PART II

POLICIES AND PROCEDURES
For
Oral Maxillofacial Surgery 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.)
10/1/2024	Appendix H	Appendix H contain the links for Policy Fee Schedule , Georgia Families Overview and Georgia Families 360 Overview		

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

Part II: Oral Maxillofacial Surgery Services
Chapter 600: Special Conditions of Participation

601. Conditions of Participation

In addition to the general conditions of participation identified in Part I, Section 106 and other stipulations outlined in the Part II Physician Services Policy and Procedure Manual for medical and surgical providers, oral surgeons enrolled in the Oral Maxillofacial Surgery Services Program must meet the following conditions:

601.1. Each enrolled oral surgeon agrees to bill the Department for only those services that are performed by the oral surgeon or under the oral surgeon's direct supervision. For purposes of this policy, only those necessary and appropriate services, which meet the following conditions, will qualify as services performed under the direct supervision of the oral surgeon:

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

601.1.2. The person performing the services must be a salaried employee of the oral surgeon or of the oral surgeon's group practice as defined below; oral surgeons may not bill for the services of independent contractors.

601.1.3. The oral surgeon must periodically and regularly review the patient's medical records.

601.1.4. The oral surgeon must be immediately available on the site at the time the services are delivered.

601.1.5. The person performing the service must not be of a class of persons eligible for enrollment as direct providers of service in any covered Medicaid program, regardless of whether the service being provided is specifically covered by another Medicaid program.

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

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

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

The common practice of one oral surgeon covering for another will not be construed as a violation of this section when the covering oral surgeon is on call and provides emergency or unscheduled services for a period of time not to exceed fourteen continuous days.

For purposes of this policy, the explanations and limitations contained in Subsection 903.2 shall also apply.

Note: The covering oral surgeon must also be an enrolled Medicaid provider. Refer to the Billing Manual for billing instructions.

601.2. Teaching oral surgeons agree to bill only when the services are personally furnished by an oral surgeon who is not a resident; or the services are furnished by a resident in the presence of a teaching oral surgeon. When residents participate in a service furnished in a teaching setting, oral maxillofacial surgery fee schedule payment is made only when a teaching oral surgeon is present during the key portion of any surgery or procedure for which payment is sought. In the case of surgery or a dangerous or complex procedure, the teaching oral surgeon present during all critical portions of the procedure and immediately available to furnish services during the entire services or procedure. In the case of evaluation and management services (visits, consults, etc.), the teaching oral surgeon must be present during the portion of the service that determines the level of service billed (type of decision making, type of history and exam, etc.). For every service billed, the patient's medical record must contain documentation of the presence of the teaching oral surgeon at the time of the service. The presence of the teaching oral surgeon may be demonstrated by notes made by the oral surgeon, resident or nurse.

As evidence that covered services were rendered by the teaching oral surgeon, the medical record must contain signed or countersigned notes which clearly specify that the oral surgeon personally reviewed the history and confirmed or revised the diagnosis and prescribed treatment.

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

601.4. The oral surgeon agrees to bill the Division the lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date(s) of service, or the lowest price charged to other third-party payers for the procedure code most closely reflecting the service rendered. The Oral surgeon also agrees to maintain records on both Medicaid eligible and private paying patients for the same procedure during the same period. The oral surgeon also agrees to maintain records on both Medicaid eligible and private paying patients for a minimum of five (5) years to fully disclose compliance with this section. The oral surgeon further agrees to furnish the Division, its authorized representatives or contractual agents, with such information as they may request from time to time regarding "usual and customary" fees.

601.5. The oral surgeon agrees not to bill for services performed by an independent laboratory or x-ray facility. An independent laboratory or x-ray facility is one, which is independent of both the attending oral surgeon and consulting oral surgeon and of a hospital, which meets at least the requirements to qualify as an emergency hospital. A consulting oral surgeon is an oral surgeon, whose services include history taking, examination of the member, and in each case, furnishing to the attending oral surgeon an opinion regarding the diagnosis or treatment.

An oral surgeon providing clinical laboratory or x-ray services for the patient of another oral surgeon is not considered to be a consulting oral surgeon. A laboratory or x-ray facility which is not located in an oral surgeon's office or hospital is presumed to be independent unless written evidence establishes that it is operated by or under the supervision of the referring oral surgeon or a hospital which meets at least the definition of an emergency hospital.

601.6. The oral surgeon agrees to cooperate with the appropriate guidelines of other Medicaid service programs adjunctive to Dental Services such as Non-Emergency Transportation, Ambulance, Durable Medical Equipment, Orthotics and Prosthetics, Pharmacy and out-of-state Services.

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

601.8. The oral surgeon agrees to bill the Department the procedure code(s) which best describes the level and complexity of the service rendered and not bill under separate procedure codes for services which are included under a single procedure code.

601.9. Services provided by a Teaching Dentist are eligible for reimbursement when the teaching Dentist personally renders the services, or the services are rendered by a dental student in the presence of a Teaching Dentist for services. These services must be rendered on the premises of the school where employed within the scope of their employment as a faculty member for the sole purpose of teaching and/or instructing. Dental fee schedule payment(s) is made only when:

601.9.1. The Teaching Dentist is present during the key portion of any exam, surgery or procedure for which payment is sought.

601.9.1.1. In the case of surgery, a dangerous or complex procedure, the Teaching Dentist must be present during all critical portions of the procedure and immediately available.

601.9.2. The Teaching Dentist must be present for the portion of the service that determines the level of service(s) billed.

601.9.3. The Teaching Dentist must personally document his/her presence and participation in the services in the patient's medical record. Refer to the Rules of Georgia Board of Dentistry Chapter 150-7- 02(2) and O.C.G.A. Secs. 43-1-42, 43-11-7, 43-11-8 and 43-11-52 for specific guidelines.

Chapter 700: Special Eligibility Conditions

701. Eligibility Conditions

There are no special eligibility conditions for oral maxillofacial surgery.

Chapter 800: Prior Approval – Hospital Precertification

801. Services That Require Prior Approval or Hospital Precertification

As a condition of reimbursement, the Division requires that certain services be approved prior to the time they are rendered. Prior approval from the Division pertains to medical necessity only; the patient must be Medicaid-eligible at the time the service is rendered. If the service is to be performed in an inpatient setting, precertification is required. Selected services performed in an outpatient hospital or ambulatory surgical center (ASC) setting also require precertification. Hospitalization for non-emergency procedures requires precertification for ALL Medicaid Members (0-999). Precertification includes approval of medical necessity on surgery or other procedures that would otherwise require prior approval. (See Section 804. -- Hospital Precertification.)

The Department may require prior approval of all, or certain procedures performed by a specified oral surgeon or group of oral surgeons based on the findings or recommendations of the Department, its authorized representatives or agents, the Secretary of the U. S. Department of Health and Human Services or the applicable State Examining Board. This action may be invoked by the Commissioner as an administrative recourse in lieu of or in conjunction with an adverse action described in Chapter 400. In such instances, the Department will serve written notice to the provider of this requirement and the grounds for such action.

Oral surgeons should seek prior approval on any service for which reimbursement might be questionable.

FAILURE TO OBTAIN THE REQUIRED PRIOR APPROVAL WILL RESULT IN DENIAL OF REIMBURSEMENT.

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

If the service to be performed requires precertification only and will be performed in an inpatient hospital, outpatient hospital or ambulatory surgical center setting, precertification is required. (See Section 804—Hospital Pre-certification). If the procedure requires prior approval and is to be performed in an oral surgeon's office, inpatient hospital, outpatient hospital or ambulatory surgical center setting, the attending oral surgeon's request for prior approval must be submitted to the GHP PA/UM on the GHP PA/UM well in advance of planned surgery. Determinations are made within ten working days of receipt except for requests sent for specialty panel review. Surgeries should not be performed prior to receipt of an approved request. Requests for Prior Approval should be requested via the MMIS web portal.

All approved requests are effective for ninety days from the date of approval unless an extension is requested and approved.

Reimbursement is contingent on patient eligibility at the time services.

The prior approval number shown on each approved request must be furnished to the assistant oral surgeon (if applicable) by the primary oral surgeon. This number must be placed on the claim form. Reimbursement for services is contingent on the oral surgeon's enrollment in the Medicaid program, the patient's eligibility at the time services are rendered, and compliance with all other applicable policies and procedures.

803. Prior Approval Procedures-Pharmacy

Optum Rx is responsible for all outpatient pharmacy services, including but not limited to requests for prior approvals.

Prior Authorization requests may be made telephonically

1-866-525-5827 Phone Requests

1-866-525-5826 Technical Support

For detailed information pertaining outpatient pharmacy prior approvals and related pharmacy services, refer to the Part II Policy and Procedure Manual for Pharmacy Services.

Chapter 900: Scope of Services

901. General

The oral and maxillofacial surgery services program provides reimbursement for a broad range of surgical services, subject to the limitations established in this manual. Federal regulations allow the state agency to place appropriate limits on medical necessity and utilization control. The Department has developed reimbursement limitations to ensure appropriate utilization of funds. These limitations consist of (a) prior approval requirements described in Chapter 800 (b) service limitations and restrictions described in Section 903, and (c) non-covered procedures described in Section 904.

902. Coding of Claims

Coding of both diagnoses and procedures is required for all claims. The coding schemes acceptable by the Department are the ICD-10-CM (International Classification of Diseases - 10th Edition - Clinical Modification) for diagnoses and the CPT (Current Procedural Terminology - 4th Edition) for procedures.

Certain codes from these coding schemes are not accepted by the Department, and certain modifications to the CPT coding scheme have been made. These are discussed in the following Sections.

902.1. ICD-10-CM

Codes deleted from previous editions of the ICD are not accepted by the Department.

902.2. Current Procedural Terminology (CPT)

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

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

902.2.2. Codes for “Unlisted Procedures” which end in “99” are not accepted by the Department.

902.2.3. Modifiers for clarifying circumstances are accepted by the Department. All modifiers are subject to post payment review.

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

Oral surgeons will be notified as to the effective date of these changes. It is the oral surgeon’s responsibility to maintain an up-to-date CPT publication.

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

902.3. Current Dental Terminology (CDT)

In addition to billing CPT codes, the oral surgeons performing dental procedures that are within the scope of practice, must select the CDT code that most nearly describes the dental services rendered.

903. Service Limitations and Restrictions

The services or groups of services in this Section are covered with limitations. If an oral surgeon has special medical justification for exceeding a service limitation, the medical justification should be well documented and made available to the Department upon request.

Such documentation may be requested in a prepayment or post payment review, and lack of appropriate medical justification will be grounds for the denial, reduction or recoupment of reimbursement.

903.1. Charts and Records

The oral surgeon must maintain legible, accurate, and complete charts and records in order to support and justify the services provided. Chart means a summary of essential medical information on an individual patient. Record means dated reports supporting claims submitted to the department 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 but not be limited to:

903.1.1. Date(s) of service.

903.1.2. Patient's name and date of birth.

903.1.3. Name and title of person performing the service.

903.1.4. Chief complaint or reason for such visit.

903.1.5. Pertinent medical history.

903.1.6. Pertinent findings on examination.

903.1.7. Medications, equipment or supplies prescribed or provided.

903.1.8. Description of treatment (when applicable).

903.1.9. Recommendations for additional treatment, procedures, or consultations.

903.1.10. X-rays, tests, and results.

903.1.11. Plan of treatment, care and outcome.

903.1.12. All medical records must be in Standard English Language.

903.1.13. The original handwritten personal signature or initial or electronic signature1 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 Department. The signature on the superbill does not satisfy this requirement. Medical record entries without specified signature may result in recoupment of payment.

Records must be available to DMA 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.

903.2. Anesthesia Services

Reimbursement for anesthesia services includes the usual preoperative and postoperative visits, the administration of the anesthetic, and the administration of fluids and/or services "incident" to the anesthesia or surgery. Two separate mechanisms for reimbursement of anesthesia are as follow:

903.3. Services by the Operating Oral Surgeon

903.3.1. The Department will reimburse the operating oral surgeon for regional anesthesia only. These CPT codes appear in the 60000 series of codes for the nervous system.

903.3.2. Reimbursement for regional anesthesia provided by the operating oral surgeon will be at fifty percent of the rate normally reimbursed to an anesthesiologist.

903.3.3. Reimbursement for local infiltration, digital block or topical anesthesia is included in the reimbursement for oral surgery.

Note: 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 date in such a manner that if the data are changed the signature is invalidated." O.C.G.A. 10-12-3. (1) (1997)

These charges, therefore, are not separately reimbursable and should be included in the oral surgery fee.

903.3.4. General Anesthesia for Routine Dental Procedures – Reimbursement of anesthesia must be billed under appropriate dental sedation codes (see Dental Services Manual section 903 Adjunctive General Services). Prior approval is required or in an emergent situation post approval must be obtained. These requests are to be submitted to Alliant Health Solution via MMIS web portal.

NOTE: Post-operative pain management is not reimbursable by the Division.

903.4. Auxiliary Personnel

The Department has no provision for direct enrollment of or payment to auxiliary

personnel employed by the oral surgeon, such as nurses, non- physician anesthetists or unlicensed surgical assistants, nurse practitioners (except Certified Pediatric, OB/GYN and Family Nurse Practitioners, CRNA's, licensed Physical Therapists, Occupational Therapists and Speech Pathologists), or other aides. Assistant Oral Surgeon services are reimbursable only under criteria set forth in subsection 601.1 a thru e of this manual.

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

903.4.1. The services are rendered in a manner consistent with the requirements of Section 601.1 of this manual;

903.4.2. The services furnished are "incident to" services performed under the direct supervision of the oral surgeon as an adjunct to the oral surgeon's personal service;

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

903.4.4. The services are not traditionally reserved to oral surgeons. Services traditionally reserved to oral surgeons include but are not limited to hospital, office, home or nursing home visits; prescribing of medication; and surgery

903.5. Consultations

The purpose of consultation procedure codes is to reimburse an oral surgeon for time and effort when the oral surgeon's opinion or advice is sought by another oral surgeon or physician for a patient not under the direct care of the oral surgeon billing the consultation. A consultant is expected to render an opinion only. If the consultant assumes responsibility for patient management or care, the case is a referral rather than a consultation and may not be billed as a consultation. Additionally, the following limitations apply:

903.5.1. The different types and levels of consultations recognized, as well as the precise definitions and limitations applying to these codes, are contained in the CPT and are incorporated herein by reference.

903.5.2. Whenever a consultation charge is indicated on a claim, the name of the referring oral surgeon or physician must be indicated. In addition, if the referring oral surgeon or physician is a Medicaid provider, the Medicaid provider number must be indicated on the claim form. If the referring oral surgeon or physician is not a Medicaid provider, the oral surgeon's Medicare UPIN number must be indicated.

903.5.3. When a procedure is performed in an Emergency Room by a consulting oral surgeon, the proper code for the procedure must be billed, not the consultation code.

903.5.4. Consultations are covered only if requested by the patient's attending physician or oral surgeon and documented in the medical records.

903.5.5. A consultation charge and an office or hospital visit on the same day must be included under one procedure code.

NOTE: Refer to Appendix C for Co-payment policies and procedures.

903.6. Hospital Evaluation and Management Services (Procedure Codes 99221/99233)

All levels of hospital evaluation and management (E/M) codes as specified in the CPT, including definitions and instructions, are incorporated herein by reference.

Evaluation and management codes associated with surgical procedures are discussed in Section 903.13 - Surgery.

903.6.1. Daily Hospital E/M Services

903.6.1.1. Initial hospital care using codes 99221 through 99223 is reimbursable only to the admitting oral surgeon. Only one unit of any one of these codes is reimbursable per admission.

903.6.1.2. Hospital E/M Services provided on the same date of service are not separately reimbursable to the same oral surgeon or members of an oral surgery group. Only one charge for a hospital visit may be billed for one date of service.

903.6.1.3. Hospital, emergency room, observation, consultation or critical care E/M Services on the same date of service are not separately reimbursable to the same oral surgeon or group of oral surgeons. Only one charge for the most appropriate level of care may be reimbursed for one date of service.

903.6.1.4. Hospital E/M Services must be documented in the hospital records on the date of each visit. Documentation of service in the oral surgeon's office records will not be sufficient for reimbursement of hospital E/M services.

903.6.1.5. Hospital E/M Services to members awaiting nursing home placement are not reimbursable unless the services are medically necessary.

903.6.1.6. 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 (12) hours.

903.7. Injectable Drugs - Private Office

Procedure codes and descriptions for Injectable drugs are listed in the Department's Injectable drug list, which may be obtained from the Department's fiscal agent. The codes for injectable drugs are identified with a "J," "Q," "X," or "Z" prefix and must be used in lieu of CPT codes.

Reimbursement for Injectable drugs is limited to the lower of acquisition cost, submitted charges, or the AWP.

Additional limitations for injections are listed in the aforementioned Drug List and are incorporated herein by reference.

903.8. Laboratory Procedures

Laboratory procedures are defined in the Pathology and Laboratory section of the CPT. Combinations of laboratory procedures performed on multi-channel equipment must be coded with the appropriate procedure codes. When automated or multi-channel tests are performed, the individual components must not be billed separately. Procedure codes in the range 80055 through 80091 should be used to bill for problem-oriented panels. The maximum allowable shown in the Schedule of Maximum Allowable Payments for Clinical Laboratory and Anatomical Pathology Services apply to laboratory procedures that are performed in an oral surgeon's office or in an independent laboratory. The Department has established the following limitations for reimbursement for laboratory services.

903.8.1. Oral surgeons 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 CMS.

For tests performed of moderate or higher complexity, the oral surgeon must meet the CLIA requirements for certification.

Providers who do not have a Certificate of Waiver or Registration on file with the Health Care Financing Administration (HCFA) will have claims denied for laboratory services. If erroneous payment is made to providers without a Certificate, the Department will initiate recovery procedures.

903.8.2. The Division will not reimburse oral surgeons for laboratory procedures which are sent to state, public, or independent laboratories. Independent laboratories are enrolled separately in the Medicaid program and must bill the Department directly for their services. Reimbursement for the collection and handling code, 99000, is included in the E/M Services code reimbursement and is not separately reimbursable. The laboratory procedures shown below must be sent to the appropriate state laboratory with the member's name and Medicaid number for the test procedures to be performed without charge. The following procedures are to be sent to the State Laboratory System:

903.8.2.1. Hemoglobin testing for sickle cell detection (Homocysteine, Galactose, Phenylalanine, Thyroxine, Tyrosine and Mucopolysaccharides);

903.8.2.2. Syphilis Serology

903.8.2.2.1. Qualitative VDRL, RPR; and

903.8.2.2.2. Quantitative, precipitation or flocculation and Fluorescent Treponema Antibodies (FTA); and

903.8.2.3. AIDS Testing - It will be necessary to indicate the member's eligibility or place the words "Medicaid Member" on the back of the State laboratory requisition.

The State Laboratory locations and telephone numbers are listed below:

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

Waycross Regional Laboratory
Georgia Department of Human Resources
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

903.8.3. Reimbursement for laboratory charges billed with an inpatient or outpatient hospital place of service is included in the payment for the medical or surgical management of the patient; therefore, such charges may not be billed separately by the attending oral surgeon.

903.8.4. Reimbursement for laboratory procedures performed in the oral surgeon's office is for the technical and professional components. Charges for such laboratory procedures must be billed using the CPT codes in the 80002 through 89365 ranges.

903.9. Medicare Deductible/Coinsurance

If a member is eligible for both Medicaid and Medicare, all claims must be sent to the Medicare carrier first. Medicare upper limits of reimbursement will apply for all services

covered by Medicare. Policies and procedures for billing these services and detailed coverage limitations are described in Part I, Chapter 300.

903.9.1. Section 201.3 of this manual addresses timely submission of claims when conditions exist that is beyond the control of the provider. In accordance with Section 201.3, when an individual is made retroactively eligible, requests for certification must be received within six (6) months from the month of determination of retroactive eligibility. Additionally, when members are eligible for both Medicare and Medicaid, and Medicare benefits are exhausted, requests for certification must be received within three (3) months of the month of notification of exhaustion of benefits.

903.10. Office or Other Outpatient E/M Services

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

903.10.1. Reimbursement for office E/M services are limited to twelve per member per year (January 1- December 31, regardless of the number of providers rendering care).

903.10.2. Only one office E/M service per date of service is reimbursable to the same provider or provider group regardless of extenuating circumstances.

903.10.3. Office E/M services after office hours, during night hours, Sundays and holidays are reimbursed at the same maximum allowable as regular office E/M Services.

903.11. Out-of-State Services - Non-enrolled Providers

The Georgia Department of Medical Assistance will pay for medical services provided to Georgia members while out of state so long as the claim is received within twelve months from the month of service and if one or more of the following conditions are met:

903.11.1. The service was authorized from the Hospital Reimbursement Services Section of the Georgia Department of Medical Assistance,

903.11.2. The service was provided as a result of an emergency or life- endangering situation; or

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

Routine health care or elective surgery is not covered unless prior authorization is obtained.

The referring in-state provider is required to request prior approval by documenting in writing the medical necessity of obtaining services out of state and providing the name and address of the out-of-state medical provider.

Reimbursement and coverage of out-of-state services are determined in accordance with current policies and procedures of the Georgia Department of Medical Assistance and are contingent on the patient's eligibility at the time services are provided.

All services provided to members while out of state by providers not properly enrolled will be subject to prepayment review.

Requests for prior approval or questions regarding out-of-state services must be directed to:

Alliant Health Solutions
Out-of-State Processing Unit
P. O. Box 105329
Atlanta, Georgia, 30348

Telephone: 800-766-4456

903.12. Radiological Services

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

903.12.1. Professional Component - (26 modifier)

Radiology services should be billed as professional component when:

903.12.1.1. The oral surgeon provides only the professional service for the procedure; or

903.12.1.2. The service is provided in a hospital; or

903.12.1.3. The technical portion of the service is performed by someone other than the oral surgeon's salaried employee.

903.12.2. Technical Component - (TC modifier)

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

903.12.3. 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 $17.07 per unit to equal $51.21 for the line charge.

903.12.4. Computerized Tomography - (CAT SCANS)

The Department reimburses for all medically necessary CAT scans.

903.13. Site of Service Differential

Services that are primarily performed in office settings will be subject to a reimbursement reduction when performed in an inpatient, outpatient, emergency, or ambulatory surgery setting. The reduced reimbursement is calculated as part of RBRVs and is updated annually in the Department's Physician Services Manual.

903.14. Supplies and Materials

Office medical supplies will be considered to be practice expenses which are included in the payment for the service to which they are incidental. No additional reimbursement will be made.

903.15. Surgery

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

903.15.1. Major Surgery

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

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

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

The payment level for re-operations to deal with complications will be set

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

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

Procedures with a 90-day post-operative follow-up period, which are subject to the major global surgery policy, are listed in the current Federal Register.

903.15.2. Minor Surgery and Non-Incisional Procedures

In addition to the major global surgeries in the surgery section of the CPT, there are a number of minor surgeries, many of which are designated by a "star" following the procedure code number.
These relatively minor surgical services are not traditionally paid using a global surgery policy.

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

For minor surgeries and endoscopic procedures, no payment generally will be made for a visit on the same day in addition to the surgical procedure or endoscopy procedure unless a separately identifiable service is furnished (see also description of CPT modifier 25 in the CPT code book). For example, a visit could properly be billed in addition to payment for suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit would not be appropriate if the evaluation consisted only of identifying the need for sutures and confirming allergy and immunization status.

Minor surgeries will have post-operative periods of 0 to 10 days. Those with 10 days will have all post-operative services related to recovery from the surgery during this period included in the fee for the surgery. Services furnished during this period for treatment of the underlying condition will be paid for separately (see description of CPT modifier 24 in the CPT code

book).

Minor surgeries with a 10-day post-operative period are listed in the current “Federal Register”.

903.15.3. Bilateral Procedures - (Modifier 50)

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

903.15.4. Multiple Procedures

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

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

903.15.4.2. The second procedure - the lower of 50% of the maximum allowed amount or the submitted charge. A non-related second major procedure may be reimbursed at 75% of the maximum allowed amount.

903.15.4.3. The third procedure - the lower of 25% of the maximum allowed amount or the submitted charge.

A non-related third major procedure may be reimbursed at 50% of the maximum allowed amount.

Each individual surgical procedure for which reimbursement is being requested must be coded on separate lines on the claim form with an associated charge for each procedure. In order for the reimbursement methodology to be quickly and accurately applied, separate procedures must be arrayed from major to minor on the claim form and a description of the surgery on the line entitled “Procedure/Services, or Supplies” must be provided.

903.15.5. Incidental Procedures

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

903.15.6. Surgical Team

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

903.15.7. Co-Surgeons - (Modifier 62)

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

903.15.8. Surgical Assistant - (Modifier 80)

A surgical assistant may be required for the management of specific oral surgical procedures. The upper limit of reimbursement for the assistant surgeon is 16% of the maximum allowable for the surgical procedure. The services of an assistant surgeon are not anticipated for non-critical surgical procedures.

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

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

903.15.8.2. A resident oral surgeon was available to assist; or

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

Claims for appropriate assistant oral surgeon charges must be billed by the enrolled oral surgeon who is assisting at the surgery. The “type of service” code “80” - “Assistant at Surgery” must be placed on the claim form and the “80” modifier must be added to the procedure code(s). (See the CPT code book for a description of the “80” modifier). The procedure codes billed must be the same as those billed by the primary surgeon. If the oral surgeon is assisted by a Physician’s Assistant whose supervising oral surgeon is not enrolled for PA services, or a non-physician who is not separately enrolled as a Certified Nurse Midwife, or an Advanced Certified Pediatric Nurse Practitioner, the charge for such service is not separately reimbursable but may be included in the oral surgeon’s fee

for the procedure.

903.15.9. Surgery and Follow-up Care Provided by Different Oral Surgeons (Modifiers 54 and 55)

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

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

NOTE: Failure to file the 54 modifiers with the oral surgery procedure code will prevent payment to the provider rendering post-operative care.

904. Non-Covered Services

The services and procedures listed below are not covered by the Department under the Oral Maxillofacial Surgery Services program. This list is representative of non-covered services and procedures and is not meant to be exhaustive:

904.1. Cosmetic surgery.

904.2. Therapeutic Injections except those contained in the Department's Physician and Oral Maxillofacial Surgery Services Injectable Drug List.

904.3. Acupuncture.

904.4. All procedures listed in the CPT as "unlisted procedure" which ends in "99."

904.5. Educational supplies, medical testimony, special reports, travel by the physician, 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.

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

904.7. Hospital Discharge Summaries.

904.8. 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.

904.9. Experimental services, investigational procedures or those procedures which are not recognized by the profession or the United States Public Health Service as universally accepted treatment.

904.10. Services and/or procedures performed without regard to the policies contained in this Policy Manual.

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

904.12. Hospital visits to members awaiting placement in a nursing home, unless medically necessary.

904.13. Hospital visits if the hospital admission and/or length of stay are disallowed by the Hospital Utilization Review staff or the Department.

904.14. Radiologic procedures performed by a portable x-ray service.

904.15. Services provided in a State-owned facility.

904.16. Drugs used in the oral surgeon's office or dispensed by the oral surgeon except those injectables authorized on the Department's Injectable Drug List.

904.17. Thermography.

904.18. Services provided to Georgia Better Health Care members without prior authorization from their case managers.

904.19. 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 Department's contracted peer review organization as universally accepted treatment, including but not limited to, positron emission tomography, dual photon absorptiometry, etc.

904.20. Substance Abuse Clinic Services

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

Alliant Health Services Medical Review
P.O. Box 105330
Atlanta, Georgia 30348

Chapter 1000: Basis for Reimbursement

1001. Reimbursement Methodology

The Department will pay the lower of the oral surgeon's submitted usual and customary charge, or the statewide maximum allowable amount for the procedure code reflecting the service rendered. Effective with dates of service October 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.

Services provided by a physician's assistant will be limited to no more than 90% of the maximum allowable amount paid to a physician.

A copy of the Department's Schedule of Maximum Allowable Payments (by procedure code) is available upon written request to:

Gainwell Technologies
Provider Services Contact Center
P. O. Box 105200
Tucker, GA. 30085-5200

This is not a fee schedule. As required in Section 601.4, oral surgeons must bill the Department their usual and customary fees. Oral surgeons must not change their fees to the rates in this schedule, even if their fees are higher than the maximum allowable payment for services rendered.

1002. Co-payment

Member co-payment is required for all evaluation and management procedure codes (99202- 99495) billed by oral surgeons unless the member is less than twenty-one (21) years of age.

Appendix A
Covered Oral and Maxillofacial Surgery Services

All approved oral maxillofacial surgical procedure and services are listed on the Georgia Medicaid Schedule of Maximum Allowable Payment (SMAP) for Physicians, Advance Nurse Practitioners, Nurse Midwife, Oral Maxillofacial Surgery, and Podiatry. For covered oral and maxillofacial surgery services, refer to the SMAP.

The SMAP is accessible via the Georgia Health Partnership (GHP) website at www.mmis.georgia.gov or by contacting the GHP directly at (800) 766-4456.

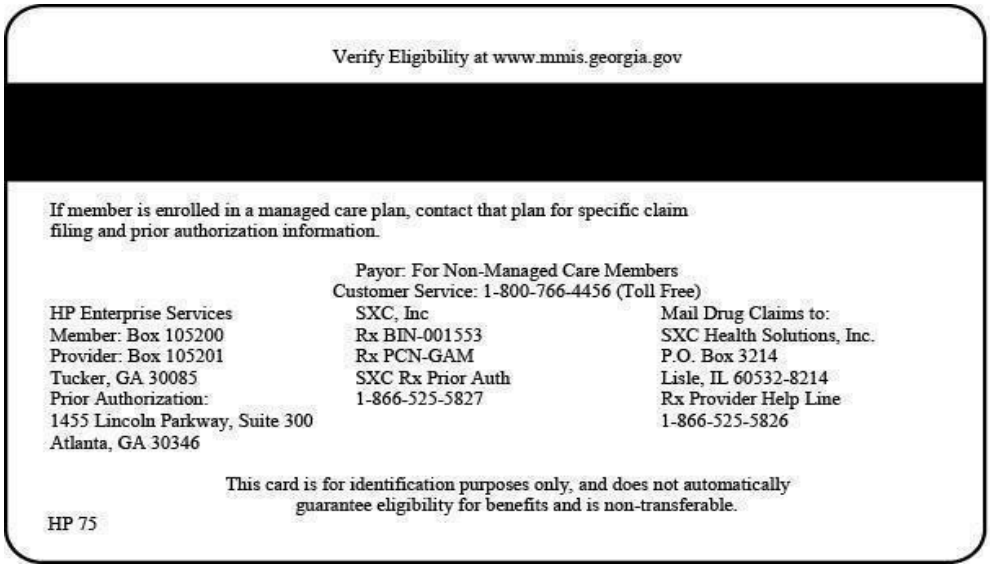
The following laboratory procedure codes are available for Oral Pathologist to bill. Please consult the Schedule of the Maximum Allowable Payments for Clinical Laboratory and Anatomical Pathology Services or the Schedule of Maximum Allowable Payments for Physicians, Podiatry, Certified Nurse Mid-wife, and Oral Max to determine which procedure codes allow modifier 26 (professional component). If the technical component or the entire procedure code (the professional component and the technical component) is billed, the provider must have the appropriate CLIA certification on their provider file with Georgia Medicaid. Please consult the provider enrollment unit at GHP for assistance. The Department will monitor to ensure that an Oral Pathologist is performing these procedure codes.

83540	88311	88342
88302	88312	88346
88304	88313	88348
88305	88321	
88307	88323	
88309	88325	

Appendix B
Medical Assistance Eligibility Certification

A. Medicaid & PeachCare for Kids Member Identification Card Sample

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 C
Co-Payments For Oral Maxillofacial Surgery Services

A. Co-payments

Effective with dates of service October 1, 2005, the Division is implementing a tiered member co-payment scale as described in 42CFR447.54 on all evaluation and management procedure codes (99202 - 99495) including the ophthalmologic services procedure codes (92002 - 92014) used by physicians or physicians' assistants.

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

State's payment for the service	Maximum co-payment chargeable to members
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

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

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

1. Pregnant women
2. Nursing facility residents
3. Hospice care members
4. Members under 21
5. Women diagnosed with breast or cervical cancer and receiving Medicaid under the Women's Health Medicaid Program, aid categories 245 and 800, only. This change is effective January 1, 2007 and applies to all services rendered beginning January 1, 2007 and thereafter.

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

1. Emergency services
2. Waiver Services
3. Family Planning services
4. Dialysis Services

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

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

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

1. P = Pregnant

2. S = Nursing facility members

3. H = Hospice

4. E = Emergency services

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

Appendix D
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 105201
Tucker, GA 30085-5201

Or

Phone your request to:

1 (800) 766-4456

Appendix E
Billing Instructions and Claim Forms

A. Claims must be filed on the required form with appropriate information in specific blocks for payment. Claim forms for Oral Maxillofacial services are:

i. Health Insurance Claim Form (CMS-1500)

Claims must be submitted within six (6) months form the month of service. Claim(s) with third party resource(s) must be submitted within twelve (12) months from the month of service. Please refer to the Medicaid Secondary Claims User Guide for additional instructions.

ii. Medicaid-Medicare Crossover or (CMS –1500)

A special crossover claim form is no longer required when billing Medicaid/Medicare crossover. Claims must be submitted using the CMS – 1500 format. This claim must have an Explanation of Medicare Benefits (EOMB) from Medicare for Medicaid payment. Claim (s) must be submitted within twenty-four (24) months from the month of service. Please refer to the Medicaid Secondary Claims User Guide for additional instructions.

Detailed instructions for completing the CMS 1500 form were deleted from this manual. For detailed instructions for completing the CMS 1500 claim form and a copy of the newly revised CMS 1500 refer to the Appendix I, Section 5.1.1 of the Medicaid Billing Manual located in the Part I Policy and Procedure Manual for Medicaid and PeachCare for Kids.

Appendix F
Georgia Health Partnership (GHP)

A. Gainwell Technologies
Provider Services Contact Center
P.O. Box 105200
Tucker, GA 30085-5200

B. Alliant Health Solutions
Prior Authorization
(Submit Prior Authorization thorough web portal www.mmis.georgia.gov)
P.O. Box 105329
Atlanta, GA 30348

C. Electronic Data Interchange (EDI):
1-877-261-8785

i. Asynchronous

ii. Web portal

iii. Physical media

iv. Network Data Mover (NDM)

v. Systems Network Architecture (SNA)

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

D. Provider Inquiry Number:
800-766-4456 (Toll free)

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

Appendix G
Acceptable Modifiers

A. Modifiers:

i. 22: Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure.

ii. 24: Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure.

iii. 25:Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.*

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

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

vi. 50: Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier '-50'.

vii. 52: Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '-52', signifying that the service is reduced.

viii. 54: Surgical Care Only: When one physician performs a surgical procedure, and another provides preoperative and/or postoperative management.

ix. 55: Postoperative Management Only: When one physician performed the postoperative management, and another physician performed the surgical procedure.

x. 57: Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding the modifier '-57' to the appropriate level of E/M service.

xi. 58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was:

1. planned prospectively at the time of the original procedure (staged);

2. more extensive than the original procedure; or

3. for therapy following a diagnostic surgical procedure.

This circumstance may be reported by adding the modifier '-58' to the staged or related procedure.

NOTE: The modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

xii. 62: Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure, each surgeon should report his/her distinct operative work by adding the modifier '-62' to the procedure.

xiii. 78: Return to the Operating Room for a Related Procedure During the Postoperative Period: The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier '-78' to the related procedure.

xiv. 79: Unrelated Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier '-79'.

xv. 80: Assistant Surgeon: Surgical assistant services may be identified by adding the modifier '-80' to the usual procedure number(s)

xvi. AA: Anesthesia services personally rendered by an Anesthesiologist

xvii. QK: Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individual(s) [CRNA's] or [PAAA's] by an anesthesiologist.

xviii. QX: Medically Directed—salaried employee of Anesthesiology

xix. QY: Medical direction of on anesthesia procedure involving a qualified individual [CRNA's] or [PAAA's] by anesthesiologist

xx. QZ: Non medically Directed self employed

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

Appendix H

A. Georgia Families and Georgia Families 360

For information on the Georgia Families and Georgia Families 360 please access the overview document at the following link:

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

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

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

Appendix I
National Provider Identifier (NPI) Requirements

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.

A. 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:

i. All Medicaid healthcare providers and

ii. All CMO healthcare providers.

B. 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.

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

i. Applying to be a Medicaid Provider

ii. On all electronic claims submission including claims submitted via WINASAP.

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

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

i. Paper claims submission (CMS 1500)

ii. Resubmission of electronic claims on paper

iii. Submission of web claims

iv. IVR System inquiries

1. Provider authentication

2. All claim inquiries

3. All other inquiries

v. Telephone inquiries

1. Provider authentication

2. All claim inquiries

3. All other inquiries

vi. Prior authorizations

1. Requests

2. Inquiries

vii. Referrals

1. Request

2. Inquiries

viii. Medicaid forms

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

i. Adding a location to my Provider record Changing my Provider information

ii. Written inquiries and correspondence

iii. E-mail and ‘Contact Us’ inquiries