is not a fee schedule. As required in Chapter 600, nurse-midwives must bill the lowest price regularly and routinely offered to any segment of the general public for the same service of item on the same date of service, or the lowest price charged to other third party payers for the procedure code most closely reflecting the service 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
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 (GHP) Inquiry Unit at 1-800-766-4456 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 9:00 p.m. on weekends.

The newborn Medicaid certification form 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 C
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
76801	OB US<14 weeks, Single Fetus
76802	OB US<14 weeks, Addl Fetus
76805	OB US>/=14 weeks, Single Fetus
76810	OB US>/=14 weeks, Addl Fetus
76811	OB US, Detailed , Single Fetus
76812	OB US, Detailed, Addl Fetus
76813	OB US, Nuchal Meas, 1 GEST
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 D
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 Gainwell Technologies at 800-766-4456.

Appendix E
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 F
Hysterectomies

The Division will make reimbursement only for those hysterectomy procedures that meet the criteria established in Chapter 900 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
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". 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".

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 H
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, which concerns medical treatment to a member as the physician's authorization for the services therein, stated.

E. 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.

F. 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.

G. Emergency Prescriptions

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

H. 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.

I. 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)

J. 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).

K. 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.

L. Children's Intervention Services – Members under Age Twenty-One (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.

M. Advanced Nurse Practitioner Services

The Advanced Nurse Practitioner Services Program reimburses for a broad range of medical services provided to Medicaid members. National certification as a family, pediatric, OB/GYN, adult, certified registered nurse anesthetist (CRNA), or geriatric nurse practitioner is required for enrollment, as well as a current Georgia nurse's license.

NOTE: Nurse practitioners may also enroll in the EPSDT - Health Check Program and can also be providers under the Rural Health Clinic program as well as the Federally Qualified Health Center program.

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 age 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/Birthing Centers

i. Ambulatory Surgical Center

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:

1. Surgery
2. Nursing services, services of technical personnel, and other related services
3. Use of operating and recovery rooms, patient preparation areas and waiting rooms
4. Drugs, biologicals, surgical dressings, supplies, splints, carts, appliances, and equipment
5. Administrative services
6. Blood and blood products
7. Intraocular lenses, corneal tissue implants, and vascular portal implants

ii. Birthing Center

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 age 21 or older. Services provided under the EPSDT - Health Check 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

iv. Physical development, including vision and hearing

v. Communication development

vi. Social or emotional development

vii. 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. Outpatient Hospital Observation Policy:

Outpatient services are those services furnished by a hospital, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. If the patient's medical condition meets medical necessity and using inpatient qualifying criteria such as those published by InterQual, inpatient admission is appropriate, and the patient must remain hospitalized until concurrent review performed by the hospital indicates discharge is necessary. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests and when provided in compliance with all policies and procedures described in this manual. 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 inpatient qualifying criteria designated by the Division, such as InterQual, are met. When a hospital places a patient under observation, but has not formally admitted them as an inpatient, the patient is considered an outpatient. 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 health condition. (See Part I Policies and Procedures Manual, Section 106.12.) A maximum of 48 hours of observation may be reimbursed. Count as the first hour the time of admission to an observation status. 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 covered.

Observation is generally covered as an outpatient service. Observing the patient for up to 24 hours should be adequate in most cases. A hospital, which believes that exceptional circumstances in a particular case justify approval of more than 48 hours in an outpatient observation setting, may submit a claim by hard copy with documentation of the exceptional circumstances. The claims will pend 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.

If medical review determines that observation beyond 48 hours was not medically necessary, payment will be made for the hours determined to be medically appropriate, up to 48 hours. When the patient's condition does not meet inpatient criteria and the hospital does not wish to file an appeal for the observation beyond 48 hours, all charges past the 48-hour period are non-covered.

When medical necessity dictates an inpatient admission of a patient in observation, this should be billed under revenue code 762, as referred to in the billing manual, (form locator 42) which reflects this transaction.

Observation is a covered revenue code on an inpatient claim.

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 department and the recovery afterwards; and the observation billed concurrently with therapeutic services such as chemotherapy, physical therapy, etc.

The outpatient status becomes inpatient when the determination is made that inpatient services are medically necessary. Inpatient services must be certified as explained in Chapter 800. Certification must be obtained within thirty calendar days of the beginning date of this episode of care. In order to receive certification for the admission, documentation must be provided evidencing that the admission is medically necessary and appropriate.

The date of the inpatient admission will be the actual date the patient is formally admitted as an inpatient and will count as the first inpatient day. When a patient is admitted to the hospital from outpatient observation, all observation charges must be combined and billed with the inpatient charges. The availability of outpatient observation does not mean that services for which an overnight stay is anticipated may be performed and billed to the Division on an outpatient basis. Services, such as complex surgery, clearly requiring inpatient care may not be billed as outpatient. Request for updates to the precertification file and retroactive certification (except pediatrics as per current policy) of inpatient admissions following a procedure or service clearly indicating an inpatient level of care that should have been anticipated will not be considered timely and will be denied.

The Division only covers services, which are medically appropriate and necessary. The services provided in the setting must be appropriate to the specific medical needs of the member. (See Part I Policies and Procedures Manual, Section 106.12.) 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 or treatment of the patient but are not provided for the convenience of the patient or a physician are not covered. (See Part I Policies and Procedures Manual, Section 106.12.)

To determine appropriateness of inpatient admission, inpatient qualifying criteria designated by the Division, such as InterQual, will be used by the hospital, DMA, GHP, and any other Division contractors, based on information about the patient's medical condition available at the time of presentation. Hospitals will be required to conduct concurrent review and will be required to keep the hospitalized patient until the same criteria indicates hospitalization is no longer necessary. DMA will notify providers in writing at least 30 days prior to the date of any changes in the criteria or version of criteria being used to certify inpatient admissions. Written notice should be provided on banner messages, on remittances, and on the DMA web site (www.state.ga.us/dma). The same version of criteria will be used for any retrospective medical reviews as were used prospectively or concurrently.

A physician's order must document the change from inpatient status to outpatient or observation if it is determined that the patient does not require an inpatient admission.

Note: Hospitals should not substitute outpatient observation services for medically appropriate inpatient admissions. An inpatient is not considered to have been discharged if placed in observation status after an inpatient admission. The availability of outpatient observation does not mean that services, for which an inpatient stay is anticipated, may be performed and billed to the Division on an outpatient basis. Services such as complex surgery clearly requiring inpatient care and pre-certification may not be billed as outpatient.

DD. 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

EE. Independent Laboratory

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

FF. 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.

GG. New Options Waiver Program

The New Options Waiver Program (NOW) 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.

HH. 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.

II. 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

JJ. 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.

KK. 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)

LL. 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.

MM. 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.

NN. 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)

OO. 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.

PP. 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 Chapter 600 and Chapter 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.

QQ. 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.

RR. 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.

Appendix I
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

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

i. prior history of HIV counseling and testing

ii. nature of AIDS and HIV-related illness

iii. benefits of early diagnosis and medical intervention

iv. HIV transmission and risk reduction behaviors

v. Benefits of early diagnosis for preventing perinatal transmission and for treatment of newborn

B. Informed Consent For HIV Blood Test

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

i. Obtain written informed consent, prior to ordering test, from patient or person authorized to consent

ii. Provide the patient with a copy of the consent form or document containing all pertinent information

iii. 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

iv. Explain test and procedures:

1. purpose of the test
2. meaning of test results
3. testing is voluntary
4. consent may be withdrawn at any time

v. Explain protections of confidential HIV-related information and conditions of authorized disclosures

vi. 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

vii. 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.

i. 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

ii. 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.

Before Prescribing Any Regimen:

i. 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

ii. discuss patient concerns

iii. obtain ZDV use history

Appendix J
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 K
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 L
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 M
Provider Preventable Conditions, Never Events, And Hospital Acquired Conditions

Based on the Centers for Medicare and Medicaid Services (CMS) directive, Georgia Medicaid implemented the 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 N
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 O
Early Elective Deliveries (EED) and Elective Inductions Policy

The Medicaid Division within the Department of Community Health changed its benefit coverage for non-medically necessary cesarean deliveries prior to 39 weeks gestation. Claims submitted for ANY labor inductions or cesarean sections on or before 39 weeks gestation that are not properly documented as medically necessary will be denied in the Georgia Medicaid Management System (GAMMIS). Gainwell Technology's current MMIS will be updated later for claims processing of this benefit coverage for early elective deliveries (EED) including non-medically necessary cesarean deliveries and early inductions. This policy was approved as a mandate by the 2013 Georgia legislature in Georgia's SFY 2014 budget bill.

Hospital UB 04 Claims

There are no proposed changes to the current billing process of inpatient claims for induction/delivery services when processed through the claims adjudication process for payment. Hospitals are strongly encouraged to collaborate with their physicians privileged to provide obstetric services in order to develop guidelines and protocols (i.e., a scheduling protocol or Hard Stop Policy and/or establish documentation standards) for deliveries prior to 39 weeks gestation. Hospitals are also encouraged to enforce those guidelines and protocols.

Professional 1500 Claims

Practitioners are to continue billing obstetric procedure codes on their professional 1500 claim forms for payment: 59400, 59409, 59410, 59514, 59510, 59515, 59610, 59612, 59614, 59618, 59620, and 59622, along with one of the three (3) modifiers (UB, UC, or UD) appended to the billed delivery procedure code. GAMMIS will be configured with system edit(s) for the delivery claims that do not append one of the required EED modifier and/or that do not meet the approved guidelines of billing certain clinical indications. Delivery claims that are submitted with medical conditions that do not warrant an exception prior to 39 weeks gestation will post the EED edit requiring medical review by our state's peer review organization, Georgia Medical Care Foundation (GMCF). Clinical justification and the proper documentation must be submitted to GMCF for review of the denied obstetric delivery claim. Also, ALL Medicaid practitioners' claims for elective inductions/C-sections must include EITHER the last menstrual period (LMP) or the estimated date of confinement (EDC) or the estimated delivery date (EDD) in field locator 14 of the CMS 1500 paper/electronic form.

A. Delivery Modifiers for Professional 1500 Claims

One of the following modifiers is required when billing obstetric services for payment:

i. UB - Medically-necessary delivery prior to 39 weeks of gestation

1. For deliveries resulting from members presenting in labor, or at risk of labor, and subsequently delivering before 39 weeks, or

2. For inductions or cesarean sections that meet the ACOG or approved medically necessary guidelines, the appropriate ACOG Patient Safety Checklist must be completed and maintained for documentation in the GA enrolled member's file, or

3. For inductions or cesarean sections that do not meet the ACOG or approved guidelines, the appropriate ACOG Patient Safety Checklist must be completed. Additionally, the enrolled provider must obtain approval from the state's peer

review organization, Alliant Health Solutions, and maintain this checklist in the enrolled member's file. The practitioner must submit to Alliant the clinical justification and documentation for review along with the Patient Safety Checklist.

ii. UC - Delivery at 39 weeks of gestation or later

4. For all deliveries at 39 weeks gestation or more regardless of method (induction, cesarean section or spontaneous labor).

iii. UD - Non-medically necessary delivery prior to 39 weeks of gestation (Elective non-medically necessary deliveries less than 39 weeks gestation)

5. For deliveries less than 39 weeks gestation that do not meet ACOG or approved guidelines or are not approved by the Georgia Medical Care Foundation as medically necessary with clinical justification. Examples of unacceptable medical reasons include patient choice, physician going out of town, history of a fast labor, etc.

Note: Obstetric delivery claims that are submitted without one of the required modifiers listed above will be denied. To avoid claim denials, the two-digit modifier is required whenever billable obstetrical procedure codes are submitted for payment either for vaginal deliveries or cesarean sections.

Documentation Requirements

Providers should utilize medical standards before performing cesarean sections, labor inductions, or any delivery following labor induction. The documents required for peer review are the member's history and physical, admission notes for the delivery, operative report, if applicable, for cesarean sections, physician progress notes, labor and delivery report, discharge summary, and the ACOG Patient Safety Checklist or an appropriate checklist that meets national guidelines. There are medically necessary conditions that may warrant clinical justification with the proper documentation for an early induction or cesarean section for some approved exceptions of medical conditions for deliveries prior to 39 weeks. The list of conditions is not meant to be exclusive. Please reference the Clinical and Practice Management information found on the American College of Obstetricians and Gynecologists (acog.org) website for additional guidance.

Appendix P
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