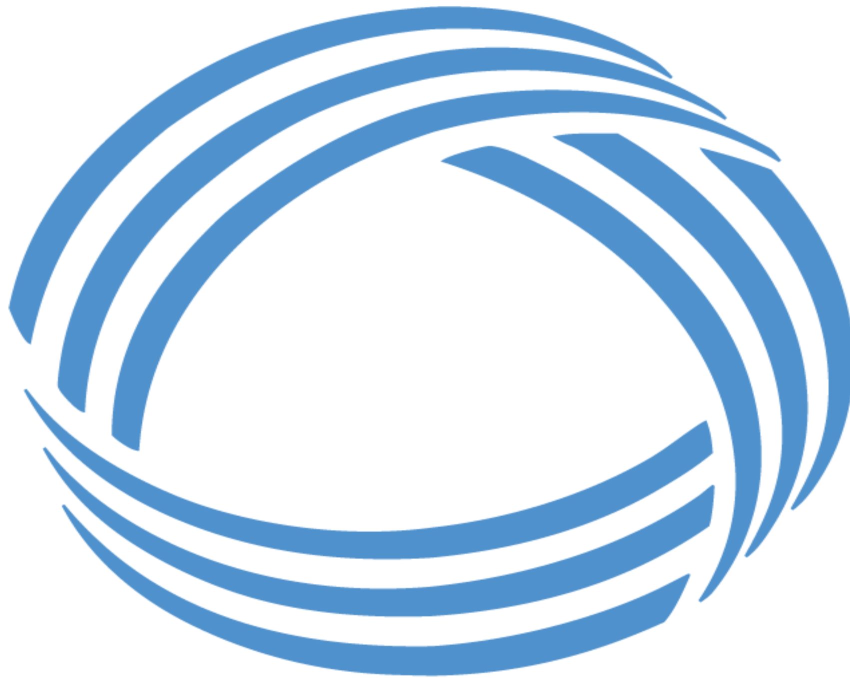
PART II

POLICIES AND PROCEDURES
for
PHYSICIAN SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: October 1, 2024

PREFACE

This manual contains basic information concerning the Physician Services Program and is intended for use by all participating providers and in conjunction with the Part I Policies and Procedures Manual for *Medicaid and Peach Care for Kids*. Part I of any DCH manual outlines the Statement of Participation for participating providers. Part II of any DCH manual outlines the policies and procedures specific to that program as well as the terms and conditions for receipt of reimbursement.

We urge you and your office staff to familiarize yourself with the contents of Part I and Part II of the manual and refer to it when questions arise. Use of the manual will assist in the elimination of misunderstandings concerning program policies, coverage levels, eligibility, and billing procedures that can result in delays in payment, incorrect payment, or denial of payment.

Amendments to this manual will be necessary from time to time due to changes in federal and state laws and the Department of Community Health (the Department), Division of Medical Assistance (Division) policy. Manuals are posted quarterly on the Gainwell Technology web portal at www.mmis.georgia.gov and will include any amendments when such amendments are made, if applicable. These postings shall constitute formal notification to providers of any changes or amendments. The amended provisions will be effective on the date of the notice on the manual or as specified by the notice itself. All providers are responsible for complying with the amended manual provisions as of their effective dates.

Thank you for your interest and participation in Georgia's Medicaid/Peach care for Kids program. Your service is greatly appreciated.

TABLE OF CONTENTS

PREFACE 1
Policy Revision Record 7
Physician Services 8
Chapter 600: Special Conditions of Participation 8
601. Special Conditions 8
602. Locum Tenens 9
603. Locum Tenens services are permitted if: 9
604. Teaching Physician 10
605. Primary Care Exception Rule 10
Chapter 700: Special Eligibility Conditions 16
701. Special Eligibility 16
Chapter 800: Prior Approval - Hospital Pre-Certification 17
801. Services That Require Prior Approval or Hospital Pre-Certification 17
802. Prior Approval 17
803. Procedures for Obtaining Prior Approval 17
804. Hospital Pre-certification 18
805. Procedure for Obtaining Hospital Pre-certification. 18
806. Procedures for Obtaining Prior Approval for Pharmaceuticals 19
807. Prior Approval: Office or Nursing Home Visits 19
808. Procedures for Obtaining Pre-certification for Transplants. 20
Chapter 900: Scope of Services 21
901. General 21
902. Coding of Claims 21
903. Division 21
904. ICD-10-CM 21
905. CPT 21
906. Appeals (Electronic Submissions) 22
907. General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Provider 22
908. Accepted Modifiers 23
909. Coding Modification and Service Limitations 25
910. Charts and Records 25
911. Anesthesia Services 26
912. Antigen Therapy 26
913. Allergy Testing 27

914. Allergen Immunotherapy 28
915. Ingestion Testing 28
916. Allergy Blood Testing 28
917. Office Visits 28
918. Non-Covered Services 29
919. Billing Guideline 29
920. Auxiliary Personnel 31
921. Consultations 32
922. Co-payment 32
923. Dialysis Services 32
924. Chronic Renal Failure 33
925. Electrocardiograms (EKG) 33
926. Family Planning Services 33
927. Hospital Evaluation and Management Services 33
928. Observation 34
929. Providers Administered Drug List (PADL) 36
930. Laboratory Procedures 36
931. Medicare Deductible/Coinsurance 40
932. Neurology and Neuromuscular Procedures 40
933. Newborn Care 40
934. Non-Invasive Vascular Studies 41
935. Nursing Home Services 41
936. Obstetrical Services 41
937. Lactation Consultation Services 42
938. Total Obstetrical Care 42
939. Partial Obstetrical Care Due to Member Eligibility 44
940. Partial Obstetrical Care Due to Involvement of More Than One Physician during Pregnancy 44
941. Ultrasound and Amniocentesis 44
942. Tobacco Cessation Services for Medicaid Eligible Members 48
943. Office or Other Outpatient E/M Services 48
944. Out-of-State Services- Non-Enrolled Providers 49
945. Psychiatric Services 51
946. Radiological Services 54
947. Reduced Services (52 Modifier) 59
948. Site of Service Differential 59
949. Supplies and Materials 59

950. Surgery 59
951. Telemedicine Consultation 65
952. Therapy Services 65
953. Children's Intervention Services 65
954. Transplant Services 65
955. Vaccines for Children Program (VFC) 65
956. Vision Care Service 66
957. Durable Medical Equipment (DME) 66
958. Addiction Medicine 66
959. Service Restrictions 66
960. Abortions 68
961. Supply of Forms 68
962. Colorectal Cancer Screening 68
963. Non-Covered Services 70
Chapter 1000: Basis For Reimbursement 73
1001. Reimbursement Methodology 73
1002. This is not a fee schedule 73
1003. Medicare Crossover Claims 73
1004. Physician Services 73
1005. Contact Information 74
Appendix A 75
Medical Assistance Eligibility Certification 75
Appendix B 77
Vaccines for Children Program 77
Appendix B1 79
Vaccines Covered in the Physician and Advanced Nurse Practitioner Service Programs 79
Appendix C 81
Health Check and Adult Preventive Visit 81
Appendix D 83
Prior Approval and/or Prepayment Review 83
Appendix E 104
Attachment "1" to Appendix E 104
Appendix F 105
Sterilizations 105
Appendix G 109
Hysterectomies 109

Appendix H 110
Member Information (DMA-276) 110
Appendix I...111
Abortions 111
Appendix I-1..112
Certificate Of Necessity For Abortion (DMA-311) 112
Appendix J...113
Newborn Certification – Temporary Enrollment 113
Appendix K 114
Procedure Codes Subject to the Site of Service Differential..114
Appendix L...0
Radiology Services requiring Prior Authorization 0
Appendix M..3
Change in Publication of "V" Codes Available 3
Appendix N 4
Physician's Certification of Medical Evaluation of Hearing Loss 4
Appendix O 5
Outpatient Hospital, Inpatient Hospital and Ambulatory Surgical Center Procedure Requiring Prior Approval/Pre-Certification 5
Appendix P 9
Drug and Pharmacy Information 9
Appendix Q 10
Georgia Medicaid FFS Tamper Resistant Prescription Pad (TRPP)- Prescriber Update 10
Appendix R...17
Copayments for Certain Services 17
Appendix S 19
Telemedicine and Telehealth..19
Appendix T...20
Provider's Guide to HIV Pre-Test and Post-Test Counseling...20
Appendix U 23
Statement of Participation 23
Appendix V 24
Gainwell Technology 24
Appendix W 25
National Provider Identifier (NPI) Requirements 25
Appendix X 27
Provider Preventable Conditions, Never Events, and Hospital Acquired Conditions.........27

Appendix Y 28
New CMS 1500 Claim Form..28
Appendix Z..30
Georgia Families & NEMT 30

Policy Revision Record
from 2024 to Current

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
1/1/2024	ALL	Added 2024 CPT/HCPCS new codes	M	NA
1/1/2024	903.2	Antigen Therapy/Billing Guidelines language update	M	NA
04/01/2024	Appendix D	Added EPSDT child preventive checkup EM codes (99381-99385, 99391-99395) to Appendix D.	M	NA
04/01/2024	Pharmacy	PBM changes to Health plan	M	NA
07/01/2024	903.6 Dialysis Services	Revised language Acute Kidney Injury/ Acute Renal Failure	M	NA
07/01/2024	Appendix E	Appendix E – Add PA indicator to Diagnostic Mammography of Breast for codes 77065 and 77066.	M	NA
10/01/2024	All	Transfer Physician Services Manual to SharePoint	NA	NA
10/01/2024	Appendix Z	GA Families and NEMT consolidated and links to documents added	A	

Physician Services
Chapter 600: Special Conditions of Participation

601. Special Conditions

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

601.1. Each enrolled physician agrees to bill the Division only for services that are rendered by the physician, or for services rendered under the physician's direct supervision. Only necessary and appropriate medical services that meet the following conditions will qualify as services performed under the direct supervision of the physician:

601.1.1. The services must be performed by medical 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 physician, or of the physician's group practice as defined below; physicians may not bill for the services of independent contractors.

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

601.1.4. The physician must be immediately available on the site at the time the services are delivered, except as provided in Section 601.9.

601.1.5. A physician 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.

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

The provider must maintain an office, clinic, or other similar physical facility, which complies with local business and building license ordinances. (See Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual, Chapter 100, Section 105, for General Conditions of Participation.)

In a group practice, each physician 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 physicians in a space sharing arrangement in which the physicians each maintain offices, and treatment facilities in a contiguous space. Services performed by non-enrolled physicians in a group practice are not covered.

Indiscriminate billing under one physician'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. Locum Tenens

Locum Tenens are physicians that temporarily take over the practice when the regular physician(s) are absent for reasons such as illness, vacation, or military, and for the regular physician to bill and receive payment for the locum tenens services as though he/she performed the service. The locum tenens physician generally does not have a practice of his/her own and move from area to area as needed. GA Medicaid locum tenens policy does not apply to mid-levels substituting for a regular physician practice. Physicians may retain substitute physicians to take over their professional practices when the regular physicians are absent for reasons such as illness, vacation, and military for the regular physician to bill and receive payment for the locum tenens services as though he/she performed them himself. Payment may be made to a physician for services furnished by the locum tenens if the services are not provided by the substitute physician over a continuous period of more than 60 days. Rev. Oct 2017

603. Locum Tenens services are permitted if:

603.1. Medicaid members have arranged or seek to receive the services from the regular physician.

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

603.3. The locum tenens physician does <u>not</u> provide the visit services to Medicaid patients for a period of time exceeding 60 consecutive days.

603.4. The locum tenens physician must be an enrolled Medicaid provider. The locum tenens provider must have a valid Georgia Medicaid provider number.

603.5. The regular physician must place the locum tenens physician’s provider number on the CMS1500 claim form.

603.6. Services provided by locum tenens physician must be identified in the member’s medical record held by the regular physician and must be available for inspection.

603.7. Reimbursements shall be limited to services the regular physician is entitled to submit.

603.8. Any provider who falsely certifies any of the above requirements may be subject to civil and criminal penalties for fraud.

603.9. The explanations and limitations contained in subsection 903.3 apply.

603.10. A physician covering for another physician shall not be construed as a violation of this chapter. The regular physician must identify the services as locum tenens services.

604. Teaching Physician

Services provided by a teaching physician, or resident, are eligible for reimbursement when the teaching physician personally furnishes services; or, when a resident in the direct presence of a teaching physician furnishes the services. These services must be furnished in a center located in the hospital outpatient department of a designated teaching hospital, or in another ambulatory care teaching setting. These requirements are not met when the resident is assigned to a physician's office away from the center or home visits. Physician's fee schedule payment is made only when: Revision Oct 2014

604.1. Except as indicated in the Primary Care Exception Rule, the teaching physician is present during the key portion of any exam, surgery or procedure for which payment is sought. In the case of surgery or a dangerous or complex procedure, the teaching physician must be present during all critical portions of the procedure and immediately available.

604.2. In E/M services, the teaching physician must be present for the portion of the service that determines the level of services billed.

604.3. The teaching physician must personally document presence and participation in the services in the patient's record.

605. Primary Care Exception Rule

The Primary Care Exception Rule enhances residency training by allowing residence independence and allows the physician to bill for services performed by residents without the presence of the teaching physician. The Primary Care Exception Rule applies to Family Practice, General Internal Medicine, Geriatric Medicine, Pediatrics, OB/GYN, and Community Health/Preventive Medicine. (Rev Oct 2014).

Reimbursement is available for services furnished by a resident without the direct presence of a teaching physician for evaluation and management codes of lower and mid-level complexity. For the Primary Care Exception to apply, all the following conditions must be met:

605.1. Services must be provided in an outpatient department of a hospital or ambulatory care entity where time spent by residents in patient care activities is included in determining reimbursement to a hospital.

605.2. Any resident providing service without the direct presence of a teaching physician must have completed more than six months of an approved residency program.

605.2.1. The teaching physician cannot supervise more than four residents at any given time and must supervise the care delivered to members from such proximity as to constitute immediate availability. The teaching physician must have:

605.2.1.1. No other responsibilities at the time of care provided other than supervision of resident education

605.2.1.2. Assumed management responsibility for members seen by the residents

605.2.1.3. Ensured the services provided are appropriate.

605.2.1.4. Reviewed with each resident during, or immediately after, each visit, the member's medical history, physical examination, diagnosis and record of tests as well as therapies; and

605.2.1.5. Documented in each medical record the extent of the teaching physician's participation in the review and direction of services provided.

605.2.2. The range of services that may be furnished by residents include the following:

605.2.2.1. Acute care for undifferentiated problems or for chronic care for on-going conditions. The following outpatient E/M codes are acceptable:

605.2.2.1.1. New Patients: 99202, 99203

605.2.2.1.2. Established Patients: 99211, 99212, 99213

605.2.2.2. Coordination of care provided by other physicians and providers.

605.2.2.3. Comprehensive care is not limited by organ system or diagnosis.

605.2.3. The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care, and where services are furnished by residents under the medical direction of teaching physicians. Coordination of care provided by other physicians and providers. (Rev Oct 2014)

605.2.4. The resident must follow the same approximate group of patients throughout the course of their residency program but are not required to follow the same teaching physicians over any period. (Rev Oct 2014)

605.3. The physician shall not bill for adjunctive services provided in a nursing facility unless the service is prescribed by the member's attending and prescribing physician. "Adjunctive services" are any service provided by a physician or licensed practitioner other than the patient's primary care physician who is legally responsible for the medical care of the patient. The attending and prescribing physician's name must appear on the patient's chart. (Rev Oct 2014)

605.4. The physician shall bill the Division the lowest price regularly and routinely offered to any group of the 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 physician shall maintain records on both Medicaid eligible and private paying patients for a minimum of five years to fully ensure compliance. The physician shall provide the Division, its authorized

representative or contractual agents, with information requested regarding fees at no charge. (Rev Oct 2014)

605.5. The physician 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 physician and the consulting physician, of a hospital which meets at least the requirements to qualify as an emergency hospital. 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. Services performed by a physician in an independent facility shall not be reimbursed through the physician program unless any one of the following conditions applies: (Rev Oct 2014)

605.5.1. Any documented ownership in the practice

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

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

605.5.4. 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.

At least one of the above criteria must be met 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 provider is enrolled in the proper Medicaid category of service to deliver these services.

A physician providing clinical laboratory, x-ray, and certain diagnostic services for the patient of another physician is not considered to be a consulting physician. A laboratory, x-ray, or freestanding diagnostic facility that is not located in a physician's office or hospital is presumed to be independent.

605.6. The physician agrees to cooperate with the appropriate guidelines of other Medicaid service programs adjunctive to Physician Services.

605.7. The physician shall immediately notify the Division's Provider Enrollment Unit in writing of any changes in enrollment status that occur, including but not limited to a 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.

605.8. The physician 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.

605.9. The physician shall not bill for services provided by a physician's assistant unless all the following conditions are met:

605.9.1. The physician's assistant is licensed by the Georgia Board of Medical Examiners.

605.9.2. The physician's assistant is be associated with one or more sponsoring physicians on file with the Georgia Composite Medical Board.

605.9.3. Services provided by the physician's assistant shall be billed under their own assigned provider number. The physician's assistant shall not bill under the provider number assigned to the physician.

605.9.4. No more than four PA s may provide services under the sponsoring physician at one time (O.C.G.A. § 43-34-103 et seq). Revision April 2013

605.9.5. The PA's current job description must be signed by the sponsoring physician.

605.9.6. Only medical services authorized in the PA's job description are billable to Medicaid by PAs.

605.9.7. The physician shall be readily available for supervision and shall be responsible for follow-up care. Readily available is defined as available by telecommunications (phone, pager, and telemedicine video), or in the facility.

605.9.8. All entries to the medical record must be co-signed and dated by the supervising physician within seven days. Rev. Oct 2014

605.10. To bill for services provided in Remote Practices Sites, the following criteria shall be met:

605.10.1. The 'remote site' shall be designated as such by the Georgia Composite Medical Board (GCMB). The 'remote site' designation is associated with the physical facility location, and not with the provider, and a separate enrollment is necessary for each approved site. A copy of the GCMB designation of a remote site is required for each provider enrolling for remote site or location.

605.10.2. The remote site must qualify as a principal office where the supervising physician regularly sees patients. Principal offices shall mean an office, clinic, or facility maintained by the supervising physician for the purpose of providing primary care services and where the supervising physician is physically present for at least

25% of the time the site is open for patient care or calls. (Rural Health Clinics and Federally Qualified Health Centers are not considered Remote Practice Sites. Services provided in these settings are not reimbursable under the Physician Services category of service.) A supervising physician may qualify more than three offices or practice settings as principal offices.

605.10.3. The supervising physician must be available for supervision at the remote site as needed and shall be immediately available to the physician assistant for consultation and supervision either in person or via telecommunication. The supervising physician must be physically present to review patient records and to personally provide patient care at the remote site as needed and at a minimum of at least twice weekly. The supervising physician must provide patient medical record review (via telecommunications) daily. All entries to the medical record must be co-signed by the supervising physician within seven business days.

605.10.4. Any patient seen on a regular basis by a physician's assistant shall be scheduled to be seen by the supervising physician at routine intervals as deemed necessary in the setting and as outlined in the physician application and proposed job description as submitted to the GCMB. Reimbursement of Evaluation and Management (E/M) services are limited to the level of service authorized by the GCMB in the appropriate primary care job description.

605.10.5. A predetermined plan for the initial management and referral of emergencies must be established for each individual site and approved by the GCMB.

605.10.6. The sponsoring physician bears full liability and responsibility for the PA, including but not limited to billing for services rendered.

605.11. The Physician and Physician Assistant shall not bill the Division for services rendered that are reimbursable under the programs below:

605.11.1. Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC), or,

605.11.2. Community Mental Health Program

605.12. The physician shall not bill for psychiatric services provided to members who reside in Therapeutic Residential Treatment facilities. All psychiatric services, including but not limited to testing, interviewing, consulting family therapy, group therapy, and somatic therapy, are included in the Therapeutic Residential Treatment program and are not separately billable to the physician program.

605.13. The Psychiatric Residential Treatment Facility (PRTF) provide inpatient, comprehensive mental health and substance abuse treatment services for individuals under the age of 21 and who, due to severe emotional disturbance or substance abuse, need quality active treatment that can only be provided in an inpatient setting, and for whom alternative, less restrictive forms of treatment have not been successful or are not medically indicated.

Chapter 700: Special Eligibility Conditions

701. Special Eligibility

There are no special eligibility conditions for physician diagnostic and treatment services. Other services available to members include but are not limited to: Health Check (EPSDT) services for members under the age of twenty-one, hearing aids, durable medical equipment, non-emergency transportation, refractive services.

Chapter 800: Prior Approval - Hospital Pre-Certification

801. Services That Require Prior Approval or Hospital Pre-Certification

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

802. Prior Approval

As a condition of reimbursement, the Division requires certain services or procedures to be approved prior to the time of rendering. Prior approval pertains to medical necessity only; the patient must be Medicaid-eligible at the time the service is rendered. See Appendix E for a list of procedures requiring prior approval. (Rev 10/2011).

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

Prior Approval for pregnancy related ultrasounds is required after the first ultrasound, or in some cases, prior to rendering the service. Refer to Appendices E, L, and O for detailed information regarding specific procedures that require prior approval before services are rendered. Physicians should seek prior approval on any service for which reimbursement might be questionable. The ordering physician is responsible for obtaining the Prior Approval. Failure to obtain prior approval shall result in denial of payment to all providers billing for services including the facility. (Rev.10/ 2011)

803. Procedures for Obtaining Prior Approval

The physician is responsible for obtaining the prior authorization before rendering the service. Requests for prior approvals may be submitted online via the Web portal at www.mmis.georgia.gov.

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

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

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

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

Prior approval is not required for obstetrics.

804. Hospital Pre-certification

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

A prior authorization may be required in addition to the pre-certification required for all inpatient admissions and certain outpatient services. Rev. Sep 2011

A request for pre-certification should be initiated at least one week prior to the planned admission or procedure. Approval is valid for ninety days from the date of issuance. Rev. Jun 2009, Oct 2014

Hospital admissions exceeding ninety days require recertification within three calendar days prior to the ninetieth day of the continued stay.

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

Emergency outpatient services, vaginal or C-section deliveries, and members who have Medicare Part A are not subject to hospital pre-certification.

Appendix O provides detailed information regarding specific outpatient procedures that must be certified prior to the time rendered. Urgent outpatient procedures performed because of a condition which if not treated within 48 hours would result in significant deterioration of the member's health status must be certified within thirty calendar days of the date of the procedure.

Failure to obtain the required certification will result in denial of reimbursement.

805. Procedure for Obtaining Hospital Pre-certification.

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

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

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

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

For determining timeliness of pre-certification update requests, if pre-certification has been obtained for an outpatient procedure and after the procedure has been performed, it is determined that inpatient services are necessary, the admission should be considered an emergency. The request for an update of the pre-certification file will be considered timely if received within thirty days of the date of the admission.

806. Procedures for Obtaining Prior Approval for Pharmaceuticals

Approved injectable drugs listed on the Providers Administered Drug List (PADL) do not require pre-certification, unless indicated by the PA symbol. A request for injectable drugs must be submitted via the web portal at www.mmis.georgia.gov. The request must include applicable clinical information and the corresponding ICD-10 diagnosis code, CPT or HCPCS code 11-digit National Drug Code (NDC) number. Requests that are incomplete may be delayed or denied for insufficient information. (Rev Jul 2012)
Failure to obtain a prior authorization shall result in denial of reimbursement. Providers should not obtain injectable drugs for administration in the office setting through outpatient pharmacy program and written prescriptions. For information regarding outpatient pharmacy prior approvals refer to the Pharmacy Services manual located at web portal at www.mmis.georgia.gov

807. Prior Approval: Office or Nursing Home Visits

Requests for prior approval for more than ten (10) office or nursing home visits per calendar year for one member may be made if additional visits are medically necessary. Medically necessary visits include life threatening situations and situations involving serious acute or serious chronic illnesses. (Rev Jan 2016)

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

807.1. The member's name and Medicaid number,

807.2. The diagnoses of the member,

807.3. Explanation of medical necessity for more than ten (10) visits per year, and

807.4. The physician's signature (physician's stamps are not acceptable over a typed address).

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

808. Procedures for Obtaining Pre-certification for Transplants.

Requests for approval of coverage of transplants should be submitted online via the web portal at www.mmis.georgia.gov.

Prior approval and pre-certification accompanied by medical records must be received for review prior to rendering a transplant. Records must be current, and must include medical history, pertinent laboratory findings, x-ray and scan reports, social history and test results that exclude viremia, and justify the medical necessity of the transplant. Rev Jul 2009

Transplant procedures and related services must be approved prior to the time that services are rendered, regardless of age. These services cannot be approved retroactively. The members must be eligible at the time services are provided.

Physician services in connection with the acquisition of tissue or an organ from a living donor for transplant in an eligible member are consider as services for the treatment of the member and are covered a such, although the donor may or may not be Medicaid eligible.

If approval is given for the transplant procedure, a pre-certification number will be assigned.

Chapter 900: Scope of Services

901. General

Federal regulations allow the state agency to place appropriate limits on medical necessity and utilization control. The Division has developed reimbursement limitations to ensure appropriate utilization of funds. These limitations consist of (a) prior approval requirements described in Chapter 800 and in Appendix E, (b) service limitations described in Section 903, (c) service restrictions described in Section 904, (d) non-covered procedures described in Section 905, and (e) eligibility limitations described in Chapter 700.

902. Coding of Claims

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

903. Division

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

42 CFR 456.3 requires the Division to “safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments.” The Division utilizes a claims adjudication system that encompasses edits and audits to facilitate the Federal mandate. The claims adjudication system’s exceptions used are based on nationally accepted standards, including but not limited to the American Medical Association’s CPT guidelines, National Correct Coding Initiative (NCCI) edits, Centers for Medicare and Medicaid Services (CMS) standards and publications, and other related medical literature and proprietary software.

904. ICD-10-CM

Codes deleted from previous editions of the ICD are not accepted by the Division. The provider must select the diagnosis codes from the ICD 10 CM which most nearly describes the diagnosis of the patient.

In coding the diagnosis on your claims, the code must be placed on the claim form using the identical format (including the decimal point) as shown in the ICD 10 CM codes (example: I11, I11.0 and I11.9). Coding must be to the lowest level.

It is the responsibility of the laboratory to obtain the member’s diagnosis from the prescribing practitioner at the time the referral is made.

905. CPT

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

905.1. Code deleted from previous editions of the CPT is not reimbursable.

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

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

906. Appeals (Electronic Submissions)

To check the status of a claim or require assistance with a billing problem, contact the Gainwell Technology Provider Inquiry line on 1-800-766-4456. Rev Jul 2009, Mar 2018

For assistance with resolving denied claims with explanation of benefit (EOB) codes (e.g., timeliness or conflict with another claim and/or payment inquires), submit a completed DMA520 form electronically to Gainwell Technology at www.mmis.georgia.gov within thirty (30) days of the denial. Follow the appeals process and deadlines in Chapter 500, section 502, of the Policies and Procedures for Medicaid Peach Care for Kids Part 1 Manual for additional information.

For claims requiring clinical review for medical necessity, submit electronically those requests via the medial review web portal (www.mmis.georgia.gov) for medical reviews/provider inquiry form (DMA-520A). Rev. July 2009

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

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

906.3. Providers can electronically attach and download the supporting documentation at the time of the inquiry request.

906.4. All provider inquiries and appeals for clinical review and reconsideration that are faxed or mailed (DMA-520A) will not be accepted and will be discarded.

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

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

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

The Patient Protection and Affordable Care Act (PPACA) requires physicians and other eligible practitioners who order, prescribe, and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. CMS expanded the claim editing requirements in § 1833(q) of the Social Security Act and the providers definitions in §1861-r and §1842(b) (18) C to align with the PPACA. (Rev. 04/2014)

To comply with the PPACA, claims for services that are ordered, prescribed, or referred must indicate the ordering, prescribing, or referring (OPR) practitioner. The Division will utilize an

enrolled OPR provider identification number verify Georgia Medicaid enrollment. Any OPR physician, or other eligible practitioner, who are not enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the rendering provider. If the NPI of the OPR Provider denoted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim will be denied.

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

907.1. For CMS-1500 claim form:

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

907.2. 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 details were updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

907.3. 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.

The following resources are available for more information:

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

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

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

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

908. Accepted Modifiers

22	Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure

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

	use of the operating room, it may be reported by adding the modifier 78 to the related procedure.
79	Unrelated Procedure or Service by the Same Physician by the same Physician or Other Qualified Health Care Professional During the Postoperative Period: The provider 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.
80	Assistant Surgeon: Surgical assistant services may be identified by adding the modifier 80 to the usual procedure number.
AA	Anesthesia services rendered by an Anesthesiologist.
FQ	Audio-only service
FR	Two-way a/v dir supervision
FS	Split or shared e/m visit
FT	Split or shared e/m visit
FX	X-Ray taken using film.
GQ	Must be used in conjunction with the appropriate codes for Telemedicine following full implementation of HIPAA compliance (see "Telemedicine Consultations.")
GT	Must be used in conjunction with the appropriate codes for Telemedicine following full implementation of HIPAA compliance (see "Telemedicine Consultations.")
Q1	Clinical Research
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving a qualified individual, CRNA's or PAAA's, by an anesthesiologist.
Q6	Service furnished by Locum Tenens Physicians
QX	Medically directed salaried employee of Anesthesiology.
QY	Medical direction of on anesthesia procedure involving a qualified individual [CRNA's] or [PAAA's] by anesthesiologist.
QZ	Non-medically directed, self-employed.
TC	Technical Component: Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances, the technical component charge is identified by adding modifier 'TC' to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.
UN	Portable x-ray (two patients served)
UP	Portable x-ray (three patients served)
UQ	Portable x-ray (four patients served)
UR	Portable x-ray (five patients served)
US	Portable x-ray (6 or more patients served)

909. Coding Modification and Service Limitations

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

910. Charts and Records

The physician must maintain legible, accurate, and complete charts and records to support and justify

the services provided. A chart is a summary of essential medical information on an individual patient. A record is a date report supporting the claim submitted to the Division for services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. A record of service must be entered in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible and shall include at a minimum, the following information:

910.1. Date of service

910.2. Patient's name and date of birth

910.3. Name and title of person performing the service.

910.4. Chief complaint or reason for such visit

910.5. Pertinent medical history

910.6. Pertinent findings on examination

910.7. Medications, equipment, or supplies prescribed or provided.

910.8. Description of treatment (when applicable)

910.9. Recommendations for additional treatment, procedures, or consultations

910.10. X-rays, tests, and results

910.11. Plan of treatment, care, and outcome

The original handwritten personal signature, initial, or electronic signature of the person performing the service must be on the patient's medical records within three months of the date of service. This includes, but is not limited to, progress notes, radiological, and laboratory reports for each date of services billed to the Division. A signature on the super bill does not satisfy this requirement. Medical record entries without specified signature can result in recoupment of payment.
All medical records must be written in Standard English Language. Records must be available to the Division or its agents, and to the U.S. Division of Health and Human Services, on request. Documentation must be timely, complete, and consistent with the bylaws and medical policies of the office or facility where the service is provided.

911. Anesthesia Services

Note: Please refer to Schedule of Maximum Allowable CPT Anesthesia Base Units for further clarification regarding anesthesia services.

912. Antigen Therapy

The Division reimburses for allergy services that are performed to determine a member's immunologic sensitivity or reaction to allergens for the purpose of identifying the cause of the allergic state. Allergy skin testing is a clinical procedure that is used to evaluate an immunologic response to allergenic material. The Division considers specific allergy testing and allergy immunotherapy medically necessary for members with clinically significant allergic symptoms. (Rev Jan 2020)

Allergy testing are the diagnostic and therapeutic procedures relating to hypersensitivity disorders that may be manifested by generalized systemic reactions as well as by localized reactions in any organ system of the body. Skin allergy testing involves scratching, pricking or puncturing of skin. Allergy blood test measure the number of antibodies in the body.

Allergen immunotherapy is the repeated administration of specific allergens to members with IgE-mediated conditions, for is a treatment program for individuals who have hypersensitivity to one or more allergens. The objective of the therapy is to lessen or diminish symptoms when the individual is exposed to the allergen in the future. Immunotherapy consists of injections that contain progressively larger amounts of allergen until the individual research and then can continue a maintenance dose level.

The physician or qualified non-physician practitioner performs the appropriate allergy test from the list below.

912.1. Direct skin testing (immediate hypersensitivity)

912.2. Intracutaneous skin tests

912.3. Percutaneous skin test (scratch, prick, or puncture)

912.4. In vitro specific IgE test or inhalant (pollens, molds, dust mites, and animal dander), foods, insect stings and drugs

912.5. Ingestion challenge testing

913. Allergy Testing

The Division will reimburse specific allergy skin testing medically necessary for members with clinically significant allergic symptoms. Allergy skin testing codes are divided into environmental, venom and food. Testing is used to identify the offending antigen(s) by in vitro (skin) testing, percutaneous (scratch, puncture, prick), intradermal and patch, and photo patch tests.

913.1. Percutaneous and intracutaneous skin test.

913.1.1. Percutaneous testing (scratch, prick, puncture; codes 95004, 95017, 95018) for allergens

913.1.2. Intracutaneous (intradermal) sequential and incremental testing (95024, 95027, 95028) when percutaneous tests are negative.

913.2. Patch testing (95044) is used for diagnosing contact allergic dermatitis.

913.3. Photo tests (95056) are performed with patch test (95044), only the photo tests should be reported.

913.4. Photo patch test. If photo patch test (95052) are performed with patch test (95044) same antigen /same session, only the photo patch tests should be reported.

913.5. Ophthalmic mucous membrane or direct nasal mucous membrane tests. Nasal or

ophthalmic mucous membrane tests (procedure codes 95060 and 95065) are used for the diagnosis of either food or inhalant allergies and involve the direct administration of the allergen to the mucosa.

913.6. Inhalation bronchial challenge testing. Bronchial challenge testing with methacholine, histamine or allergens (95070 and 95071) is used for defining asthmas or airway hyperactivity when skin testing results are not consistent with the client's medical history.

914. **Allergen Immunotherapy**

Allergy immunotherapy, commonly known as "allergy shots", is performed after allergy testing is completed and the provider has determined the allergen, a regimen of immunotherapy is formulated using codes 95115, 95117, 95120-95134, and 95144-95180. Allergen immunotherapy reduces allergen sensitivity and usually results in long-term relief of allergy symptoms. The goal is to reduce the allergy patient's sensitivity when exposed to the offending allergen in the future.

Allergen immunotherapy (allergy shots) is a type of long-term therapy doctors use to reduce symptoms in individual with:

914.1. Allergic asthma

914.2. Allergic rhinitis

914.3. Insect venoms allergy

914.4. Conjunctivitis (eye allergy)

914.5. Stinging (wasps, hornets, bees, fire ants)

914.6. Asthma

914.7. Rhinitis

915. **Ingestion Testing**

Ingestion challenge test. Procedure code 95076 is used to confirm an allergy to a food or food additive.

916. **Allergy Blood Testing**

Blood in vitro testing (blood serum analysis) immediate hypersensitivity testing by measurement of allergen specific serum IgE in the blood stream. The blood test are used to test for inhalant allergens (pollens, molds, dust mites, animal dander), food, insect stings, and drugs or latex, when direct skin testing is impossible. Codes 86001, 86003 and 86005 are used for blood testing, which are limited per the NCCI Medically Unlikely (MUE) allowable units, per rolling year.

917. Office Visits

An office visit must not be billed in conjunction with an allergy injection unless the office visit represents another significant separately identifiable service.

918. Non-Covered Services

918.1. Procedure codes which describe the complete service code for the combined supply of antigen and allergy injection provided during a single encounter will not be covered.

918.2. Administration of antigen(s) is included in the applicable allergen immunotherapy CPT code and is not separately billable.

919. Billing Guideline

Evaluation and management (E/M) codes reported with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is administered. When appropriate, use E/M code, to indicate separately identifiable service. If E/M services are reported, medical documentation of the separately identifiable service should be in the medical record. (Rev. 03/2023)

919.1. Allergy testing is not performed on the same day as allergy immunotherapy in standard medical practice, therefore, should not be reported together.

919.2. Provider(s) shall report the appropriate code(s) used, which determines the billing units(s).

919.2.1. Administration of Antigen(s) by Injection

919.2.1.1. For 95115, one unit is billed when only one injection is given on the same day.

919.2.1.2. For 95117, one unit is billed when two or more injections are given on the same day of service.

919.2.2. Allergy Testing

919.2.2.1. For code 95180, rapid desensitization must be billed as one hour equals one unit.

919.2.2.2. For code 95144 professional service for the supervision of preparation and provision of antigens for allergen immunotherapy single dose vial(s)

919.2.3. Preparation of Antigen(s)

919.2.3.1. CPT procedure code 95165 is used to report multiple dose vials of non-venom antigens. For CPT code 95165, a billable unit dose is now defined as 1 cc (cubic centimeter) aliquot. When billing code 95165, providers should report the number of units representing the number of 1 cc doses being prepared. This does not mean that 1 cc aliquot must be removed, but the professional may not bill for this antigen preparation code for more than 10 doses per vial. The patient's medical record must contain documentation of the volume of antigen prepared to substantiate the number of

1 cc doses billed on the Medicaid claim.

919.2.3.2. A maximum of 10 doses per vial is allowed for provider billing, even if more than 10 preparations are obtained from the vial. In cases where a multidose vial is diluted, providers should not bill for diluted preparations more than the 10 doses per vial allowed under code 95165. If the provider dispenses two or more multiple dose vials of antigen, for each vial dispensed CPT code 95165 must be listed on a separate line along with the corresponding number of doses.

919.2.3.3. The antigen codes (95144-95170) are considered single dose codes. To report these codes, specify the number of doses provided.

919.2.3.4. If a patient's doses are adjusted (e.g., due to reaction), and the antigen provided is more or fewer doses than originally anticipated, the provider should make no change in the number of doses billed. Report the number of doses anticipated at the time of the antigen preparation. A dosing schedule or other documentation should be present in the patient's medical record to substantiate the number of doses anticipated at the time of preparation. These instructions apply to both venom and non-venom antigen codes.

919.2.3.5. Antigen preparation services are subject to the direct supervision requirements listed in Section 601 of this manual. Antigen preparation codes should only be billed by the enrolled provider who performed direct, on-site supervision of the antigen preparation. This provider may be different than the provider who prescribed the immunotherapy treatment. The medical record must include the name and dated signature of the provider that performed on-site supervision of the preparation service. Billing for antigen preparation for antigens that were prepared off-site or under the supervision of a different provider is prohibited.

919.2.3.6. The personnel performing the antigen preparation must be a direct employee of the billing provider or of the billing provider's group practice. Antigen preparation services performed by an independent contractor are not billable.

The supply (preparation) of antigen(s) must be billed separately, the administration of antigen(s) is included in the applicable allergen immunotherapy CPT code and is not separately billable.

Allergy testing should be based on the member's medical history and epidemiologic factors related to the allergens. Providers must document medical necessity in the member's medical record. Claims billed with allergy testing and allergen immunotherapy that do not have supporting medical documentation may result in recoupment.

920. Auxiliary Personnel

The Division has no provision for direct enrollment of, or payment to auxiliary personnel employed by the physician, such as nurses, non-physician anesthetists, unlicensed surgical assistants, or other aides. Physician's Assistant services are reimbursable only under criteria set forth in subsection 601.11 of the manual.

Certified Pediatric, OB\GYN and Family Nurse Practitioners, and CRNAs are eligible for Georgia Medicaid enrollment. Licensed physical, occupational, and speech pathology therapists are eligible for enrollment to provide services to members less than twenty-one years of age. Services provided by practitioners eligible for enrollment cannot be billed by the physician. Physicians cannot be reimbursed for services provided by physician extenders except for their enrolled physician's assistants.

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

920.1. The services are rendered in a manner consistent with the requirement of Section 601.1 of this manual.

920.2. The services provided are "incident to" services performed under the direct supervision of the physician as an adjunct to the physician's personal service.

920.3. The services are of the kinds that are commonly rendered in the medical setting.

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

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

Services provided by auxiliary personnel not employed by the physician are not covered regardless of the services provided on physician's order.

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

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

"Commonly rendered" services are those customarily considered incident to the physician's personal services in the medical setting.

921. Consultations

A consultation is a type of evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem.

The Division consultation codes 99251-99255 were reopened for eligible Medicaid members. All hospital consultation visits must be initiated by the initial hospitalist or an initiating provider for another physician of a different specialty to provide a consultation in the hospital. The written request for consultation must be part of the initiating physician's record. The request must require an opinion from the consultation.

Any overuse and misuse of billing hospital initial visit codes 99221-99223 rather than the most appropriate inpatient consultation codes 99251-99255 may result in an internal review by the DCH's Program Integrity Unit/Office of Inspector General or external Recovery Audit Contractor.

If after the completion of a consultation the consultant assumes responsibility for management of a portion or all the patient's condition(s), the appropriate Evaluation and Management services code for the site of service should be reported. In the hospital or nursing facility setting, the consultant should use the appropriate inpatient consultation code for the initial encounter and then subsequent hospital, or nursing facility care codes. In the office setting, the consultant should use the appropriate office or other outpatient consultation codes and then the established patient office or other outpatient services codes.

922. Co-payment

See Appendix Q for details. Rev Sep 2009

923. Dialysis Services

923.1. Acute Kidney Injury (AKI). Rev June 2014

923.1.1. Dialysis services provided for acute kidney injury (AKI) are reimbursable under the Physician Program using hospital visit codes, critical care codes, or appropriate surgical care codes. CPT dialysis services codes are not covered.

923.1.2. Acute Kidney Injury, previously known as Acute Renal Failure, denotes a sudden episode of kidney failure or damage causing reduction in kidney function. Acute kidney injury is commonly reversible.

Please refer to Dialysis Services manual for care provided to members diagnosed with

acute kidney injury/acute renal failure which is not a part of this program and must be billed through the Dialysis Services Program.

924. Chronic Renal Failure

924.1. Medicaid-Only Members

Dialysis services are available to Medicaid-only members under the Dialysis Services program. All professional and technical services must be billed in compliance with the Dialysis Services manual. Physicians rendering the professional component of the dialysis services must enroll separately in the dialysis program under each facility where they are affiliated. Reimbursement is not available for professional services rendered in a non-enrolled facility.

924.2. Medicare/Medicaid Members

Medicare is the primary payer for dually eligible members. Medicare reimbursement applies for all dialysis related services. No reimbursement will be made for non-covered Medicare dialysis services.

925. Electrocardiograms (EKG)

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

CPT code 93268 should be used to report transmission, physician review, and interpretation of event recordings produced by a cardiac event recorder.

926. Family Planning Services

Please refer to the Family Planning Services Manual.

927. Hospital Evaluation and Management Services

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

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

927.3. Evaluation and management codes associated with surgical procedures are discussed in Section 953: Surgery.

927.3.1. Daily Hospital E/M Services

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

927.3.1.2. E/M services and psychiatric services rendered on the same date of service by the same provider or provider group must be billed using 90832 through 90837.

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

927.3.1.4. Hospital E/M services must be documented in the hospital records on the date of each visit.

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

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

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

928. Observation

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

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

If a patient is retained on observation status for 48 hours without being admitted as an inpatient, further observation services will be denied as not reasonable and necessary for the diagnosis or treatment of a physical or mental condition. (See section 106, Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual.) A maximum of 48 hours of observation may be reimbursed. If

the 48-hour observation limit is exceeded and the patient does not meet the criteria for inpatient admission, the submitted claim may include the total number of units, but the facility will only receive reimbursement for the 48 hours or units. However, any services provided beyond the medically necessary time are non-covered.

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

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

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

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

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

The Division covers services that are medically appropriate and necessary. The services provided in the setting must be appropriate to the specific medical needs of the member. (See section 106 of Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual.) The medical record must substantiate the medical necessity and appropriateness including appropriateness of the setting. When the outpatient observation setting is non-covered, all services provided in the outpatient observation setting are also non-covered. Services that are not reasonable or necessary for the diagnosis and treatment of patients but are provided for the convenience of patients or physicians are not covered. (See section 106 of Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual.)

Level of care and setting determinations are based on patient assessment, medical condition and anticipated or actual treatment as documented in the request for approval. Peer review, in conjunction with inpatient/outpatient qualifying criteria such as InterQual, may be used by PAUM

contractors to assess the patient's medical condition and to substantiate medical necessity for inpatient or outpatient status. s. Hospitals are required to conduct concurrent review and to keep the hospitalized patient until the same criteria indicate hospitalization is no longer necessary. The Division will notify providers in writing 30 days prior to the date of any changes in the criteria or version of criteria being used to certify inpatient admissions. Written notice will be provided on banner messages and on remittances. The same version of criteria will be used for any retrospective medical reviews as were used prospectively.

929. Providers Administered Drug List (PADL)

929.1. Procedure codes and descriptions for injectable drugs (other than allergy injections) are listed in the Providers Administered Drug List (PADL). Unless otherwise specified, immunization drugs for members less than 19 years of age are covered under the Health Check for Kids Program. Rev Jul 2012/Oct 2017

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

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

929.4. The Division's maximum allowable reimbursement for approved drugs on the Providers Administered Drug List to the lesser of: (Rev 07/2009)

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

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

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

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

929.4.5. Administration fees are not separately reimbursable under the Physician Services Program for injectable drugs except for chemotherapy administration codes 96401-96542 and certain vaccines. Rev July 2009/Oct 2019

929.4.6. Please refer to the Provider Administered Drug List (PADL) manual for drug pricing information. The injectable drugs are contained in the Provider Administered Drug List may be billed by the physician.

930. Laboratory Procedures

Laboratory procedures are defined in the CPT in the ranges 80300 through 89398 and panels 80047 through 80076. Providers must select the procedure code that most closely describes the procedure performed.

930.1. Multi-channel Tests

930.1.1. Individual components of automated, multi-channel tests must be billed separately. These tests must be billed using codes in the ranges 80300 through 89398 and panels 80047 through 80076. Only one unit of the appropriate test may be billed for one date of service.

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

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

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

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

930.1.2.4. Please refer to Lab Maximum Allowable Fee Schedule for list of covered services and reimbursement rates.

930.2. Newborn Screens

The following follow up tests are allowed on infants less than three (3) months of age when

the initial screenings are positive. These claims must be billed with the diagnosis code ICD 10 CM P09. However, neonatal metabolic screens are required by the State on all infants between 24 hours after birth or by the seventh day of life. The initial screening specimen shall continue to be sent on filter paper (DHR Form 3491) to the Public Health Laboratory, Central Facility in Atlanta only.

930.2.1. Procedure Codes:

82016	82017	82127	82131	82261
82775	82776	83020	83498	83788
84030	84150	84436	84437	84442
84443				

Specimens for the above battery of tests may be on a full blood sample (not filter paper) and must be performed by any CLIA certified participating laboratory.

930.3. Hemoglobin Testing

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

CPT 83020 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.

930.4. Syphilis Serology

Refer to the Independent Lab Services Manual for a list of covered procedure codes for syphilis testing. The Division will not reimburse for syphilis serology. (Rev Jan 2016)

930.5. Tuberculosis Testing

The following procedures are for tuberculosis diagnosis ICD 10 CM A15.0 through A15.9 & A18.4 testing.

The procedures are: 87116 and 87118

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

930.6. Salmonella and Shigella Testing

Diagnoses included are ICD 10 CM A02.0 – A03.9.

The procedures are: 87045 and 87081

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.

930.7. HIV/AIDS Test Procedures:

The Division reimburses for screening tests when ordered by the members. 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 Jan 2016)

930.8. Drug Testing

Drug procedures are divided into three subsections: Therapeutic Drug Assay, type of patient results obtained. Therapeutic Drug Assays are performed to monitor clinical response to a known, prescribed medication. The two major categories for drug testing in the Drug Assay subsection are: (Rev. 10/2014)

930.8.1. Presumptive Drug Class procedures are used to identify possible use or non-use of a drug or drug class. A presumptive test many be followed by a definitive test to specifically identify drugs or metabolites.

930.8.2. Definitive Drug Class procedures are qualitative or quantitative tests to identify possible use or non-use of a drug. These tests identify specific drugs and associated metabolites, if performed. A presumptive test is not required prior to a definitive drug test.

Presumptive Drug Class Screenings are drugs or classes of drugs may be commonly assayed first by presumptive screening method followed by a definitive drug identification method. The list of drug classes and the methodology are considered when coding presumptive procedures. If a drug class is not listed in List A or List B and it is not performed by Thin-Layer Chromatography (TLC), use 80304 unless the specific analyte is listed in the Chemistry Section.

930.9. Definitive Drug Testing

Definitive drug identification methods can identify individual drugs and distinguish between structural isomers but not necessarily stereoisomers. Definitive methods include, but are not limited to, gas chromatography with mass spectrometry and liquid chromatography mass spectrometry and exclude immunoassays and enzymatic methods. The Definitive Drug Classes Listing provides the drug classes, their associated CPT codes, and the drugs included in each class. Each category of a drug class, including metabolite(s) if performed (except stereoisomers), is reported once per date of service. Metabolites not listed in the table may be reported using the code for the parent code for the parent drug. Drug class metabolite(s) is listed as a separate category in Definitive Drug Classes Listing.

The code is based on the number of reported analytes and not the capacity of the

analysis.

Specimen outfits for testing to be done in the Regional Laboratories should be ordered directly from those laboratories at the below listed address.

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) 285-6000

931. Medicare Deductible/Coinsurance

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

932. Neurology and Neuromuscular Procedures

Codes for certain neurology and neuromuscular procedures have two billing formats:

932.1. Professional Component

932.1.1. Charges billed with an inpatient or outpatient hospital place of service are reimbursed for the professional component only. These charges will automatically assign a modifier 26 to the procedure code.

932.2. Complete Procedure

932.2.1. Codes used for complete procedures performed in the physician's office are identified in the range 95819 through 95999 of the CPT.

933. 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:

933.1. 99238 (Hospital discharge day management) cannot be billed on the same date as

99461. See Section 933.2 for Neonatal test requirements.

933.2. 99460 History and Examination

933.3. 99462 Subsequent hospital care

933.3.1. Hospital services for all babies must be billed under the baby's Medicaid number and must contain the diagnosis code reflective of the medical condition. Care for infants whose condition requires neonatal intensive care, whether performed in the NICU or another area, must be billed using the NICU codes 99468 and 99469. Services specified by the CPT as being included in the NICU E/M codes are not separately reimbursable. Rev Jan 2009.

933.3.2. On the day of delivery, in addition to the initial NICU procedure code (99468), the physician can bill for procedure code 99465 (newborn resuscitation) or 99464 (attendance at delivery) if appropriate. (CPT code 99465 can be reimbursed separately on the day of delivery, if the newborn resuscitation occurred prior to admission to the NICU).

933.3.3. Only one initial NICU procedure code 99468 is allowed per hospital admission. Preventative health screening of eligible children performed after the newborn examination is covered under HealthCheck only. See section 701, Appendix D, and the HealthCheck Manual.

933.3.4. Newborn circumcisions and routine newborn care provided in the hospital setting must be billed under the baby's name and Medicaid number. Newborn circumcisions are covered procedure without prior authorization prior to discharge.

933.3.5. Please see Section 113.1 of Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual for information regarding Medicaid eligibility for newborns.

933.3.6. Newborn Certification Form, See Appendix J

934. Non-Invasive Vascular Studies

No reimbursement will be made for the use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional flow as this is part of the physical examination of the patient. All procedures are valued based on the assumption that the procedures are bilateral.

935. Nursing Home Services

Please refer to the Nursing Facility Manual

936. Obstetrical Services

936.1. Initial Visit and Prenatal Profile

936.1.1. The Division provides reimbursement for the initial and prenatal 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.

936.2. Antepartum, Delivery and Postpartum Care

936.2.1. The Division provides reimbursement for the initial and prenatal 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.

937. Lactation Consultation Services

937.1. Effective July 1, 2022, The Department of Community Health will reimburse lactation consultations services provided for post-partum and breastfeeding mothers. Services must be rendered by an Internationally Board-Certified Lactation Consultant (IBCLC) credentialed by the International Board of Lactation Consultant Examiners (IBLCE) with possession of a valid and current IBCLC certification. The services are available to mothers after delivery during the postpartum care period of 365 days and are a component of pregnancy related services. The services include a face-to-face visit of no less than 30 minutes. Also included is a comprehensive feeding assessment related to lactation, interventions that focus on positional techniques/proper latching/counseling, community support information and evaluation of interventional outcomes. Within the scope of these services is the provision of group and individual breastfeeding education support. (Rev July 2022)

937.1.1. A maximum of five (5) lactation consultation visits per pregnancy will be reimbursed for a single or multiple gestational pregnancy. Each visit can last up to 60 minutes and only one visit is reimbursable per date of service. Claims for IBCLC services are to be submitted utilizing the mother's member identification number. Documentation must support the need for maternal lactation support, education, a begin time and end time of services provided, and a comprehensive description of the professional interventions provided.

937.1.2. An IBCLC providing lactation consultation services must bill one of the following HCPCS codes, S9443 (Lactation Class) or S9445 (Patient Education). Additionally, at least one of the following applicable diagnosis codes should be included on the claim: Z39.1, Z39.2, Z34.9, P92.1, P92.2, P92.5, P92.8, P92.9, R63.3, R63.30, O92.5, O92.4, O92.13, or O92.70 to indicate the type of the lactation consultation service provided. Lactation consultation services will not require prior approval, but provider referral is recommended.

938. Total Obstetrical Care

938.1. 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.

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

938.3. When a C-section is performed and the attending is not part of a 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.

938.4. 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 met, contact Gainwell Technology for pre-certification.

938.5. 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.

938.6. 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.

938.7. 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.

938.8. If during delivery, the attending physician 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 Gainwell Technology.

938.9. 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.

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

938.11. Total obstetrical care cannot be billed for a delivery of less than 20 weeks gestation (by dates or ultrasound). Procedure code 59025 (non-fetal stress test) cannot be billed for members with a gestation period of less than 34 weeks. A physician may bill one fetal non-stress test in 24 hours for members that are at or past 34 weeks gestation. If the member is on continuous monitoring, only an initial non-fetal stress test should be required. In a rare instance where more than one non-fetal stress test would be required, while the member is on continuous monitoring, there must be clearly documented evidence of medical necessity.

939. Partial Obstetrical Care Due to Member Eligibility

939.1. If a member becomes eligible for Medicaid because 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 by ultrasound) cannot be billed as a delivery.

940. Partial Obstetrical Care Due to Involvement of More Than One Physician during Pregnancy

940.1. If a physician 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.

940.1.1. Four to six antepartum care visits that do not include the delivery should be billed using procedure code 59425.

940.1.2. Seven or more antepartum care visits that do not include delivery should be billed using procedure code 59426.

940.1.3. E/M codes for antepartum services cannot exceed 3 visits.

941. Ultrasound and Amniocentesis

941.1. The eleven medically necessary obstetric ultrasounds shall be allowed per pregnancy. This includes obstetric ultrasounds performed by all providers regardless of place of service. Obstetrical providers shall utilize the following four OB ultrasound procedure codes. (Rev Jan 2018, Sept 10)

941.2. Prior authorization is required after the service has been rendered regardless of the member age or place of service. Reimbursement is limited to services rendered that are medically necessary.

941.2.1. 76801 OB US < 14 weeks single fetus

941.2.2. 76802 OB US < 14 weeks additional fetus

941.2.3. 76805 OB US > / = 14 weeks single fetus

941.2.4. 76810 OB US > / = 14 weeks additional fetus

941.2.5. 76811 OB US detailed single fetus

941.2.6. 76812 OB US detailed additional fetus

941.2.7. 76813 OB US nuchal meas 1 gest

941.2.8. 76814 OB US nuchal meas add on

941.2.9. 76815 OB US limited fetus(s)

941.2.10. 76816 OB US follow up per fetus

941.2.11. 76817 Transvaginal OB US

941.2.12. Out-of-State Deliveries

941.3. First Trimester Incentive Pay

941.3.1. The Division provides incentive pay if the provider begins routine antepartum care during the first trimester of pregnancy (on or before 14 weeks gestation) and continues to provide normal prenatal care through the entire antepartum, delivery, and postpartum period.

941.3.2. Voluntary HIV counseling and testing must be offered or provided. Documentation must be included in the medical records. See Appendix S for Provider's Guide to HIV Pre-test and Post-test Counseling. Failure to document may result in recoupment of the entire incentive payment.

941.3.3. To bill for this incentive 22 modifier should be added to either code 59400 Total Obstetrical Care - Vaginal Delivery; 59510 - Total Obstetrical Care - Cesarean delivery; 59610 - Total Obstetrical Care Vaginal Delivery After Previous C-Section; or 59618 - Total Obstetrical Care, C-Section Delivery After Previous C-Sections; as appropriate. Please note that these codes are mutually exclusive and only one can be billed per pregnancy.

941.4. Early Elective Deliveries

941.4.1. Effective October 1, 2013, 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.

941.4.2. Hospital UB 04 Claims

941.4.3. 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 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.

941.4.4. Professional 1500 Claims

941.4.5. 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 modifiers 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, Alliant Health Solutions (AHS). Clinical justification and the proper documentation must be submitted to Alliant Health Solutions 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.

941.4.6. Delivery Modifiers for Professional 1500 Claims

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

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

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

941.4.8.2. 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

941.4.8.3. 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 Health Solutions the clinical justification and documentation for review along with the Patient Safety Checklist.

941.4.9. UC—Delivery at 39 weeks of gestation or later

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

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

941.4.10.1. 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.

941.4.11. Documentation Requirements

941.4.11.1. 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 (refer to links in references) for some approved exceptions of medical conditions for deliveries prior to 39 weeks. The list of conditions is not meant to be exclusive.

Reference

http://www.acog.org/~/media/Patient%20Safety%20Checklists/psc005.pdf?dmc=1&ts=20130911T1426455280 (Scheduling Induction of Labor Checklist)

http://www.acog.org/~/media/Patient%20Safety%20Checklists/psc003.pdf?dmc=1&ts=20130911T1426455290 (Scheduling Planned Cesarean Delivery Checklist)

https://manual.jointcommission.org/releases/TJC2013A/AppendixATJC.html#Table_Number_11_07_Conditions_Po (Joint Commission Conditions) exclusive.

942. Tobacco Cessation Services for Medicaid Eligible Members

942.1. Effective 1 January 2014, the Division began coverage of tobacco cessation services to all Medicaid members. Medicaid enrolled providers may bill for this service in addition to billing the appropriate Evaluation and Management (E/M) office visit along with CPT codes 99406 or 99407 only. Procedure codes 99406 and 99407 are to be rendered in a face–to-face setting with the member. (Rev Apr 2011)

942.2. Only two 12-week tobacco cessation treatment period will be allowed per member per year. A face-to-face counseling session is required for this service and must be documented in the member's medical record every 30 days during the 12-week treatment period.

942.3. Pharmacotherapy medication is also covered. Please refer to the Pharmacy Services Manual for detailed information on the covered medications and prior authorization procedure.

943. Office or Other Outpatient E/M Services

943.1. 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:

943.1.1. 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, section 804 for prior approval procedures.) Claims for emergency office E/M services must be clearly marked "EMERGENCY" and describe the emergent condition. Office records or notes must be submitted with all claims marked "EMERGENCY" to support medical necessity. All emergency claims must be submitted to:

Prior Authorization & Pre-Certification
Alliant Health Solutions
www.mmis.georgia.gov
(800) 766-4456 (Toll Free)

943.1.2. Please see the Family Planning Manual for Reimbursement of Family Planning E/M services.

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

943.1.4. Office E/M services rendered after hours are billable using After Hours codes 99050 and 99051 as Add On codes to Evaluation and Management (E/M) codes 99211–99215 and 99201–99205.

943.1.5. 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 the medical necessity of obtaining services out of state and providing the name and address of the out-of-state medical provider. Out-of-state providers should submit medical documentation including a care plan and notification of discharge for evaluation of care to the Division's medical peer review contractor, Alliant Health Solutions.

Reimbursement and coverage of out-of-state services is determined in accordance with the Division's current policies and procedures and are contingent on the patient's eligibility at the time services are rendered.

Reimbursement shall be limited to the lesser of the Medicaid reimbursement amount for the state where the service was rendered, or 45% of the billed charges, or the current reimbursement for Georgia Medicaid enrolled physicians, as cited in Section 1001—Reimbursement Methodology.

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:

Prior Authorization & Pre-Certification
Alliant Health Solutions
www.mmis.georgia.gov
(800) 766-4456 (Toll Free)

944. Out-of-State Services- Non-Enrolled Providers

The Division will pay for medical services for members rendered out of state if the claim is received within twelve months from the month of service and if one or more of the following conditions are met:

944.1. The service was prior authorized by the Division,

944.2. The service was provided because of an emergency or life-endangering situation (If the out-of-state provider the medical record must supports the existence of an emergency, but the diagnosis does not justify an emergency, the claim must be submitted with a copy of the medical records.), or,

944.3. The service was rendered 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.

Members should be transferred to another in-state Georgia facility before transferring the member out-of-state for emergent care. The medical record should document why the member was not transferred to another Georgia facility.

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. The out-of-state provider is required to submit medical documentation to include a care plan and notification of discharge for evaluation of care to the Division's medical peer review contractor, Alliant Health Solutions. (Rev Jan 2010/Oct 2014)

For elective out-of-state prior approvals, a letter of financial agreement should be attached along with the letter of medical necessity. The financial letter of agreement should be submitted from the out-of- state provider notifying Georgia Medicaid that financial responsibility has been determined for the out-of-state services being requested.

Reimbursement and coverage of out-of-state services is determined in accordance with the lesser of the following:

944.4. Medicaid reimbursement amount for the state where the service was rendered, or

944.5. 45% of the billed charges, or

944.6. The current reimbursement for Georgia Medicaid enrolled physicians, as cited in Section 1001—Reimbursement Methodology.

944.7. The out All services rendered to members out of state by providers not properly enrolled will be subject to prepayment review.

944.8. Requests for prior approval or questions regarding out-of-state services must be directed to out-of-state providers who cannot obtain a prior authorization request.

Out Out-of-State Processing
Gainwell Technology/ Alliant Health Solutions Processing – Out of State PA Requests
P.O. Box 105208
Atlanta, Georgia 30348
1-800-766-4456 (Toll free) Customer Service
Alliant Health Solutions fax line: 678-527-3003 (local)
Alliant Health Solutions fax line: 1-877-393-8226 (toll free)

944.9. Out-of-state claims submitted for reimbursement must have a copy of the authorization letter attached if services were prior authorized or medical justification if the services were due to an emergency or life-endangering situation.

944.10. Georgia Medicaid does not cover services provided in foreign countries. Rev Aug 2022

945. Psychiatric Services

945.1. Refer to the Psychology Manual for additional information for services to children under the age of 21 years of age. Rev Jan 2013/Oct 2014

945.2. When billing for psychiatric services, the medical record must indicate the presence or signs of mental illness for which psychological testing is indicated as an aid in diagnosis and therapeutic planning. The medical record must show the test performed, scoring, and interpretation and the time involved. Rev Oct 2018/Jan 2019

945.2.1. Covered Services

945.2.1.1. Effective January 1,2019, Georgia Medicaid has expanded its list of Psychological/Neuropsychological services, which are limited to those services personally provided by the enrolled physician. Adaptive Behavior Assessments and Psychological/Neuropsychological Testing services that span more than eight hours per member per calendar year. Only one hour per date of service can be billed. Services more than this limitation must provide documentation.

945.2.1.2. Limitations as documented in the Psychology Manual apply regardless of previous physician treatment. Physicians should coordinate all aspects of care. Individual psychotherapy codes should only be used when treatment involves individual psychotherapy. These codes should not be used as generic psychiatric service codes when other codes (e.g., Evaluation and Management codes) would be more appropriate.

945.2.1.3. Adaptive Behavior Assessments and Psychological/Neuropsychological services are allowable only for members receiving psychology and psychiatry, counseling and therapy services, the member's medical record must indicate the presence or signs of mental illness for which psychological testing is indicated as an aid in diagnosis and therapeutic planning.

945.2.1.4. In order, for the provider to receive reimbursement for Adaptive Behavior Assessments and Psychological/Neuropsychological Testing services, providers must report the following codes:

96105: Assessment of Aphasia

96125: Cognitive testing

96112: Developmental test administration

96113: Developmental test administration (each additional 30 minutes)

96116: Neurobehavioral status examination

96121: Neurobehavioral status examination (each additional 1 hour)

96130: Psychological testing evaluation

96131: Psychological testing evaluation (each additional 1 hour)

96132: Neuropsychological testing evaluation

96133: Neuropsychological testing evaluation (each additional 1 hour)

96136: Psychological or neuropsychological test administration

96137: Psychological or neuropsychological test administration (each additional 30 minutes)

96138: Psychological or neuropsychological test administration, two or more tests.

96139: Psychological or neuropsychological test administration, two or more tests (each additional 30 minutes)

96146: Psychological or neuropsychological automated testing

97151: Behavior identification assessment

97152: Behavior identification – supporting assessment

97153: Adaptive behavior treatment by protocol

97154: Group adaptive behavior treatment

97155: Adaptive behavior treatment with protocol modification

97156: Family adaptive behavior treatment guidance

97157: Multiple family group adaptive behavior treatment guidance

97158: Group adaptive behavior treatment with protocol modification

90791: Psychiatric diagnostic evaluation
Maximum of 1 per member per 3 calendar years.

90792: Psychiatric diagnostic evaluation with medical services
Maximum of 24 units within one calendar year.

90870: Electroconvulsive therapy (includes necessary monitoring) 1 per day.

945.3. Documentation Requirements

Documentation of the patient's capacity to participate in and to benefit from the therapy must be kept. The type of treatment must be documented in the patient medical records for each service rendered.

945.3.1. An explanation of why the rendered therapy is the appropriate treatment must be documented. Rev Apr 2010

945.3.2. The estimated duration of treatment, in terms of number of sessions be specified. Rev Sept 2010/Oct 2012

945.3.3. For an acute problem, documentation must be included in the medical record that the treatment is expected to improve the health status or functioning of the patient.

945.3.4. For chronic problems, documentation must be included in the medical record indicating that stabilization or maintenance of health status or function is expected.

945.3.5. The medical record should document the target symptoms, the goals of therapy, and the methods of monitoring outcomes

945.4. Limitations

945.4.1. Reimbursement for psychotherapy (90847 and 90853) is limited to a maximum of twelve hours per member per calendar year. Only one hour per date of service can be billed. Services in excess of this limitation may be available through local community mental health programs.

945.4.2. Reimbursement for electroconvulsive therapy is limited to twelve treatments per member per calendar year.

945.4.3. Reimbursement for family therapy service (90847) is limited to one Medicaid ID number, regardless of the number of covered family members participating in the family therapy session.

945.4.4. If medical rounds are made and no psychotherapy is performed, the psychiatrist may bill the most appropriate evaluation and management code.

945.4.5. Psychiatrists are limited to the supervision of no more than three qualified salaried employees.

945.5. Non-Covered Services

945.5.1. No reimbursement will be made for any type of psychiatric, psychological, family therapy and group therapy services provided by other health care professionals, including but not limited to medical social workers, psychiatric nurses, physician assistants, or other physician extenders.

945.5.2. No reimbursement will be made for any type of psychiatric services provided to patients enrolled in the Therapeutic Residential Treatment program (see section 601.14 for additional information). See section 905 for additional information on non-covered service.

946. 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:

946.1. Professional Component: (26 modifier)

Radiology services should be billed as professional component when:

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

946.1.2. The service is provided in a hospital; or

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

946.2. Technical Component: (TC modifier)

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

946.3. Radiology Component (FX modifier)

946.4. Complete Procedure

946.4.1. To bill for complete radiological procedures, which include charges for 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.

946.4.2. The physician may bill for complete procedure when one of the conditions outlined in Section 601.5 is met.

946.4.3. 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. 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 modifiers 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 all-inclusive charge for the procedure will be reimbursed at the lower of 100% of the allowed amount or the submitted charge.

946.5. Computerized Tomography - (CAT SCANS)

946.5.1. The Division reimburses for medically necessary CAT scans.

946.6. Low Osmolar Contrast Media

Payment will be made for medically necessary low osmola (non-trast material (LOCM) used in conjunction with intrathecal, intra-arterial, and intravenous radiological procedures when provided for non-hospital patients. The physician's medical records must support the medical necessity of low osmolar contrast material.

946.6.1. The following procedure codes must be used when billing for Low Osmolar Contrast Media:

946.6.1.1. Q9960 High Osmolar Contrast Material, 200-249 mg/ml Iodine Concentrate, per ml (replacement for A4645)

946.6.1.2. Q9961 High Osmolar Contrast Material, 250-299 mg/ml, Iodine Contrast, per ml (replacement for A4645).

946.6.1.3. Q9962 High Osmolar Contrast Material, 300-349 mg/ml, Iodine Concentration, per ml (replacement for A4646).

946.6.1.4. Q9963 High Osmolar Contrast Material, 350-399 mg/ml, Iodine Contrast Material Concentration, per ml (replacement for A4646).

946.6.1.5. Q9965 Low Osmolar Contrast Material, 100-199 MG/ML Iodine Concentration, per ML (replaces Q9946

946.7. Magnetic Resonance Imaging (MRI)

946.7.1. Medically necessary MRI is covered by the Division 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.

946.7.2. CT scans or MRIs that do not require contrast, or are of a lower acuity,

may be done under the general supervision of the physician. CT scans and MRIs that require contrast, or are at an increased level of acuity, must be performed under the direct supervision of the physician.

946.8. Portable X-ray and CT scan

946.8.1. Effective July 1, 2017, the Department of Community Health enacted a new policy for medically necessary portable radiological and CT scan services to GA Medicaid eligible members who are unable to travel to radiological facilities. These services are only considered for payment when they are medically necessary and ordered by the member's physician.

946.8.2. The portable radiologic services will serve GA Medicaid members receiving home community-based services, skilled nursing facility services, home health, hospice services (POS 31,32 or 33) and eligible member's home (POS 12,13). The portable x-ray and CT scan services are only considered for payment when they are medically necessary and ordered by the member's primary care physician.

946.8.3. Transportation of portable x-ray equipment is reimbursable only when the equipment used is transported to the location where portable x-ray and CT scan services are provided. GA Medicaid will not reimburse for the transportation of the portable x-ray equipment when the x-ray equipment is stored at a facility for use as needed.

946.8.4. GA Medicaid will only pay for single transportation payments per trip to a facility or location for a single date of service. Therefore, providers should make every effort to schedule all members at a single location during a single trip to that location. If more than one member at the same location is x-rayed, the portable X-ray transportation fee is allocated among the members who receive portable X-ray services in a single trip.

946.8.5. GA Medicaid reimburses procedure code R0075 (Transportation of portable X-ray equipment), per trip to facility or location for portable X-ray providers, more than one member seen. The Division also reimburses procedure code R0070 (Transportation of portable X-ray equipment), per trip to facility or location, one member seen.

946.8.6. When submitting a claim for procedure code R0075, the provider is required to use a modifier to indicate the total number of Medicaid members served at the location. The provider is required to submit a separate claim for each Medicaid member. A claim with procedure code R0075 will be denied if it is submitted without an appropriate modifier. Each claim for a single location and date of service must indicate the same x-ray transportation procedure code and modifier for all members seen during that visit.

946.8.6.1. R0070 Portable x-ray equipment and personnel to the member's home or nursing home, per trip to a facility or other location.

946.8.6.2. R0075 Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one member seen, per trip to facility or location. The following modifiers are to be billed with R0075:

Modifiers:
(no modifier if one patient served)
UN - Two patients served
UP - Three patients served
UQ - Four patients served
UR - Five Patients served
US - Six or more patients served

946.8.7. The physician order must be written and ordered by the member's primary care physician before any portable x-rays and /or CT scan services are provided. The claim for reimbursement must indicate the name of the physician who ordered the service before payment may be made. The submitted claim with place of service in a facility, facility and provider National Provider Identifier (NPI) is required.

946.8.8. Portable X-ray services may be provided to a member in his or her place of residence. The member's place of residence is defined by the Division of Medicaid as the member's own dwelling, a residential care facility or nursing facility. Portable X-ray services are not covered in hospital settings.

NOTE: GA Medicaid will only pay for a single transportation payment per trip to a facility or location for a single date of service. Therefore, providers should make every effort to schedule all members at a single location during a single trip to that location.

946.8.9. All providers, including their staff, contracted staff and volunteers must comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements.

946.8.10. The portable x-ray provider is responsible for determining that a member is Medicaid eligible on the date of service.

946.8.11. Portable x-ray providers must keep the following records for each member for a period of at least 7 years:

946.8.11.1. A copy of the written, signed and dated order by the member's physician.

946.8.11.2. The date of the x-ray examination

946.8.11.3. The name of the physician who performed the professional interpretation of the procedure

946.8.11.4. The date the radiograph was sent to the physician

946.8.12. Portable x-ray providers will not be reimbursed for the following services:

946.8.12.1. Procedures involving fluoroscopy.

946.8.12.2. Procedures involving the use of contrast media

946.8.12.3. Procedures requiring the administration of a substance to the member the injection of a substance, or the spinal manipulation of the member

946.8.12.4. Procedures requiring special technical competency and/or special equipment or materials

946.8.12.5. Routine screening procedures such as annual physicals

946.8.12.6. Procedures which are not of a diagnostic nature, e.g., therapeutic x-ray treatments

946.8.12.7. Set-up component (Level II HCPCS code Q0092) non-covered

946.8.12.8. Portable X-ray services are not covered in hospital settings

946.8.12.9. Annual x-rays

946.9. Fee Schedule

Information regarding the Fee Schedule to be used for Portable X-rays and CT scan can be obtained on www.mmis.georgia.gov following the links under "Provider Manual", "Provider Information", and "Fee Schedules."

946.10. Mammography

946.10.1. All mammograms must be performed at a state certified facility and the results must be interpreted by a physician certified by the American Board of Radiology, or the American Osteopathic Board of Radiology, or certified as qualified to interpret the results of mammograms as determined by the Secretary of Health and Human Services. The Division does not reimburse mobile or portable x-ray mammography units at-home or on site.

Contact the office below with questions on obtaining certification.

Office of Regulatory Services
Health Care Services
Georgia Department of Community Health
2 Martin Luther King Jr. Drive SE, East Tower

Atlanta, Georgia 30334
(404) 657-5407

946.10.2. The Division must have an update and valid copy of your certification. Please fax new certification to Gainwell Technology at 1-866-483-1044 or 1-866-483-1045 or forward to: Rev Jul 2009

Prior Authorization & Pre-Certification
Alliant Health Solutions
(800) 766-4456 (Toll Free)
www.mmis.georgia.gov

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

947. Reduced Services (52 Modifier)

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

948. Site of Service Differential

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

949. Supplies and Materials

949.1. Office medical supplies, except for drugs and certain supplies associated with performing the procedures shall be considered practice expenses which are included in the payment for the service to which they are incidental. No additional reimbursement will be made. Rev Apr 2011

950. Surgery

950.1. Foot care for members twenty-one years of age and older is limited to essential care, including but not restricted to, treatment for trauma or complications related to a chronic disease, such as diabetes.

950.2. Elective surgeries for members twenty-one years of age and older for correction of conditions that have little or no substantial effect on the health status of the individual are not covered. Decisions on the urgent status of these conditions will be made by the Division's medical peer review contractor.

950.3. Reimbursement for surgical procedures is based on the global fee where a single fee is billed, and reimbursement includes all necessary services normally furnished by the surgeon before, during, and after the procedure. Four modifiers (24, 25, 78, and 79) identify a service or procedure furnished during a global period that is not normally a part of the global fee.

950.3.1. Major Surgery

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

950.3.1.2. 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 prior or the day the decision for surgery is made. Modifier 57 cannot be used with minor surgeries.

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

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

950.3.1.5. A standard 90-day post-operative period includes all services rendered by the surgeon during this period, unless the service is for a problem unrelated to the diagnosis for which the surgery was performed, or, is for an added course of treatment other than normal recovery from the surgery. (See also description of CPT modifiers 24 and 79.) Immunosuppressive therapy following transplant surgery is not included in the global fee and will be paid separately. The global fee includes 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.

950.4. 90-Day Post-Operative Period, (major procedures)

950.4.1. One day pre-operative included

950.4.2. Day of the procedure is generally not payable as a separate service

950.4.3. Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery.

950.5. Procedures with a 90-day post-operative follow-up period which are incident to major global surgery policy are listed at CMS Cahaba, located at www.cahabagba.com. Rev Oct 2014

950.5.1. Minor Surgery and Non-incisional Procedures

950.5.1.1. 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 identifiable service is furnished (see also description of CPT modifier 25). For example, a visit could properly be billed in addition to payment for suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit is not appropriate if the evaluation consists solely of identifying the need for sutures and or confirming allergy and immunization status.

950.5.1.2. There is no post-operative period for endoscopic procedures performed through an existing body orifice. Procedures requiring an incision for insertion of a scope (e.g., a laparoscopic cholecystectomy) will be subject to either the major or minor surgical policy, whichever is appropriate. (Rev. 07/2016)

950.5.1.3. Minor surgeries have post-operative periods of 0 days or of 10 days. Reimbursement for surgeries within a 10-day post-operative period includes all post-operative services related to recovery from the surgery. Services rendered during the 10-day recovery period for treatment of the underlying condition will be paid for separately (see also description of CPT modifier 24). Minor surgeries with

a10-day post-operative period are listed in the current "CMS Cahaba Register."

950.6. Zero Day Post-Operative Period (endoscopies and some minor procedures).

950.6.1. No pre-operative period

950.6.2. No post-operative days

950.6.3. Visit on day of procedure is generally not payable as a separate service

950.7. 10-Day Post-Operative Period, (other minor procedures).

950.7.1. No pre-operative period

950.7.2. Visit on day of the procedure is generally not payable as a separate service

950.7.3. The total global period is 11 days. Count the day of the surgery and 10 days following the day of the surgery.

950.8. Bilateral Procedures (Modifier 50)

950.8.1. 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 lessor of 50% of the allowed amount, or at 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 an all-inclusive procedure code for a bilateral procedure exists, the all-inclusive charge for the procedure will be reimbursed.

950.9. Multiple Procedures

950.9.1. If multiple surgical procedures add significant time or complexity to the surgery during the same operative session, each clearly identified and defined procedure shall be reimbursed according to the following:

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

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

950.9.1.3. The subsequent procedures: the lesser of 25% of the maximum allowed amount or of the submitted charge.

Each individual surgical procedure for which reimbursement is being requested must be identified on separate lines on the claim form with an

associated charge for each procedure. For the reimbursement methodology to be accurately applied, separate procedures must be arranged in order from major to minor on the CMS 1500 claim form, on field 24.

950.10. Incidental Procedures

950.10.1. Additional charges for incidental procedures performed while other services are rendered are not covered unless substantiated by medical documentation. Examples of such incidental procedures 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. Evaluation and Management codes billed with minor procedure codes require medical documentation.

950.11. Surgical Team

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

950.12. Co-Surgeons - (Modifier 62)

950.12.1. Co-surgeons will be reimbursed one-half of 125% of the global fee. No payment will be made for an assistant-at-surgery.

950.13. Surgical Assistant - (Modifier 80)

950.13.1. 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 reimbursed for non-critical surgical procedures including but not limited to routine appendectomy, herniorrhaphy, or sterilization.

Reimbursement will not be made for an assistant-at-surgery when:

950.13.1.1. The specified surgery does not meet the guidelines for use of an assistant,

950.13.1.2. A resident was available to assist, or

950.13.1.3. An assistant at surgery was not medically necessary.

950.13.2. Claims for appropriate assistant surgeon charges must be billed by the enrolled physician who is performing at the surgery. The “type of service” code “8” - “Assistant at Surgery” must be placed on the claim form and the “80” modifier must be added to the procedure code.

950.13.3. The Division provides reimbursement for an assistant surgeon (modifier 80) according to guidelines set forth by the American College of

Surgeons. The procedure codes billed must be the same as procedures codes billed by the primary surgeon.

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

950.14. Surgery and Follow up Care Provided by Different Physicians (Modifier 54 and 55)

950.14.1. The total amount of all reimbursements for all practitioners who render parts of the services included in a global fee (and who bill using one of the modifiers 54 and 55) shall not exceed the total amount of the reimbursement that would have been paid to a single practitioner under the global fee for the procedure. Each physician will be paid directly for the portion of the global surgery services rendered, providing all parties utilize the appropriate modifiers. The surgeon renders the usual and necessary pre- and intra-operative services, and, with a few exceptions, the in-hospital post-operative services. When the surgeon transfers the outpatient recovery care to another health care provider, reimbursement will be adjusted in accordance with the weighted percentages for post-operative care as published in the November 25, 1991, Federal Register.

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

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

950.15. Ambulatory Surgical Center Services

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

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

951. Telemedicine Consultation

See Appendix R and Telemedicine for additional information

952. Therapy Services

Therapy services provided to members over the age of 21 are not covered under the Physician Services program. If the therapy services are part of the member's inpatient admission under precertification requirements and are determined to be medically necessary, the therapy service may be covered under the Hospital Services program (e.g., therapy services after a mastectomy, physical therapy, occupational therapy, and speech therapy). Please refer to the Children's Intervention Services (CIS) manual for therapy services for members under 21 years of age

953. Children's Intervention Services

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

954. Transplant Services

Covered transplant services, including organ harvesting, may be billed to the Division if the individual receiving the transplant is eligible for Georgia Medicaid and is not eligible for Medicare services. For kidney transplant services, a copy of the Medicare letter denying the Georgia Medicaid member enrollment in the Medicare program must be submitted with the claim. Claims for members eligible to enroll in Medicare for kidney transplant services will not be reimbursed. For further information on transplant services, contact Gainwell Technology at 1-800-942-4623.

955. Vaccines for Children Program (VFC)

Effective 1 October 1994, vaccines given to Medicaid eligible children will be covered only in accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). Certain immunization drugs for members 19-21 years of age are covered under the Physician Services Program. For further clarification regarding specific CPT immunization codes covered under the Health Check program, in conjunction with Vaccines for Children (VFC), refer to the Health Check Services Manual Appendix E, and the Physician Services Manual, Appendix B and B1.

955.1. Administration:

955.1.1. Reimbursement for immunization drugs supplied by VFC and administered to children ages birth to 18 years of age, under the Health Check Program is not covered. Reimbursement is limited to the

administration of the vaccine only.

956. Vision Care Service

Refractive services are available to members under the age of twenty-one. All refractive services must be billed on the CMS 1500 claim form and in compliance with the Policies and Procedures for Vision Care Services. Ophthalmologists who render refractive services must enroll in both the Physician Services and in Vision Care Services programs.

957. Durable Medical Equipment (DME)

In accordance with the Patient Protection and Affordable Care Act §6407, a face-to-face encounter with patients is required before physicians may certify eligibility for durable medical equipment (DME). Providers who are ordering, prescribing, or rendering, in any other manner supplying durable medical equipment, must comply with the Division's policy and documentation requirements for face-to-face encounters for initial and replacement durable medical equipment, supplies, and modifications. For additional information, refer to the Durable Medical Equipment manual.

958. Addiction Medicine

Effective October 1, 2019, The Department of Community Health, Division of Medicaid announces the expansion of Services to include Addiction Medicine to combat the opioid crisis in part by potentially reducing opioid abuse and misuse. The Addiction Medicine services aim to reduce opioid overdose misuse and abuse through prevention, counseling and behavioral therapies for the treatment of substance use disorders.
In order to receive reimbursement, the Addiction Medicine provider must have the following board certifications: American Board of Preventive Medicine (ABPM), subspecialty board certification in addiction psychiatry from the American Board of Psychiatry and Neurology (ABPN), board certification in addiction medicine from the American Board of Addiction Medicine (ABAM) or a certification of added Qualification in Addiction Medicine conferred by the American Osteopathic Association (AOA).

959. Service Restrictions

959.1. Sterilizations and Hysterectomies

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

959.1.2. Sterilizations The individual is at least twenty-one years old when consent for sterilization is obtained.

959.1.3. The individual is not mentally incompetent.

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

959.1.5. At least 30 days, not more than 180 days, have passed between the date

of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery, if the premature delivery occurs before 37 weeks of gestation per the ACOG guidelines, or emergency abdominal surgery if at least seventy-two hours have passed since informed consent for the sterilization was given. In the case of premature delivery, the informed consent must have been given at least thirty days before the expected date of delivery. The expected date of delivery must be provided on the DMA-69 form;

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

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

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

959.2. Hysterectomies

959.2.1. The hysterectomy must have been rendered for medical necessity, and not for the purpose of family planning, sterilization, hygiene, or mental retardation.

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

959.2.3. The individual and the attending physician sign the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" form DMA 276 (6/84) either before or after the surgery is performed (the individual is not required to sign in the cases of prior sterility or emergency hysterectomy); and

959.2.4. The properly executed "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" is attached to the claim form submitted to the Division.

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

960. Abortions

960.1. In accordance with federal regulations and a recent congressionally enacted revision 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.

960.2. A "Certification of Necessity for Abortion" (Form DMA-311) certifying the above 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. In compliance with 42 CFR 441.206, this documentation is required for "any expenditures for abortions or other medical procedures otherwise provided for under Sec. 441.203...," which will include associated services such as lab tests or ultrasound studies.

961. Supply of Forms

961.1. 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 at www.mmis.georgia.gov/portal. These forms are the only forms accepted by the Division for the reimbursement of sterilizations, hysterectomies, abortions, and prior approved medical services.

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

962. Colorectal Cancer Screening

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

962.1.1. Screening fecal-occult blood test,

962.1.2. Screening flexible sigmoidoscopy,

962.1.3. Screening colonoscopy for high-risk individuals and

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

962.2. The following HCPCS and CPT codes have been established for these services:

962.2.1. G0104 – Colorectal cancer screening; flexible sigmoidoscopy

962.2.2. G0105 – Colorectal cancer screening; colonoscopy on an individual at high risk. Rev Jan 2010

962.2.3. G0106 Colorectal cancer screening; barium enema as an alternative to G0104, screening sigmoidoscopy

962.2.4. G0120 – Colorectal cancer screening; as an alternative to G0105, screening colonoscopy

962.2.5. 82270 – Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple cards for consecutive collection)

962.3. Limitations:

962.3.1. Screening flexible sigmoidoscopies (G0104) are covered once every 48 months for members 50 years of age and older. If during this procedure a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed, not G0104. This screening must be performed by a Doctor of Medicine or osteopathy.

962.3.2. Screening colonoscopies (G0105) are covered at a frequency of every 24 months for members at high risk for colorectal cancer. If during this procedure a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed, not G0105. A Doctor of Medicine or osteopathy must perform this screening.

962.3.3. High risk for colorectal cancer means an individual has one or more of the following:

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

962.3.3.2. A family history of familial adenomatous polyposis;

962.3.3.3. A family history of hereditary non polyposis colorectal cancer;

962.3.3.4. A personal history of adenomatous polyps;

962.3.3.5. A personal history of colorectal cancer; or

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

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

sigmoidoscopy and colonoscopy applies.

962.3.5. Screening fecal-occult blood test is covered once every 12 months for members 50 years of age and older.

963. Non-Covered Services

963.1. The services and procedures listed below are not covered by the Division under the Physician Program. This list is representative of services and procedures that are not covered, and is not meant to be exhaustive:

963.1.1. Therapeutic injections except those contained in the Physicians Injectable Drug List.

963.1.2. Acupuncture.

963.1.3. Biofeedback, hypnotherapy, sleep therapy, and all services listed in the CPT under “Other Psychiatric Therapy”.

963.1.4. All procedures listed in the CPT or HCPCS description as “Unlisted” or “Unspecified” which end in “99”.

963.1.5. Services billed using non-covered CPT or HCPCS codes.

963.1.6. 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.

963.1.7. Routine lab and x ray services required on hospital admissions.

963.1.8. Biofeedback or hypnotherapy.

963.1.9. Services provided free of charge to Medicaid members by County Health Divisions or State Laboratories (e.g., metabolic screens for members under one year of age).

963.1.10. Investigational items and experimental services, drugs or procedures or those not recognized by the Federal Drug Administration, the United States Department of Health and Human Services, Medicare, and the Division’s medical peer review contractor as universally accepted treatment.

963.1.11. Services or procedures performed without regard to the policies contained in this Policy Manual.

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

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

963.1.14. Hospital visits if the hospital admission or length of stay is disallowed by the Hospital Utilization Review staff or the Division.

963.1.15. Services provided in a State-owned facility; drugs used in the physician's office or dispensed by the physician except those injectables authorized on the Physicians Injectable Drug List.

963.1.16. Tubal reanastomosis.

963.1.17. ESRD dialysis Services for Medicare-Only members.

963.1.18. Hospital admissions and daily visits for maintenance dialysis.

963.1.19. Office visits for maintenance dialysis; insertion or removal of catheters or shunt declotting for dialysis patients enrolled in the Dialysis Services Program.

963.1.20. Penile prosthesis.

963.1.21. Psychiatric Pharmacologic Management (CPT code 90862).

963.1.22. Infertility procedures and related services.

963.1.23. Hermography.

963.1.24. Substance Abuse Clinic Services.

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

963.1.26. Sensitivity training, encounter groups, or workshops.

963.1.27. Sexual competency training.

963.1.28. Education testing and diagnosis.

963.1.29. Marriage or guidance counseling.

963.1.30. Psychiatric services rendered through, by or in mobile units 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.

963.1.31. Interactive psychotherapy.

963.1.32. Psychiatric services are provided to patients in Therapeutic Residential Treatment programs.

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

963.1.34. Provider Preventable Conditions (PPCs), Never Events (NEs), and

Hospital Acquired Conditions (HACs). "If any physician is found to be involved in a HAC/Never Event adverse situation affecting an enrolled Medicaid member, all associated and billable charges will be recouped for the days involving the incident". (Refer to Appendix Y for details related to PPCs, NEs, and HACs).

To appeal non-covered medically necessary services, call 1-800-766-4456, or email a request via the Web Portal (www.mmis.georgia.gov), and select "Contact Us"

Chapter 1000: Basis For Reimbursement

1001. Reimbursement Methodology

The Division will pay the lower of the physician's lowest price regularly and routinely offered to any segment of the public for the same service or item on the same date of service, or 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 July 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 are limited to no more than 90% of the maximum allowable amount paid to a physician.

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

1002. This is not a fee schedule

As required in section 601.4 physicians must bill the lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date of service, or the lowest price charged to other third-party payers for the procedure code most closely reflecting the service rendered.

1003. Medicare Crossover Claims

Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual Division state that payments for Medicare coinsurance and deductible obligations are limited to the Medicaid maximum allowable payment. The Division will modify its claim payment system to apply this policy effective with payments made on and after October 1, 2000, as follows:

1004. Physician Services

1004.1. The Medicaid maximum allowable payment is the amount from the Division's Schedule of Maximum Allowable Payments for each applicable procedure code.

1004.2. The Medicare coinsurance and deductible amounts for a claim are compared to the sum of the Medicaid maximum allowable amounts for each procedure code minus the Medicare payment.

1004.3. The actual Medicaid payment will be the lower of the amounts in item 2, less applicable third-party liabilities and patient co-payments.

These changes would apply to services provided to all patients dually eligible for the Medicaid and Medicare programs, including Qualified Medicare Beneficiaries

1005. Contact Information

1005.1. Gainwell Technology
Member and Provider Correspondence
Gainwell Technology
P.O. Box 105200
Tucker, GA. 30085-5200
Fax: (866) 483-1045

1005.2. Provider Enrollment

Access on-line at www.MMIS.Georgia.gov

1005.3. Electronic Data Interchange (EDI)

1-800-987-6715

Asynchronous

Web Portal

Physical media

Network Data Mover (NDM)

Systems Network Architecture (SNA)

Transmission Control Protocol/

Internet Protocol (TCP/IP)

1005.4. Provider Inquiry Number:
1-800-766-4456

1005.5. The web contact address is:
http://www.mmis.georgia.gov

Appendix A

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.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Member ID #: 123456789012
Member: Joe Q Public
Card Issuance Date: 12/01/02

Primary Care Physician:
Dr. Jane Q Public
285 Main Street
Suite 2859
Atlanta, GA 30303
Phone: (123) 123-1234 X1234

Plan: Georgia Better Health Care

After Hours: (123) 123-1234 X1234

Verify Eligibility at www.mmis.georgia.gov

If member is enrolled in a managed care plan, contact that plan for specific claim filing and prior authorization information.

Payor: For Non-Managed Care Members
Customer Service: 1-800-766-4456 (Toll Free)

HP Enterprise Services
Member: Box 105200
Provider: Box 105201
Tucker, GA 30085
Prior Authorization:
1455 Lincoln Parkway, Suite 300
Atlanta, GA 30346

SXC, Inc
Rx BIN-001553
Rx PCN-GAM
SXC Rx Prior Auth
1-866-525-5827

Mail Drug Claims to:
SXC Health Solutions, Inc.
P.O. Box 3214
Lisle, IL 60532-8214
Rx Provider Help Line
1-866-525-5826

This card is for identification purposes only, and does not automatically guarantee eligibility for benefits and is non-transferable.

HP 75

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

B. **Emergency Medical Assistance (EMA) Eligibility**

Currently, immigrants, including undocumented immigrants, who would be eligible for Medicaid except for their immigrant status, are potentially eligible for Emergency Medical Assistance. This includes

persons who are aged, blind, disabled, pregnant women, children, or parents of dependent children who meet eligibility criteria. Services rendered to Emergency Medical Assistance (EMA) recipients are limited to emergency care only. As described in the Federal Regulations 1903 (v) of the Social Security Act and the Code of Federal Regulation 42 CFR 440.255 emergency services are those that are:

i. Medically necessary;

ii. Result from the sudden onset of a health condition with acute symptoms, and;

iii. In the absence of immediate medical attention, are reasonably likely to result in at least one of the following:

    1. Placing the individual's health in serious jeopardy:

    2. Serious impairment to bodily functions:

    3. Serious dysfunction of any bodily organ or part:

A physician must verify that the service has been rendered. The physician verifies emergency medical services by completing DMA Form 526, "Physician's Statement for Emergency Medical Assistance". The form must be submitted to the County Department of Family and Children Services or out stationed Medicaid Worker as part of the Medicaid eligibility determination.

Except for emergency labor and delivery services only (prenatal and postpartum care is not covered) all claims for services provided to members eligible under the Emergency Medical Assistance program will be reviewed by the Alliant Health Solutions on a case-by-case basis. Provider claims must be submitted with documentation that supports the emergent nature of the services provided.

Appendix B

Vaccines for Children Program

A. Immunization - Vaccines for Children (VFC) General

The new federal vaccine program will provide you with free vaccines to be used for all children under nineteen years old except those who have insurance, which covers immunizations. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) created the funding for this program called Vaccines for Children (VFC).

i. The Georgia VFC program will supply vaccines for the following:

1. Children enrolled in Medicaid or qualified through a Medicaid waiver
2. Children who do not have health insurance.
3. Children who are American Indian or Alaskan Native
4. Children who have health insurance, but vaccines are not a covered benefit; and
5. Children enrolled in Peach Care for kids.

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

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

B. Enrollment

Providers who give immunizations to Medicaid children must be enrolled in the VFC program. Providers who wish to enroll must complete the Provider Enrollment Form, the Provider Profile and the Vaccine Order Form and return to:

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

Providers in Group Practices need only complete one Enrollment Form. However, a copy of the license of

each provider must be attached to the Enrollment Form. A Provider Profile must be completed for each location (separate office, clinic, etc.) where immunizations are given.

Each individual provider must attach a copy of their license to the enrollment form. Questions regarding enrollment, vaccine orders and record keeping should be directed to the Georgia Immunization Program.

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

C. COVID-19 Vaccine Administration

All physicians, physician's assistants, nurse midwives and nurse practitioners that provide COVID-19 Vaccine Administrations and Monoclonal Antibodies must be enrolled Medicaid providers. For further clarification regarding COVID-19 vaccination and administration codes covered under the Physician Services program, in conjunction with Vaccines for Children (VFC), please refer to the Provider Administered Drug List (PADL) manual for vaccination pricing information.

Appendix B1

Vaccines Covered in the Physician and Advanced Nurse Practitioner Service Programs

CPT Code	Vaccines	Age Restriction	Diagnosis Restriction
90378	Palivizumab (Synagis) 50mg vial *Effective 10/2006, PA required prior to administering.*	Limited to newborns to age 3 years	Usage is limited to perinatal chronic respiratory disease and low birth weight
90585	Bacillus Calmette-Guerin (BCG) For tuberculosis, live, for percutaneous use	None	None
90586	Bacillus Calmette-Guerin (BCG) For bladder cancer, live, for intravesical use	None	None
90632	Hepatitis A Vaccine, adult dosage, for intramuscular use	Limited to age 21 and older	None
90633	Hepatitis A Vaccine, pediatric/adolescent dosage - 2 dose schedule, for intramuscular use	Limited to age 19 to 21 years	None
90634	Hepatitis A Vaccine, Pediatric/adolescent dosage-3 dose schedule, for intramuscular use	Limited to age 19 to 21 years	None
90636	Hepatitis A and Hepatitis B Vaccine (HepA-HepB), adult dosage, for intramuscular use	Limited to age 21 and older	None
90649	Human Papilloma Virus (HPV) Vaccine, Types 6, 11, 16, 18 (Quadrivalent), 3 dose schedule, for IM use [Gardasil]	Limited to age 9-21 years	None
90650	Human Papilloma Virus (HPV) Vaccine, Types 16, 18 Bivalent, 3 doses schedule, for intramuscular use [Cervarix]	Limited to age 21-26 years	None
90651	Human Papillomavirus Vaccine Types 6, 11, 16, 18, 31, 33, 45, 52, 58, Nonavalent (HPV), 3 dose schedule, for intramuscular use [Gardasil]	Limited to ages 21-45 years	None
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use	Limited to age 3 years and older	None
90675	Rabies vaccine, for intramuscular use	None	None
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use	Limited to age 19 to 21 years	None
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous	Limited to age 19	None

CPT Code	Vaccines	Age Restriction	Diagnosis Restriction
	use	to 21 years	
90714	TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED, PRESERVATIVE FREE, WHEN ADMINISTERED TO INDIVIDUALS 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	Limited to age 19 and older	None
90715	TETANUS, DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE (TDAP), WHEN ADMINISTERED TO INDIVIDUALS 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	Limited to 19 and older	None
90716	Varicella virus (Chicken Pox) vaccine, live, for subcutaneous use	None	None
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for subcutaneous or intramuscular use	Limited to age 50 to 99 years	None
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous or jet injection use	Limited to age 1 and older	None
90736	ZOSTER (SHINGLES) Vaccine, live, for SQ injection (Zostvac)	Over age 60	None
90746	Hepatitis B vaccine, adult dosage, for intramuscular use	Limited to age 21 to 999 years	None
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use	None	Usage is limited to renal failure and AIDS diagnoses
90748	*Hepatitis B & Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use*	*Limited to age 19 to 21 years*	*None*

Appendix C
Health Check and Adult Preventive Visit

The mission of the Department of Community Health (Department) goal is to improve the health outcomes of our enrolled Medicaid members by allowing them to establish a medical home and receive preventive health services.

A. Health Check

The Health Check program is Georgia Medicaid's well-child or preventive health care program for children birth to twenty-one (21) years of age. It is the early and periodic screening, (EPS) component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.
EPSDT is the result of a 1967 Amendment of Title XIX of the Social Security Act, which directed attention to the importance of preventive health services for children. The Medicaid manual for the Health Check program covers the screening (EPS) policies and procedures for well-child check- ups. The screening consists of a comprehensive unclothed physical examination, a comprehensive health and developmental history, developmental assessment, anticipatory guidance, measurements, age-appropriate vision and hearing tests, certain laboratory procedures and lead risk assessment. Providers must use the preventive visit codes (99381-99385, 99391-99395) for Medicaid-eligible and PeachCare for Kids® (PCK)-eligible children. All preventive visits must be coded with the EP modifier and appropriate diagnosis code.

NOTE: Please refer to the Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Health Check Manual for children birth to twenty-one (21) years of age for specific details.

B. Adult Preventive Visit

Effective January 1, 2016, the Department of Community Health will implement one adult preventive visit for members 21 years of age and older. The members will have access to one preventive health visit each calendar year (CY) and 10 office visits (Evaluation and Management codes 99201 - 99215) each CY. Additional office visits (above the 10 visits) will still be available based upon documentation and supporting medical necessity that must be sent to Alliant Health Solutions for review. Providers may bill ONE (1) preventive health visit (993XX) for a member annually (between January and December of the CY). Providers must use one of the following ICD-10 diagnosis codes when billing the preventive health visit code: Z00.00 or Z00.01 (Encounter for adult examination). Each member is allowed 10 office visits (992XX) per CY without prior authorization.

The following preventive procedure codes and services are available for reimbursement for adult preventive annual visit:

i. Adult preventive services provide reimbursement for following preventive health services:

1. 99385 or 99395 - (Adults 21 through 39 years of age).

2. 99386 or 99396 - (Adults 40 through 64 years of age)

3. 99387 or 99397 - (Adults 65 years and older)

Adult preventive services benefits include, but not limited to the following:

C. Immunization:

ii. Influenza vaccination *

ii. Pneumococcal vaccination*

iii. Tetanus Diphtheria (Td) *

iv. Zoster vaccination

v. Hepatitis A & B

vi. Measles, Mumps, Rubella (MMR) *

vii. Meningococcal

viii. Varicella *

ix. Human papillomavirus (HPV) for Women and Men *

D. Screening

i. Breast cancer screening *

ii. Testicular and Prostate screening *

iii. Cervical cancer screening *

iv. Colorectal cancer screening *

v. Cholesterol screening *

vi. Body Mass Index (BMI) *

vii. Diabetes

viii. Hearing Assessment

ix. Vision (Glaucoma)

x. Lipid Disorders

xi. Osteoporosis

xii. Smoking Cessation

* Adult Preventive HEDIS measures, as defined by National Committee for Quality Assurance (NCQA).

Appendix D
Prior Approval and/or Prepayment Review

Procedures and services listed in APPENDIX E require a PA regardless to age or place of service. Certain services may also be subject to pre-payment review.

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

The following list of procedure codes is not intended by exhaustive-due to the CPT code revisions occurring throughout the year. The list of procedure codes is not all inclusive. All procedures that fall into the general categories or family of code-listed in Section 801 must be prior approved.

A. Codes Requiring Prior Approval:

Category/Family	Procedure Codes	Description
Integumentary System Skin, Subcutaneous, and Accessory Structures Excision-Benign Lesions	11440	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5cm or less
	11441	excised diameter 0.6 to 1.0 cm
	11442	excised diameter 1.1 to 2.0 cm
	11443	excised diameter 2.1 to 3.0 cm
	11444	excised diameter 3.1 to 4.0 cm
	11446	excised diameter over 4.0 cm
	11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
	11921	6.1 to 20 sq cm
	11922	11922 each additional 20.0 sq. cm or part thereof (List separately in addition to code for primary procedure)
	11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
	11970	Replacement of tissue expander with permanent prosthesis
Repair (Closure) Other Procedures	15778	Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s)
	15781	Less than face (cheeks, chin, perioral area, forehead, or nose)
	15782	Regional, other than face
	15820	Blepharoplasty, lower eyelid;
	15821	With extensive herniated fat pad
	15822	Blepharoplasty, upper eyelids
	15823	With excessive skin weighting down lid
	15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
	15832	Thigh
	15833	Leg
	15834	Hip
	15835	Buttock
	15836	Arm
	15837	Forearm and hand
	15838	Submental fat pad
	15839	Other area

	15876	Suction assisted lipectomy; head and neck
	15877	Trunk
	15878	Upper extremity
	15879	Lower extremity
Destruction, Benign or Pre-malignant Lesions	17106	Destruction of cutaneous vascular proliferative lesions; less than 10 sq cm
	17107	10.0 to 50.0 sq cm
	17108	Over 50.0 sq cm
Breast Mastectomy Procedures	19300	Mastectomy of gynecomastia
Repair and/or Reconstruction**	19316	Mastopexy
	19318	Reduction mammaplasty
	19324	Mammaplasty, augmentation; without prosthetic implant
	19325	With prosthetic implant
****When requesting prior approval on the above specific procedures, photos must be forwarded with your request for prior approval.**		
	19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
	19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
	19350	Nipple/areola reconstruction
	19357	Breast reconstruction, immediate or delayed, with tissue expander including subsequent expansion
	19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant
	19364	Breast reconstruction with free flap
	19366	Breast reconstruction with other technique
	19367	Breast reconstruction with traverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
	19368	With microvascular anastomosis (supercharging)
	19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
	19380	Revision of reconstructed breast

Musculoskeletal System Head, Excision	21011	Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm
	21012	2 cm or greater
	21013	Excision, tumor, soft tissue of face and scalp, subfacial (eg, subgaleal, intramuscular); less than 2 cm
	21014	2 cm or greater
	21015	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm
	21016	2 cm or greater
Repair Revision, and/or Reconstruction	21150	Reconstruction midface, LeFortII; anterior intrusion
	21151	Any direction, requiring bone grafts
		21154 Reconstruction midface, LeFort III, any type, requiring bone grafts without LeFort I
	21155	With LeFort I
	21159	Reconstruction midface, LeFort III with forehead advancement, requiring bone grafts; without LeFort I
	21160	With LeFort I
	21172	Reconstruction superior-lateral orbital rims and lower forehead, advancement or alteration, with or without grafts
	21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration with or without grafts
	21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts
	21180	With autograft
	21181	Reconstruction by contouring of benign tumor of cranial bones, extra cranial
	21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone, with multiple autografts; total area of bone grafting less than 40 sq cm
	21183	total area of bone grafting greater than 40 sq cm but less than 80 sq cm
	21184	Total area of bone grafting greater than 80 sq cm
	21188	Reconstruction midface, osteotomies and bone grafts
	21193	Reconstruction osteotomy; without bone graft of mandibular rami, horizontal, vertical, C, or L
	21194	With bone graft (includes obtaining graft)

	21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
	21196	With internal rigid fixation
	21198	Osteotomy, mandible, segmental;
	21199	With genioglossus advancement
Neck (Soft Tissues) and Thorax – Repair, Revision, and/or Reconstruction	21740	Reconstructive repair of pectus excavatum or carinatum; open
	21742	Minimally invasive approach (Nuss procedure), without thoracoscopy
	21743	Minimally invasive approach (Nuss procedure), with thoracoscopy
Forearm and Wrist – Vertebroplasty and Vertebral Augmentation	22510	Injection of bone cement, middle spine
	22511	Injection of bone cement, lumbosacral
	22512	Injection of bone cement, middle or lower spine
	22513	Injection of bone cement, middle spine
	22514	Injection of bone cement, lumbar
	22515	Injection of bone cement, thoracic or lumbar
Arthrodesis	25830	Arthrodesis, distal radioulnar joint with segmental resection of ulna, with or without bone graft (e.g., Sauve-Kapandji procedure)
	For Leg (Tibia and Fibula) and Ankle Joint Arthrodesis	See CPT Codes 27685-27745
	22836	Anterior thoracic vertebral body tethering, including thoracoscopy, up to 7 vertebral segments
	22837	Anterior thoracic vertebral body tethering, including thoracoscopy, 8
	22838	or more vertebral segments
	22867	Revision, replacement, or removal of thoracic vertebral body tethering, including theoracoscopy when performed
	22869	Insertion of inter laminar stabilization device into lower spine with open decompression
	27278	Insertion of inter laminar stabilization device into lower spine at single level

	27870	Arthrodesis, sacroiliac joint
	27871	Arthrodesis, tibiofibular joint, proximal or distal
	28035	Decompression of Tibia Nerve
Foot and Toes - Excision	28130	Talectomy (astragalectomy)
	28140	Metatarsectomy
	28150	Phalangectomy, toe, each toe
	28153	Resection, condyle(s), distal end of phalanx, each toe
	28160	Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each
Repair, Revision, and/or Reconstruction	28234	Tenotomy, open, extensor, foot or toe, each tendon
	28238	Reconstruction (advancement) posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)
	28250	Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure)
	28260	Capsulotomy, midfoot; medial release only (separate procedure)
	28261	With tendon lengthening
	28262	Extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)
	28264	Capsulotomy, midtarsal (Heyman type procedure)
	28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, single, each joint (separate procedure)
	28272	Interphalangeal joint, each joint (separate procedure)
	28280	Syndactylization, toes (eg, webbing or Kelikian type procedure)
	28285	Correction, (eg, interphalangeal fusion, partial or total phalangectomy)
	28286	Correction, cock-up fifth toe, with plastic skin closure (eg, RuizMora type procedure)
	28290	Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg Silver type procedure)
	28291	Correction of ridged deformity of first joint or big toe using implant
	28292	Keller, McBride or Mayo type procedure
	28293	Resection of joint with implant

	28294	With tendon transplants (eg, Joplin type procedure)
	28295	Correction of bunion
	28296	with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)
	28297	Lapidus-type procedure
	28298	By phalanx osteotomy
	28299	By double osteotomy
	28300	Osteotomy, calcaneus (eg, Dwyer or Chamber type procedure), with or without internal fixation
	28302	Osteotomy; talus
	28304	Osteotomy, tarsal bones, other than calcaneus or talus;
	28305	With autograft (includes obtaining graft) (eg, Fowler type)
	28306	Osteotomy, with or without lengtheningmetatarsal, shortening or angular correction; metatarsal; first metatarsal
	28307	First metatarsal with autograft (other than first toe)
	28308	Other than first metatarsal
	28309	Multiple, (eg, Swanson type cavus foot procedure)
	28310	Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
	28295	Correction of bunion
	28296	with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)
	28297	Lapidus-type procedure
	28298	By phalanx osteotomy
	28299	By double osteotomy
	28312	Other phalanges, any toe
	28313	Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)
	28315	Sesamoidectomy, first toe (separate procedure)
	28320	Repair of nonunion or malunion; tarsal bones
	28322	Metatarsal, with or without bone graft (includes obtaining graft)
	28345	Syndactyly, with or without skin graft(s), each web
Arthrodesis	28705	Arthrodesis; pantalar
	28715	Triple
	28725	Subtalar
	28730	Arthrodesis, midtarsal or tarsometatarsal multiple or transverse
	28735	With osteotomy (eg, flatfoot correction)

	28737	Arthrodesis, with tendon lengthening and advancement, midtarsal navicular-cuneiform (eg, Miller type procedure)
	28740	Arthrodesis, midtarsal or tarsometatarsal, single joint
	28750	Arthrodesis, great toe; metatarsophalangeal joint
	28755	interphalangeal joint
	28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure) (For hammertoe operation or interphalangeal fusion, see 28285)
Respiratory System Nose -Excision	30130	Excision inferior turbinate, partial or complete, any method
	30140	Submucous resection inferior turbinate, partial or complete, any method
Repair	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	30410	Complete, external parts including bony pyramid, lateral and alar cartilages and/or elevation of nasal tip
	30420	Including major septal repair
	30430	Rhinoplasty, secondary; minor revision (small amount nasal tip work)
	30435	Intermediate revision (bony work with osteotomies)
	30450	Major revision (nasal tip work and osteotomies)
	30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
	30462	Tip, septum, osteotomies
	30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
	30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
Destruction	30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method, (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial
	30802	Intramural (i.e., submucosal)
	31295	Nasal/Sinus Endoscopy, Surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa

	31296	Nasal /sinus Endoscopy, Surgical; with dilation of frontal sinus ostium (eg, balloon dilation)
	31297	Nasal/sinus Endoscopy, Surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)
	31551	Repair or narrowed voice box with graft, younger than 12 years of age
	31552	Repair of narrowed voice box with graft, patient age 12 years or older
	31553	Repair of narrowed voice box with graft and placement of stent, younger than 12 years of age
	31554	Repair of narrow voice box with graft and placement of stent, patient age 12 years of age
	31572	Destruction of abnormality of one side of voice box using a flex endoscope
	31573	Injection of drug into one side of voice box using a flexible endoscope
	31574	Injection of substance to augment voice box using a flexible endoscope
	31967	Nasal /sinus endoscopy, surgical; with dilation of sinus ostium (eg, balloon dilation)
	32557	Insert Cath Pleura W/ Image
	32701	Sterotatic Radiation- Thoracic target delineation for SRS/SRBT
Cardiovascular System - Heart and Pericardium Transmyocardial Revascularization	33140	Transmyocardial laser revascularization, by thoracotomy; (separate procedure)
	37248	Ballon dilation of first vein, through the skin or open procedure
	33270	Insertion or replacement of defibrillator with electrode
	33340	Repair of left upper heart
	33390	Simple repair of aortic value by open procedure on heart lung machine
	33391	Complex repair of aortic value by open procedure on heart lung machine
	33741	Creation of shunt for blood flow
	33745	Creation of shunt for blood flow within heart for congenital heart defects, via catheter using imaging guidance
	33897	Percutaneous transluminal angioplasty of native or recurrent coarctation of the aorta
	33995	INSJ PERQ VAD R HRT VENOUS
	33997	RMVL PERQ RIGHT HEART VAD

Arteries and Veins	36473	Mechanicochemical destruction of insufficient vein of arm or leg
Ligation	37700	Ligation and division of long saphenous vein at saphemofemoral junction, or distal interruptions
	37718	Ligation, division, and stripping, short saphenous vein
		37722 Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
	37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia
	37246	Ballon dilation of artery, accessed through the skin, with imaging
	37760	Ligation of perforator veins, subfascial, radical (Linton type), including, when performed, open, 1 leg
	37761	Ligation of perforator vein(s), subfacial, open, including ultrasound guidance, when performed, 1 leg
	37765	Stab phlebectomy of varicose veins, 1 extremity, 10-20 stab incisions
	37766	More than 20 incisions
Hemic and Lymphatic Systems, General Bone Marrow or Stem Cell Services/Procedures	38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic
	38241	Autologous
	38243	Transplant or post transplantation Cellular Infusion HPC boost
Insertion of Central Venous Access Device	36555	Insertion of non-tunneled centrally inserted central venous catheter, younger than 5 years of age
	36556	Insertion of non-tunneled centrally inserted central venous catheter, age 5 years or older
Digestive System Stomach Laparoscopy	43284	Placement of augmentation device in sphincter of esophagus
	43285	Removal of augmentation device from sphincter of esophagus

	43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon
	43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)
	43497	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])
	43651	Laparoscopy, surgical; transection of vagus nerves, truncal
	43652	Transection of vagus nerves, selective or highly selective
Bariatric Surgery	43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components
	43771	Revision of adjustable gastric restrictive device component only
	43772	Removal of adjustable gastric restrictive device component only
	43773	Removal and replacement of adjustable gastric restrictive device component only
	43774	Removal of adjustable gastric restrictive device and subcutaneous port components
Other Procedures	43842	Gastoplasty, vertical-banded
	43843	Gastoplasty, other than vertical-banded
	43845	Partial gastrectomy, duodenoileostomy and ileoileostomy
	43846	Gastric bypass with Roux-en-Y gastro enterostomy
	43847	Gastric by-pass, short limb Roux-en-Y with small bowel reconstruction
	43848	Revision of gastric restrictive procedure for morbid obesity
	43886	Revise gastric port, open
	43887	Remove gastric post, open
	43888	Change gastric port, open
	46601	Diagnostic examination of anus
	46607	Biopsies of anus
Liver Transplantation	47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age
	47140	Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)
	47141	total left lobectomy (segments II, III, and IV)
	47142	total right lobectomy (segments V, VI, VII and VIII)
	47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age

Liver Disorders/Illnesses	End Stage Cirrhosis With Liver Failure	Due to primary biliary cirrhosis; chronic active hepatitis; secondary biliary cirrhosis; other disorders not likely to recur in the graft and which are not associated with serious coexisting system disease; and cause unknown
	Metabolic Diagnoses Involving the Liver	Alpha 1-antitrypsin deficiency; Protoporphyrin; Crigler-Najjar syndrome type I; Other metabolic disorders involving the liver for which no effective therapy exists and which are not associated with serious extrahepatic diseases.
	Miscellaneous Diagnoses	Hepatic vein thrombosis; Sclerosing cholangitis; Other disorders not listed above which are not associated with serious and irreversible extrahepatic disease, which produce life-threatening illness, for which no other effective therapy exists, and for which transplantation would be beneficial.
Laparoscopy	49321	Laparoscopy, surgical; with biopsy (single or multiple)
	49322	With aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)
	49323	With drainage of lymphocele to peritoneal cavity
	49324	drainage of lymphocele to peritoneal cavity
	49325	With revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed
	49591	Repair of anterior abdominal hernia(s) initial including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, reducible
	49592	Repair of anterior abdominal hernia(s) initial including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, incarcerated or strangulated
	49593	Repair of anterior abdominal hernia(s) initial including placement of mesh or other prosthesis, when performed total length of defect(s); 3 cm to 10 cm, reducible
	49594	Repair of anterior abdominal hernia(s) initial including placement of mesh or other prosthesis, when performed total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated
	49595	Repair of anterior abdominal hernia(s) initial including placement of mesh or other prosthesis,

	49596	Repair of anterior abdominal hernia(s) initial including placement of mesh or other prosthesis, when performed total length of defect(s); greater than 10 cm, incarcerated or strangulated
	49613	Repair of anterior abdominal hernia(s) recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, reducible
	49614	Repair of anterior abdominal hernia(s) recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, incarcerated or strangulated
	49615	Repair of anterior abdominal hernia(s) recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); 3 cm to 10 cm, reducible
	49616	Repair of anterior abdominal hernia(s) recurrent including placement of mesh or other prosthesis, when performed total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated
	49617	Repair of anterior abdominal hernia(s) recurrent including placement of mesh or other prosthesis, when performed total length of defect(s); greater than 10 cm, reducible
	49618	Repair of anterior abdominal hernia(s) recurrent including placement of mesh or other prosthesis, when performed total length of defect(s); greater than 10 cm, incarcerated or strangulated
	49621	Repair of parastomal hernia, any approach, initial or recurrent, including placement of mesh or other prosthesis when performed; reducible
	49622	Repair of parastomal hernia, any approach, initial or recurrent, including placement of mesh or other prosthesis when performed; incarcerated or strangulate.
	53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance.
	53452	Revision of prior hypospadias repair of ultimate complexity that requires work above that of a flap, patch, or graft but also including excision of previously constructed structures.

Male Genital System	54483	Replantation, penis, complete amputation including urethral repair
Prostate - Other Procedures	55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
	55876	Placement of interstitial device(s) for radiation therapy guidance(eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple.
Female Genital System - Vagina Repair	57291	Construction of artificial vagina; without graft
	57292	with graft
Corpus Uteri - Excision	58150	Total abdominal hysterectomy (corpus and cervix) with or without removal of tube(s), with or without removal of ovary(s)
	58152	With colpo-urethrocystopexy (Marshall-Marchetti-Krantz, Burch type)
	58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
	58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)
	58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)
	58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and urethral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof (For pelvic exenteration for lower urinary tract or male genital malignancy, use 51597)
	58260	Vaginal hysterectomy for uterus 250g or less;
	58262	With removal of tube(s), and/or ovary(s)
	58263	With removal of tube(s), and/or ovary(s), with repair of enterocele
	58270	With repair of enterocele
	58275	Vaginal hysterectomy, with total or partial vaginectomy

	58280	with repair of enterocele
	58285	Vaginal hysterectomy, radical (Schauta type operation)
Laparoscopy/Hysteroscopy	58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
	58552	With removal of tube(s) and/or ovary(s)
	58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
	58554	With removal of tube (s) and/or ovary (s)
	58570	Laparoscopy,surgical, with total hysterectomy, for uterus 250 g or less
	58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 G or less; with removal of tube (s) and/or ovary (s)
	58572	Laparoscopy, surgical , with total hysterectomy, for uterus greater than 250 g
	58573	With removal of tube (s) and/or ovary(s)
	58674	Destruction of fibroid tumor of uterus using a laparoscope
Maternity Care and Delivery - Antepartum and Fetal Invasive Services	59072	Fetal umbilical cord occlusion, including ultrasound guidance
	59076	Fetal shunt placement, including ultrasound guidance
Cesarean Delivery	59525	Subtotal or total hysterectomy after cesarean delivery (this is an add-on code and is subject to add-on stipulations)
Nervous System - Skull, Meninges, and Brain - Endovascular Therapy	61635	Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed
Neurostimulators (Intracranial)	61736	Intracranial Laser Interstitial Thermal Therapy
	61737	Intracranial Laser Interstitial Thermal Therapy
	61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
	61886	With connection to 2 or more electrode arrays
	61889	Insertion of skull mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, with connection to depth and cortical strip electrode array(s)
	61891	Revision or replacement of skull mounted cranial neurostimulator pulse generator or receiver with

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System - Neurostimulators (Peripheral Nerve)	62320	Injection of substance into spinal canal of upper /middle back
	62321	Injection of substance into spinal canal of upper/middle back w/imaging
	62322	Injection of substance into spinal canal of lower back w/imaging
	62323	Injection of substance into spinal canal of lower back w/ imaging
	62324	Injection of indwelling catheter and administration of substance into spinal canal of upper or middle back
	62325	Insertion of indwelling catheter and administration of substance into spinal canal of upper middle back
	62326	Insertion of indwelling catheter and administration of substance into spinal canal of lower back w/imaging
	62327	Insertion of indwelling catheter and administration of substance into spinal canal of lower back w/imaging
	62380	Decompression of spinal cord/nerve root in lower back using endoscope
	64405	N Block Inj Occipital
	64445	Sciatic nerve, single
	64446	Sciatic nerve, continuous infusion by catheter
	64449	Lumbar plexus, posterior approach, continuous infusion by catheter(including catheter placement)
	64461	Paravertebral block, thoracic; single injection site
	64462	Second and any additional injection site
	64463	Continuous infusion by catheter
	64479	Injection (s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT) cervical or thoracic, single level
	64480	Cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
	64490	Injection (s), diagnostic or therapeutic agent, (paravertebral facet zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level

	64491	Second level (List separately in addition to code for primary procedure)
	64492	Third and any additional level(s) (List separately in addition to code for primary procedure)
	64493	Injection (s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
	64494	Second level (List separately in addition to code for primary procedure)
	64495	Third and any additional level(s) (List separately in addition to code for primary procedure
	64530	Celiac plexus, with or without radiologic monitoring
	64561	Sacral nerve (transforaminal placement) including image guidance, if performed
	64581	Sacral nerve (transforaminal placement)
	64611	Chemodenervation of parotid and submandibular salivary gland, bilateral
	64612	Chemodenervation of muscles(s); muscle(s) innervated by facial nerve, unilateral
	64615	Muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
	64616	Neck muscle(s), excluding muscles of the larynx, unilateral
	64617	Injection of chemical for destruction of nerve muscles on one side of voice box accessed through the skin
	64642	Injection of chemical for destruction of nerve muscles on arm or leg, 1-4 muscles
	64643	Each additional extremity, 1-4 muscle(s)
	64644	Injection of chemical for destruction of nerve muscles on arm or leg,5 or more muscles
	64645	Each additional extremity, 5 or more muscle(s)
	64646	Injection of chemical for destruction of nerve muscles on trunk, 5 or more muscles
	64647	Injection of chemical for destruction of nerve muscles on trunk, 6 or more muscles
Eye and Ocular Adnexa Anterior Segment - Cornea	65710	Keratoplasty (corneal transplant); anterior lamellar
	65730	Penetrating (except in aphakia or pseudophakia)
	65750	Penetrating (in aphakia)
	65755	Penetrating (in pseudophakia)

	65756	Endothelial
	65780	Ocular surface reconstruction; amniotic membrane transplantation
	65781	Limbal stem cell allograft (eg, cadaveric or living donor)
	65782	Limbal conjunctival autograft,(includes obtaining graft)
Ocular Adnexa - Eyelids	67900	Repair of brow ptosis
	67903	(tarso) levator resectionor advancement, internal approach
	67904	(tarso) levator resectionor advancement, internal
	67906	Superior rectus technique with fascial sling (includes obtaining fasica)
	67908	Conjunctivo-tarso-Muller's muscle-levator resection (eg, FasanellaServat type
	67909	Reduction of overcorrection of ptosis
Auditory System – External Ear – Repair	69300	Othoplasty, protruding ear, with or without size reduction
	65780	Ocular surface reconstruction; amniotic membrane transplantation
	65781	Limbal stem cell allograft (eg, cadaveric or living donor)
	65782	Limbal conjunctival autograft,(includes obtaining graft)
	65785	Implantation of intrastromal corneal ring segments
Middle Ear - Other Procedures	69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
	69715	With mastoidectomy
	69728	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect
Inner Ear - Introduction	69930	Cochlear device implantation, with or without mastoidectomy
Radiology - Diagnostic (Diagnostic Imaging)	77065	Diagnostic Mammography of 1 Breast
	77066	Diagnostic Mammography of both Breast
Head and Neck - Spine and Pelvis	76984	Ultrasound, intraoperative thoracic aorta diagnostic
	76987	Intraoperative epicardial cardiac ultrasound (echocardiography) for congenital heart disease,

	76988	Intraoperative epicardial cardiac ultrasound (echocardiography) for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only
	76989	Intraoperative epicardial cardiac ultrasound (echocardiography) for congenital heart disease, diagnostic, interpretation and report only.
Abdomen	77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based
	77372	Linear accelerator based
	77373	Stereotactic body to 1 or more lesions, including image guidance, entire course not to radiation therapy, treatment delivery, per fraction exceed 5 fractions
Medicine - Gastroenterology	91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy) esophagus with physician interpretation and report
	91112	Capsule endoscopy with gastrointestinal track transit times or pressure.
Cardiovascular - Echocardiography	93303	Transthoracic echocardiography for congenital cardiac anomalies; complete
On-line Medical Evaluation - Other Services and Procedures	99183	Physician attendance and supervision of hyperbaric oxygen therapy, per session
	95717	EEG Phys/QHP 2-12 HR w/o Video
	95726	EEG Phy/QHP >84 HR w/VEEG

For special Ophthalmological Services, see Appendix O.

For Photodynamic Therapy Services, see Appendix O.

B. Procedures Subjected to Pre-Payment Review:

The following procedure codes describe procedures which could be cosmetic in nature and, therefore, are non-covered by the Georgia Division Of Medicaid. However, if the procedure is performed due to medical necessity rather than for cosmetic reasons, the physician may submit the claim for processing. The claim must have an explanation of the procedure performed (e.g., removal of cyst, mass, etc.) and the medical reason the procedure was required. These explanatory remarks should be made on the face of the claim form in the space under each line entitled "Procedure Description/Remarks".

The claim should be submitted to the normal post office box used for submission and resubmission of the claim.

i. Excision, other benign lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter [Note that approval for the following procedures can only be requested in writing or

via web portal.]

1. 11441 0.6 to 1.0 cm

2. 11442 1.1 to 2.0 cm

3. 11443 2.1 to 3.0 cm

Appendix E
Attachment "1" to Appendix E

A. Protocol For Facility Selection – Liver Transplant Center

i. The staff must have experience in organ transplant programs and include a transplant surgeon who has trained at an institution with an established liver transplant program.

ii. The staff must include experts in hepatology, gastroenterology, immunology, infectious diseases, nephrology, pulmonary medicine, pediatrics, pathology, pharmacology, anesthesiology, psychiatry, and psychosocial support.

iii. The center must give assurance that satisfactory arrangements are in place for donor procurement services.

iv. The facility must have an active renal dialysis program and blood bank services which are capable of supplying large quantities of blood on short notice.

v. The hospital should have experience and expertise in the treatment of all types of hepatic diseases.

vi. The transplant center administration must have made a commitment to this program and there should be broad-based community support and hospital staff support of this commitment.

vii. The center must have a consistent, equitable, and practical protocol for selection of patients.

viii. The center should have the capacity and the commitment to conduct systematic evaluations of cost and clinical outcomes of cases.

Appendix F
Sterilizations

The Division will make reimbursement only for those sterilization procedures which meet the criteria established in Section 904.1 (a) of this Manual. A copy of the "Informed Consent for Voluntary Sterilization" (Form DMA-69) is attached as Pages F-3 and F-4 of this Appendix. 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.

A. Under the physician's statement

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

1. 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.

2. 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 (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.

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

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

B. 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.

C. 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.

D. The only consent form acceptable to the Division is: "Informed Consent for Voluntary Sterilization" (DMA-69) in current policy manual. No other consent form is acceptable.

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

F. The informed consent sterilization form may not be used for hysterectomy procedures. Medically necessary hysterectomy procedures require completion of the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" (DMA-276, Rev 10/82) form.

A copy of the properly executed "Informed Consent for Voluntary Sterilization" form 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. The attending physician is responsible for providing a copy of the properly executed consent form to each Medicaid provider associated with the case.

INFORMED CONSENT FOR VOLUNTARY STERILIZATION

NOTICE

YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

1. I have asked for and received information about sterilization from ______________________
   Physician or Clinic
2. I have asked for the sterilization, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment and I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid, that I am not getting or for which I may become eligible.

   I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE: I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN, OR FATHER CHILDREN.

3. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father children in the future. I have rejected these alternatives and chosen to be sterilized.
4. I understand that I will be sterilized by an operation known as a ______________________. The
   Sterilization Procedure
   discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.
5. I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.
6. I am at least 21 years of age and was born on ______________________
   Month Day Year
7. I ______________________ hereby consent of my own free will to be sterilized
   Print name of Member
   by ______________ by a method called ______________. My consent expires 180 days
   Print name of Physician Sterilization Procedure
   from the date of my signature below.
8. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare or Employees of programs funded by that Department but only for determining if Federal laws were observed.

   I have received a copy of this form.

______________________ Date Signed: ________/________/________
Signature of Medicaid Recipient Month Day Year

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check)

Black (not Hispanic descent) ______________
Hispanic ______________
Asian or Pacific Islander ______________
American Indian or Alaskan Native ______________
White (not of Hispanic origin) ______________

INTERPRETER'S STATEMENT

I have translated the information and advice presented orally to the individual to be sterilized by the individual obtaining this consent. I have also read the consent form to ______________ in ______________ language and explained its contents to him/her.
Name of Member Language

To the best of my knowledge and belief he/she understood this situation.

______________________ Date ______________/______________
Signature of Interpreter Month Day Year

IN ORDER FOR THIS FORM TO BE VALID BOTH SIDES MUST BE COMPLETED

DMA-69 (04/03) (Refer to Reverse Side)

FOR FISCAL AGENT USE ONLY

STATEMENT OF PERSON OBTAINING CONSENT

Before ______________________________ signed this consent form, I explained to him/her the nature of the
Name Of Member

sterilization operation, ______________________________ , the fact that it is intended to be a final and
Sterilization Procedure

irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

____
Signature Of Person Obtaining Consent

____
Date

____
Facility

____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon ______________________________ on
Name of Member

______________________________ , I explained to him/her the nature of the sterilization operation
Date Of Operation

______________________________ , the fact that it is intended to be a final and irreversible procedure and
Sterilization Procedure

the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

SELECT THE APPROPRIATE PARAGRAPH: NUMBER (1) OR NUMBER (2)

(Cross out the paragraph which is not used.)

Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used.

(1) 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.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Individual's date of expected delivery ______________________________

☐ Emergency abdominal surgery (describe circumstances): ______________________________

____

____

Physician's Signature ______________________________ Date ______________________________

DMA-69 (04/03)

Appendix G
Hysterectomies

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

A copy of the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" (Form DMA 276, (Rev 10/82)) is shown on Page G-2 of this Appendix. This form must be signed, either before or after the hysterectomy, as follows and must be attached to the claim form submitted to the Division for payment.

A. Section I - Member's Statement

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

B. 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, e.g., hospital, anesthesiology, etc. The attending physician is responsible for providing a copy of the properly signed acknowledgement form to each Medicaid provider associated with the case.

Appendix H
Member Information (DMA-276)

Georgia Division of Medicaid
Medicaid Program

GEORGIA DIVISION OF MEDICAL ASSISTANCE

Medicaid Program

This is a Federally mandated form that must accompany all claims for hysterectomy.

MEMBER INFORMATION

MEMBER NAME: LAST | FIRST | INITIAL | SUFFIX

MEMBER MEDICAID CASE NO.

PATIENT'S ACKNOWLEDGEMENT OF PRIOR RECEIPT OF HYSTERECTOMY INFORMATION

Section I — Member's Statement

I have been told and I understand that this hysterectomy (operation to remove my womb/uterus) will cause/has caused me to be permanently sterile (unable to bear children).

Signature of Medicaid Member   Date

OR

Signature of Member's Representative   Date

STATEMENT OF MEDICAL NECESSITY

Section II — Physician's Statement

The above mentioned hysterectomy will be/has been performed for medical necessity, not for sterilization, hygiene purposes or mental retardation.

Check one of the below **if applicable** — (Member's signature not required if number 1 or 2 is applicable.)

1 Member was sterile prior to hysterectomy. The member was sterile because ________

2 Emergency Hysterectomy: (Attach a copy of the discharge summary and operative record to validate the emergency hysterectomy.)

3.

Physician's Name (Please print)

Physician's Signature   Date

DMA-276 (3/03) 746-276   (ATT 05)

Appendix I
Abortions

The Division will make reimbursement only for those abortions which meet the criteria established in Section 904.2 of this Manual.

A “Certification 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 certification must accompany any other claim for services rendered in conjunction with the abortion, e.g., hospital, anesthesiology, etc. The attending physician is responsible for providing a copy of the properly executed certification form to each Medicaid provider associated with the case.

Appendix I-1
Certificate Of Necessity For Abortion (DMA-311)

This is a federal mandated form that must be completed and attached to all invoices containing claim lines submitted for reimbursement for abortion procedures and abortion-related procedures.

The Department will reimburse only for abortions which meet the criteria established in Part II, Chapter 900 of the Policies and Procedures for Physician Services Manual. (Rev 7/15)

Georgia Department Of Medical Assistance

Certification Of Necessity For Abortion

The Information Provided On This Form Is Confidential Under Federal Law And Regulations And Cannot Be Disclosed Without The Informed Consent Of The Member.

Member Information

NAME: ____

MEDICAID #: ____

ADDRESS: ____

____

Statement Of Medical Necessity

This is to certify that I am a duly licensed physician and that in my professional judgment, an abortion is medically necessary for the reason indicated below:

☐ This patient suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place this woman in danger of death unless an abortion is performed.

iv.☐ Fetal Demise

v.☐ The pregnancy is the result of rape.

vi.☐ The pregnancy is the result of incest.

vii.NOTE: Please attach all supporting medical documentation.

viii.________________________________, MD

ix. (Print Name)

x.________________________________, MD

xi.(Signature of Physician)

Appendix J
Newborn Certification – Temporary Enrollment

Summary of Newborn Certification

Effective July 1, 1995, a new process was implemented 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, 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 Technology 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 3:00 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.

Appendix K
Procedure Codes Subject to the Site of Service Differential
(The list of procedure codes may not be all inclusive)

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
10005	11044	11313	11462	11719	11952	12032	13121
10006	11045	11400	11463	11720	11954	12034	13122
10030	11046	11401	11470	11721	11971	12035	13131
10035	11047	11402	11471	11730	11976	12036	13132
10036	11055	11403	11600	11732	11980	12037	13133
10040	11056	11404	11601	11740	11982	12041	13151
10060	11057	11406	11602	11750	12001	12042	13152
10061			11603	11752	12002	12044	13153
10080		11420	11604	11755	12004	12045	14000
10081	11200	11421	11606	11760	12005	12046	14001
10120	11201	11422	11620	11762	12006	12047	14020
10121	11300	11423	11621	11765	12007	12051	14021
10140	11301	11424	11622	11770	12011	12052	14040
10160	11302	11426	11623	11771	12013	12053	14041
10180	11303	11440	11624	11772	12014	12054	14060
11000	11305	11441	11626	11900	12015	12055	14061
11001	11306	11442	11640	11901	12016	12056	14300
11010	11307	11443	11641	11920	12017	12057	14301
11011	11308	11444	11642	11921	12018	13100	15002
11012	11310	11446	11643	11922	12020	13101	15003
11042	11311	11450	11644	11950	12021	13102	15004
11043	11312	11451	11646	11951	12031	13120	15040
15050	15240	15740	16025	17281	19120	19120	20220
15100	15241	15760	16030	17282	19125	19125	20225
15101	15260	15775	17000	17283	17306	19281	20500
15110	15261	15776	17003	17284	17307	19282	20501
15111	15271	15780	17004	17286	17310	19283	20520
15115	15272	15781	17106	17311	17311	19284	20525
15116	15273	15782	17107	17312	17312	19285	20550
15120	15274	15783	17108	17314	17314	19286	20551
15121	15275	15786	17110	17340	17340	19287	20552
15130	15276	15787	17111	17360	17360	19288	20553
15131	15277	15788	17250	19000	19000	19296	20600
15135	15278	15789	17260	19001	19001	19298	20604
15136	15570	15792	17261	19020	19020	19300	20605
15150		15820	17262	19030	19030	19350	20606
15151	15572	15821	17263	19081	19081	19355	20610
15152	15574	15822	17264	19082	19082		26011
15155	15576	15823	17266	19083	19083	20100	20612
15156	15600	15837	17270	19084	19084	20101	20615
15157	15610	15839	17271	19085	19085	20102	20650
15170	15620	15851	17272	19086	19086	20103	20665
15200	15630	15852	17273	19100	19100	20200	20670

15201	15650	15860	17274	19101	19101	20205	20694
15220	15730	16000	17276	19110	19110	20206	20900
15221	15731	16020	17280	19112	19112	20100	20910
Page 3							
20922	21110	21401	22305	23665	24675	26010	27040
20974	21116	21421	22310	23675	25065	26011	27047
20979	21120	21440	22505	23930	25246	26055	27086
20983	21121	21445	23000	23931	25500	26070	27093
21025	21125	21450	23030	24065	25505	26160	27095
21026	21127	21451	23031	24066	22510	26341	27096
21029	21208	21452	23065	24075	22511	26432	27200
21030	21209	21453	23066	24200	22512	26600	27220
21031	21210	21461	23075	24201	22513	26605	27230
21032	21215	21462	23330	24220	22514	26641	27246
21034	21235	21480	23350	24362	22515	26645	27301
21040	21245	21485	23500	24500	25520	26670	27323
21076	21246	21497	23505	24505	25530	26675	27327
21077	21248	21501	23520	24530	25535	26700	
21079	21249	21550	23525	24535	25560	26705	27372
21080	21270	21555	23540	24560	25565	26720	27500
21081	21300	21700	23545	24565	25600	26725	27501
21082	21310	21720	23570	24576	25605	26740	27508
21083	21315	21820	23575	24577	25622	26742	27516
21084	21320	21920	23600	24600	25624	26750	27517
21085	21337	21925	23605	24640	25630	26755	27520
21086	21345	21930	23620	24650	25635	26770	27530
21087	21355	22010	23625	24655	25650	26775	27532
21100	21400	22015	23650	24670	25675	26991	27538
Page 4							
27550	27750	28024	28112	28222	28299	28475	28665
27560	27752	28035	28113	28225	28300	28490	28666
27603	27760	28043	28114	28230	28302	28495	28675
27604	27762	28045	28116	28232	28304	28496	28740
27605	27780	28046	28118	28234	28305	28505	28750
27606	27781	28050	28119	28238	28306	28510	28755
27613	27786	28052	28120	28240	28307	28515	28760
27614	27788	28054	28122	28250	28308	28525	28820
27618		28060	28124	28260	28310	28530	28825
27619	27808	28062	28126	28261	28312	28531	28890
27630	27810	28070	28140	28262	28313	28540	29000
27648	27816	28072	28150	28270	28315	28546	29010
27656	27818	28080	28153	28272	28322	28555	29015
27658	27824	28086	28160	28280	28340	28570	29035
27659	27825	28088	28173	28285	28341	28575	29040
27664	27830	28090	28175	28286	28344	28576	29044
27665	28001	28092	28190	28288	28345	28585	29046
27685	28002	28100	28192	28289	28400	28600	29049
27686	28003	28103	28193	28291	28405	28606	29055
27730	28008	28104	28200	28292	28430	28630	29058

27732	28010	28107	28202	28295	28435	28635	29065
27740	28011	28108	28208	28296	28450	28636	29075
27742	28020	28110	28210	28297	28455	28645	29085
	28022	28111	28220	28298	28470	28660	29105
			Page 5				
29125	29530	30220	31505	31653	33886	36473	36901
29126	29540	30300	31510	31654	33889	36474	36902
29130	29550	30560	31511	31700	33891	36475	36903
29131	29581	30580	31512	31717		36476	36904
29200	29582	30801	31515	31720	33925	36478	36905
29220	29583	30802	31525	31730	33926	36479	36906
29240	29584	30901	31570	31825	33967	36482	36907
29260	29580	30903	31572	32400	36000	36483	36908
29280	29700	30905	31573	32405	36005	36489	36909
29305	29705	30906	31574	32503	36251	36510	37184
29325	29710	31000	31575	32504	36252	36522	37185
29345	29720	31002	31576	32555	36253	36533	37186
29355	29730	31020	31577	32557	36254	36535	37187
29358	29740	31030	31578	32960	36400	36536	37191
29365	29750	31231	31579	32994	36405	36537	37192
29405	29850	31233	31612	32998	36406	36554	37193
29425	30000	31235	31615	33011	36410	36556	37188
29435	30020	31237	31622	33507	36425	36558	37220
29440	30100	31238	31623	33548	36430	36589	37221
29445	30110	31295	31624	33768	36450	36598	37222
29450	30117	31296	31625	33880	36465	36600	37223
29505	30124	31297	31628	33881	36466	36836	37224
29515	30200	31298	31634	33883	36470	36837	37225
29520	30210	31502	31652	33884	36471	36860	37226
			Page 6				
37227	37718	40810	41115	42280	42808	43770	45108
37228	37722	40812	41250	42281	42809	43771	45150
37229	37785	40814	41251	42300	42810	43772	45300
37230	38220	40816	41252	42310	43197	43773	45303
37231	38221	40819	41800	42320	43198	43774	45305
37232	38222	40820	41806	42325	43200	43886	45307
37233	38300	40830	41822	42326	43201	43887	45308
37234	38305	40844	41823	42330	43202	43888	45309
37235	38500	41000	41825	42335	43210	44180	45315
37236	38505	41005	41826	42340	43211	44186	45317
37237	38790	41006	41827	42400	43212	44187	45320
37238	40490	41007	41828	42405	43213		45330
37239	40500	41008	41830	42450	43229	44213	45331
37241	40510	41009	41874	42550	43235	44227	45332
37242	40520	41015	42000	42600	43236	44385	45333
37243	40530	41016	42100	42650	43239	44386	45335
37244	40650	41017	42104	42660	43210	44388	45338
37246	40652	41018	42106	42665	43212	44389	45340
37247	40654	41100	42107	42700	43245	44390	45378

37248	40800	41105	42140	42720	43270	44391	45379
37249	40801	41108	42145	42800	43290	44392	45380
37252	40804	41110	42160	42802	43291	44394	45381
37253	40805	41112	42180	42804	43450	45005	45382
37609	40808	41113	42182	42806	43762	45100	45384
Page 7							
45385	46285	46942	49180	50561	51705	52330	54015
45395	46320	46945	49185	50590	51710	52332	54050
45397	46500	46946	49405	50592	51715	52441	54055
45400	46505	47000	49406	50606	51720	52442	54056
45402	46600	47383	49407	50684	52000	52647	54057
45520	46604	47531	49418	50686	52005	53000	54060
45910	46606	47532	49452	50690	52010	53020	54065
45915	46608	47533	49465	50693	52204	53025	54100
46020	46610	47534	49505	50694	52214	53040	54105
46030	46611	47535	50250	50695	52224	53060	54115
46040	46612	47536	50382	50705	52234	53200	54150
46050	46614	47537	50384	50706	52235	53260	54160
46080	46615	47538	50387	50951	52240	53265	54200
46083	46710	47539	50389	50953	52265	53270	54220
46200	46712	47540	50391	50955	52270	53600	54230
46210	46900	47541	50430	50957	52275	53601	54231
46211	46910	47542	50431	50961	52276	53620	54235
46220	46916	47543	50432	51600	52281	53621	54450
46221	46917	47544	50433	51605	52282	53660	54500
46230	46922	48102	50434	51610	52283	53661	54700
46250	46924		50435	51700	52285	53850	54800
46255	46937	49082	50551	51701	52310	53852	55000
46270	46938	49083	50553	51702	52315	54000	55100
46275	46940	49180	50555	51703	52317	54001	55250
Page 8							
55700	57156	58100	59425	62284	64415	64492	64620
55870	57160	58110	59426	62290	64417	64493	64624
55874	57170	58120	59430	62291	64418	64494	64627
55876	57180	58301	59812	62302	64420	64495	64630
56405	57295	58321	59820	62303	64421	64505	64633
56420	57410	58322	59821	62304	64425		64634
56440	57415	58323	59840	62305	64430	64510	64635
56441	57420	58340	59841	62320	64435	64520	64636
56501	57421	58350	59871	62321	64445	64530	64640
56515	57452	58353	60000	62322	64461	64550	64642
56605	57454	58356	60100	62323	64462	64553	64643
56606	57455	58555	61000	62324	64463	64555	64644
56700	57456	58558	61001	62325	64470	64561	64645
56720	57460	58563	61020	62326	64472	64566	64646
56740	57461	58565	61026	62327	64479	64585	64647
56820	57500	58800	61070	62328	64480	64600	64650
56821	57505	58970	62263	62369	64483	64605	64653
57020	57510	58976	62264	62370	64484	64612	64454

57061	57511	59000	62270	64400	64486	64611	64680
57065	57513	59015	62272	64402	64487	64613	64721
57100	57520	59160	62273	64405	64488	64614	65125
57105	57522	59200	62280	64408	64489	64615	65205
57135	57558	59300	62281	64410	64490	64616	65210
57150	57800	59412	62282	64413	64491	64617	65220
Page 9							
65222	66030	67221	67906	68330	69200	90911	92316
65270	66130	67227	67908	68340	69210	91022	92317
65272	66250	67228	67909	68360	69220	91117	92330
65275	66625	67345	67914	68400	69222	92002	92335
65286	66700	67500	67915	68420	69410	92004	92504
65400	66710	67505	67916	68440	69420	92012	92506
65410	66720	67515	67917	68510	69421	92014	92507
65420	66761	67700	67921	68530	69424	92019	92508
65426	66762	67710	67922	68705	69433	92020	92511
65430	66770	67800	67923	68760	69540	92071	92512
65435	66821	67801	67924	68761	69610	92072	92516
65436	67025	67805	67930	68770	69620	92100	92520
65450	67027	67810	67935	68801	90791	92120	92565
65600	67028	67820	67938	68810	90792	92130	92571
65772	67031	67825	67950	68815	90833	92140	92575
65778	67101	67830	67961	68840	90837	92225	92576
65779	67105	67840	67966	68850	90845	92226	92577
65785	67110	67850	68020	69000		92230	92582
65800	67120	67875	68040	69005	90847	92260	92612
65805	67141	67880	68100	69020	90849	92287	92950
65815	67145	67882	68110	69100	90853	92311	92960
65855	67208	67900	68115	69105	90862	92312	93264
65860	67210	67903	68135	69110	90865	92313	93313
66020	67220	67904	68200	69145	90880	92315	93316
Page 10							
93566	95170	95874	96440	97770	99242	99336	
93567	95180	95970	96446	98925	99243	99337	
93568	95251	95971	96450	98926	99244	99341	
93720	95718	95972	96521	98927	99245	99342	
93721	95720	95973	96522	98928	99291	99343	
93722	95830	95978	96523	98929	99292	99344	
93797	95831	95979	96542	98940	99301	99345	
93798	95832		96570	98941	99302	99347	
94640	95833		96571	98942	99303	99348	
94660	95834	96112	97014	99151	99304	99349	
94664	95851	96116	97016	99152	99305	99350	
94667	95852	96118	97018	99170	99306	99354	
94668	95857	96119	97026	99183	99307	99355	
94780	95865	96120	97028		99308		
94781	95865	96401	97032	99202	99309		
95056	95865	96402	97033	99203	99310		
95065	95866	96405	97034	99204	99318		

95144	95866	96406	97036	99205	99324		
95145	95866	96409	97039	99211	99325		
95146	95873	96411	97113	99212	99326		
95147	95874	96413	97116	99213	99327		
95148		96415	97150	99214	99328		
95149		96416	97533	99215	99334		
95165		96417	97750	99241	99335		

Appendix L
Radiology Services requiring Prior Authorization

Procedure 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
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
76801	OB US<14 weeks, Single Fetus
76802	OB US<14 weeks, Addl Fetus
76811	OB US, Detailed, Single Fetus
76813	OB US, Nuchal Meas, 1 GEST
76814	OB US, Nuchal Meas, Add-on
76815	OB US, Limited, Fetus(s)
76816	OB US, Follow-up, per Fetus
76817	OB US, w/image documentation, trans-vaginal
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

Note: Prior authorization for the below listed pregnancy related ultrasounds is required after the first ultrasound (76805 and 76817) or in some cases, prior to rendering the service.

76805 OB US>/=14 weeks, Single Fetus
76810 OB US>/=14 weeks, Addl Fetus
76812 OB US, Detailed, Addl Fetus
76817 OB US, w/image documentation, transvaginal

Note: Changes for Radiology and Cardiology Services that require Prior Authorization (not limited to MRIs, CTs and similar procedures)

Effective October 1, 2014, Georgia Medicaid is expanding its list of radiology codes for medical services that require Prior Authorization (PA) for Medicaid Fee-for-Service members. If a member's medical condition warrants immediate care utilizing a service that requires a PA, a provider can submit an emergency waiver of the PA to Alliant Health Solutions by providing the appropriate supporting clinical documentation. The PA processes for the additional PA radiology requests are the same as the current (other) PA requests. Please allow Alliant Health Solutions up to 10 business days for review and response to your PA request via your Provider Workspace logon on the Gainwell Technology web portal at www.mmis.georgia.gov. The 53 additional procedure HCPCS/CPT codes fall within the radiology and cardiology areas of service. Below is the list of affected radiology codes that will require a PA with dates of service on or after October 1, 2014.

Procedure Code	Description
70540	MRI ORBIT/FACE/NECK W/O DYE
70542	MRI ORBIT/FACE/NECK W/DYE
70543	MRI ORBT/FACE/NECK W/O &W/DYE
70559	MRI BRAIN W/O & W/DYE
71260	CT THORAX W/DYE
71275	CT SCAN ANGIOGRAPHY CHEST
71550	MRI CHEST W/O DYE
71551	MRI CHEST W/DYE
71552	MRI CHEST W/O & W/DYE
71555	MRI ANGIO CHEST W & W/O DYE
72141	MRI NK SP W/O DYE
72142	MRI NK SP W/DYE
72146	MRI CH SP W/O DYE
72147	MRI CH SP W/DYE
72156	MRI NK SP W/O & W/DYE
72157	MRI CH SP W/O & W/DYE
72195	MRI PELVIS W/O DYE
72196	MRI PELVIS W/DYE
72197	MRI PELVIS W/O & W/DYE
73218	MRI UPPER EXTREM W/O DYE
73219	MRI UPPER EXTREM W/DYE
73220	MRI UPPR EXTREM W/O & W/DY
73221	MRI JOINT UPR EXTREM W/O DYE
73222	MRI JOINT UPR EXTREM W/DYE
73223	MRI JOINT UPR EXTREM W/O&W/DYE
73723	MRI JNT LOWER EXTREM W/O & W/DYE
74176	CT ABD & PELVIS W/O DYE
74181	MRI ABDOMEN W/O DYE
74182	MRI ABDOMEN W/DYE
74183	MRI ABDOMEN W/O & W/DYE
74185	MRI ANGIO ABDOMEN W/ OR W/O DYE
75557	CARDIAC MRI FOR MORPH
75561	CARDIAC MRI FOR MORPH W/O DYE
75563	CARD MRI W/STRESS IMAGING
75565	CARD MRI VELOCITY FLOW IMAGING
75580	CORONARY FRACTIONAL FLOW, COMPUTED TOMOGRAHPY ANGIOGRAPHY
76883	PRQ AV FSTL CRTJ UXTR 1 ACS

76984	ULTRASOUND, THORACIC AORTA DIAGNOSTIC
76987	CARDIAC ULTRASOUND FOR CONGENITAL HEART DISEASE
76988	CARDIAC ULTRASOUND, MANIPULATON OF TRANSDUCER AND IMAGE
76989	CARDIAC ULTRASOUND FOR CONGENITAL HEART DISEASE, INTERPRETATION AND REPORT
77047	MRI BREAST C – BILATERAL
77049	MRI BREAST C-+ W/CAD BILATERAL
76984	ULTRASOUND, THORACIC AORTA DIAGNOSTIC
78451	MYOCARDIAL IMAGING - SINGLE
78452	MYOCARDIAL IMAGING - MULTI
78453	MYOCARDIAL IMAGING
78454	MYOCARDIAL IMAGING
78466	MYOCARDIAL IMAGING
93303	TTE – INITIAL
93304	TTE – FOLLOW-UP
93306	TTE - 2D COLOR
93307	TTE - 2D COLOR/SPECTRAL
93308	TTE - 2D COLOR FOLLOW-UP

This is a policy adjustment being made by Georgia Medicaid to the scope of certain radiology procedures codes that will now require prior authorization. Claims submitted for the affected radiology procedure codes rendered on or after October 1, 2014, without prior authorization will not be paid.

Appendix M
Change in Publication of “V” Codes Available

Effective October 1, 2004, the Department will no longer publish “V” codes available for utilization within Georgia Medicaid. Utilization must be based upon correct coding guidelines and follow program policy.

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

Medical Clearance for Hearing Aid Referral:

Patient Name: ________________________________

Date: ____

The above patient has been evaluated and maybe considered a candidate for a hearing aid:

Date of Evaluation: ____

Physician's Signature: ____

Physicians Name: ____

Address: ____

Appendix O
Outpatient Hospital, Inpatient Hospital and Ambulatory Surgical Center Procedure Requiring Prior Approval/Pre-Certification

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

Effective with date of service on and after October 1, 2006, all services requiring prior approval and/or pre-certification applies to all eligible members, regardless of age.

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

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
11310	15150	15650	17281	22532	26373	27430	27707	28114
11311	15152	15740	17282	22533	26390	27435	27709	28118
11312	15155	15750	17283	22548	26392	27605	27712	28119
11313	15157	15756	17284	22551	26410	27606	27715	28120
11750	15200	15758	17286	22552	26412	27612	27745	28122
14001	15220	15760	17311	22534	26418	27620	27880	28124
14020	15240	15770	17312	22633	26420	27630	27871	28126
14021	15260	15840	17313	22634	26426	27635	28008	28171
14041	15271	15841	17314	22856	26428	27637	28045	28173
14060	15272	15842	17315	22861	26432	27638	28055	28175
14061	15273	15845	19301	22864	26433	27656	28062	28200
14300	15274	17260	19302	22900	26434	27680	28072	28202
14350	15275	17261	19303	23334	27027	27681	28080	28208
15002	15276	17262	19304	23335	27057	27685	28086	
15003	15277	17263	19305	26055	27278	27686	28088	28210
15004	15278	17264	19306	26060		27687	28090	28220
15005	15570	17266	19307	26111	27325		28092	28222
15040	15572	17270	20696	26160	27326	27690	28102	28225
15050	15574	17271	20697	26350	27329	27691	28103	28226
15100	15576	17272	20975	26352	27345	27692	28107	28230
15110	15600	17273	21032	26356	27420	27700	28110	28232
15115	15610	17274	21240	26358	27422	27702	28111	28240
15130	15620	17276	21244	26370	27424	27703	28112	28288
15135	15630	17280	21247	26372	27425	27705	28113	28340
Page 2								
28344	29916	31243	31661	34843	36222	37232	43213	43273
28360	30468	31276	32557	34844	36223	37233	43214	43274
28810	30469	31287	32851	34845	36224	37234	43217	43275
28820	30115	31288	32852	34846	36225	37252	43220	43276
28825	30117	31290	32853	34847	36226	37253	43226	43277
29870	30118	31291	32854	34848	36227	33741	43231	43278
29871	30125	31292		35302	36228	33745	43232	43279
29874	30150	31293	32998	35303	36556	37780	43233	43280
29875	30160	31294	33202	35304	36836	37785	43235	43281
29876	31020	31620	33254	35305	36837	33995	43236	43282
29877	31030	31287	33255	35306	37197	33997		43290
29879	31032	31288	33256	35506	37217	40510	43239	43291
29880	31070		33276	35535	37220	40650	43240	43324
	31200		33287	35537	37221	40652	43241	43325
29882	31201	31627	33288	35538	37222	40654		43326
29883	31205	31634	33366	35539	37223	41006	43247	43327
29884	31231	31647	33675	35540	37224	41007	43249	43328
29885	31233	31648	33676	35570	37225	41009	43251	43332
29886	31235	31649	33677	35632	37226	42145	43257	43333
29887	31237	31651	33741	35633	37227	42950	43260	43334
29888	31238	31652	33745	35634	37228	42975	43262	43335

29889	31239	31653	34805	35637	37229	43200	43263	43336
29914	31240	31654	34841	35638		43201	43264	43337
29915	31242	31660	34842	36221	37230	43213	43265	43338
Page 3								
43360	45395	47564	52240	52342	53447	57287		63005
43361	45397	48105	52250	52343	53448	57425	60225	63011
43775	45400	48548	52260	52347	53449	57520	60240	63012
44157	45402	49000	52270	52351	53450	57522	60260	63015
44158	45500	49320	52275	52352	53460	57558	60270	63016
44180	45505	49402	52276	52356	54150	58120	60271	63017
44186	45520	49446	52277	52400	54161	58353	60500	63045
44187	45560	50382	52281	52450	54520	58541	60502	63046
44188	46505	50387	52287	52500	54522	58555	60505	
44204	47531	50945	52283	52601	54530	58558	60512	63170
44205	47532	50947	52284	52630	54535	58559	60521	63180
44206	47533	50948	52285	52640	54865	58560	61586	63182
44208	47534	51990	52290	52647	55040	58561	61600	63185
44227	47535	51992	52300	52648	55041	58562	61797	63190
44360	47536	52000	52305	53400	55060	58563		63191
44361	47537	52001	52310	53405	55175	58580	61799	63194
44364	47538	52005	52315	53410	55180	58660		63195
44369	47539	52007	52317	53420	55500	58661	62310	63196
45378	47540	52010	52318	53425	55540	58662	62311	63197
45380	47541	52204	52320	53430	55605	58672	62318	63198
45383	47542	52214	52330	53431	55650	58673	62319	63199
45385	47543	52224	52332	53440	55880	60210	62367	63200
45391	47562	52234	52340	53444	56442	60212	63001	63250
45392	47563	52235	52341	53445	57268	60220	63003	63251
Page 4								
63252	63650	66830	67916	75580	93451	95717		
63265	63655	66840	67917	76828	93452	95726		
63266	63685	66850	67921	76883	93453	95970		
63267	64415	66852	67923	90911	93454	96112		
63268	64483	66920	67924	91120	93455	96570		
63270	64484	66930	67950	92065	99345	96571		
63271	64491	66940	67961	92521	93457	99471		
63272	64568	66982	67966	92522	93458	99472		
63273	64569	66983	67971	92523	93459	99475		
63275	64582	66984	67973	92524	93460	99476		
63276	64583	66985	67974	92585	93461	96202		
63277	64584	66986	67975		93503	96203		
63278	64596	67311	68320		93530			
63280	64598	67312	68325	92610	93531			
63281	64628	67320	68326	92611	93532			
63282	64633	67331	68328		93533			
63283	64634	67332	68360	92920	93561			
63285	64635	67346	68362	92924	93656			
63286	64636	67516	69110	92928	93562			
63287	64650	67808	69140	92933	93580			

63290	64653	67880	69145	92937	93653			
63295	64681	67882	69705	92941	93654			
63620	66820	67901	69706	93264	93655			
63621	66821	67914	69716	93150	93656			

Appendix P
Drug and Pharmacy Information

For specific information regarding services, coverage, and limitations under the Pharmacy program, please see the Pharmacy Services manual, the Medicaid Preferred Drug List, and relevant Banner Messages available online at www.mmis.georgia.gov. Paper copies of the manual or Drug List may be obtained from the Division's fiscal agent by contacting the Gainwell Technology at 1 (800) 766-4456.

Appendix Q
Georgia Medicaid FFS Tamper Resistant Prescription Pad (TRPP)- Prescriber Update

On October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) tamper-resistant prescription law took effect requiring all handwritten and/or computer generated (by an electronic medical record (EMR) or prescribing applications) printed prescriptions for fee-for-service Medicaid patients contain at least one industry recognized feature from each of the three categories of tamper resistance.

The Georgia Department of Community Health (DCH) Office of the Inspector General Program Integrity division is required to enforce this federal requirement. Any payment made for a prescription that does not comply with this requirement will be recouped by the Department. The Center for Medicare and Medicaid Services (CMS) strongly supports both e-prescribing and the use of tamper-resistant prescription pads as methods to reduce instances of unauthorized, improperly altered, and counterfeit prescriptions.

A. Review of CMS Requirements for TRPP:

Required tamper-resistant characteristics include one or more industry-recognized features designed to:		Examples include but are not limited to:
1	**Prevent unauthorized copying of a completed or blank prescription form**	• High security watermark on reverse side of blank • Thermochromic ink technology • Photocopied prescription blanks show the word “Copy,” “Illegal,” or “Void.”
2	**Prevent erasure or modification of information written on the prescription by the prescriber**	• Tamper-resistant background ink shows erasures or attempts to change written information
3	**Prevent the use of counterfeit prescription forms**	• Duplicate or triplicate blanks

Summary of features that could be used on a tamper-resistant pad/paper in compliance with the CMS guidelines

Category 1 – Copy Resistance: One or more industry recognized features designed to prevent unauthorized copying of a completed or blank prescription form.	
“Void” “Illegal” or “Copy” pantograph with or without Reverse “Rx”	The word “Void” “Illegal” or “Copy” appears when the prescription is photocopied. Except where state law mandates the word “Void” or “Illegal” – it is recommended that the pantograph show The word “Copy” if the prescription is copied. The pantograph should be placed so as not to obscure the security feature description contained on the

	prescription, the patient and prescriber demographics, or the medication and directions. Some pantographs can be problematic because when the Prescription is copied, the resulting "void" or other wording that appears makes the underlying prescription difficult to read. These types of pantographs should be avoided. Providers may wish to ask their pad vendor about hollow "VOID" pantograph lettering which is less likely to obscure the information. The Reverse Rx disappears when photocopied at a light setting – thus making the pantograph more effective in copy resistance. The pantograph may be used with a reverse Rx, but Reverse Rx is not effective as a feature by itself.
Micro printing – To be effective, this feature must be printed in 0.5 font or less making it illegible to the pharmacist when copied	Very small font which is legible (readable) when viewed at 5x magnification or greater, and illegible when copied.
Thermochromic ink	Ink changes color with temperature change.
Coin-reactive ink	Ink changes color when rubbed by a coin.
Watermarking Security back print (artificial watermark) Digital watermarks Watermarking on special paper	 Printed on the back of prescription form. The most popular wording for the security back print is "Security Prescription" or the security back print can include the states name. Can only be seen when viewed at an angle. Weak digital watermarks cannot be read if copied and strong digital watermarks provide digital rights management/"proof" of origin when copied. Special paper contains a watermark that can be seen when Backlit

Category 2– Erasure / Modification Resistance: One or more industry-recognized features designed to prevent the erasure or modification of information written / printed on the prescription by the prescriber.

Features to Prevent Erasure	Description
An erasure revealing background (erasure resistance)	Background that consists of a solid color or consistent pattern that has been printed onto the paper. This will inhibit a forger from physically erasing written or printed information on a prescription form. If someone tries to erase, the consistent background color will look altered and show the color of the underlying paper.

Toner Receptor Coating / Toner Lock or Color Lock paper (erasure resistance for computer generated prescriptions printed with a laser printer) OR Chemically reactive paper (erasure resistance for handwritten prescriptions)	Special printer paper that establishes a strong bond between laser printed text and paper, making erasure obvious. **Note – this is NOT necessary for inkjet printers – as the ink from inkjet printers is absorbed into normal "bond" paper.** If exposed to chemical solvents, oxidants, acids, or alkalis that can be used to alter the prescription, the chemically reactive paper will react and leave a mark visible to the pharmacist.
Features to Prevent Modification	**Description**
Quantity check boxes and refill indicator (circle or check number of refills or NR)	In addition to the written quantity on the prescription, quantities are indicated in ranges. It is recommended that ranges be in 25's with the highest being "151 and over". The range box corresponding to the quantity prescribed MUST be checked for the prescription to be valid. The refill indicator indicates the number of refills on the prescription. Refill numbers must be used to be a valid prescription.
Pre-printed language on prescription Paper Example: "Rx is void if more than XXX Rx's on paper"	Reduces ability to add medications to the prescription. Line must be completed for this feature to be valid. Computer printer paper can accommodate this feature by printing, "This space intentionally left blank" in an empty space or quadrant.
Quantity and Refill Border and Fill (this is the recommended for computer generated prescriptions)	Quantities and refill # are surrounded by special characters such as an asterisk to prevent modification, e.g. QTY **50** Value may also be expressed as text, e.g. FIFTY, (optional).
Category 3 – Counterfeit Resistance: One or more industry-recognized feature designed to prevent the use of counterfeit prescription forms.	
Feature	**Description**
Security features and descriptions listed on prescriptions – this feature is strongly recommended on all prescriptions	Complete list of the security features on the prescription paper for compliance purposes. This is strongly recommended to aid pharmacists in identification of features implemented on prescription.
Thermochromic ink	Ink changes color with temperature change.

Encoding techniques (bar codes)	Bar codes on prescription. Serial number or Batch number is encoded in a bar code.
Security Thread	Metal or plastic security threads embedded in paper as used in currency.

B. Best Practices for Tamper Resistant Printed Prescriptions (Handwritten)

Category 1	A) Photocopied "COPY", "ILLEGAL", or "VOID" Pantograph
Category 2	A) An Erasure revealing background (resists erasures and alterations) B) Quantity check boxes C) Refill indicator (circle number of refills or "NR")
Category 3	A) Security features and descriptions listed on the prescription

Best Practices for Tamper Resistant Printed Prescriptions (Handwritten)

Front

Void or Copy Pantograph: displays "VOID" or "ILLEGAL" on a color copy of an Rx. It will appear on a wide range of copier settings. (Cat. 1)

Preprinted Text Fields: Quantity check boxes, refill indicators, and preprinted limitations or guidelines make the Rx harder to modify. (Cat.2)

Back

Chemically-Protected Paper: Invisible coating causes "VOID" or a stain to appear on a handwritten Rx when altered by a wide range of chemicals. Toner receptor coating protects laser-printed Rx data from being removed or altered. (Cat. 2) Recommended for use with Preprinted Text Fields

Heat-sensitive Image: An Rx, logo, or other symbol printed with Thermochromic ink, so the image changes color or disappears when it is rubbed briskly or exposed to warm breath. (Cat. 1 and 3)

Security Features List: a prominent display of the prescriptions features, sometimes part of a "Warning Band" or box. (Cat. 3)

Example of a Color Copied Prescription

Hollow Pantograph: VOID or ILLEGAL is designed to not obscure or block vital information. Often showing strongest intensity at the "top" or the document. These pantographs generally do not "pop" on a black and white fax

C. Best Practices for Tamper Resistant Printed Prescriptions (Generated by an EMR)

Example A

Washington Medical Group
555 Pennsylvania Ave, Washington DC 20001
202-222-2222 (Fax) 202-222-1111

Name Jane Q Public — **Date** 06/29/2008
Addr 123 Main Street — **DOB** 07/04/1960
City Washington, DC 20001 — **Ph:** 202-555-5555

HYDROCHLOROTHIAZIDE 12.5 MG CAPS One (1) tab by mouth each morning
Generic: HYDROCHLOROTHIAZIDE

Disp ***30*** THIRTY (2)
Refill ***3*** THREE

Security features: (*) bound & spelled quantities, microprint signature line visible at 5x or > magnification that must show 'THIS IS AN ORIGINAL PRESCRIPTION' & this description of features (3)

(1) John Smith, MD
NPI# 1111111111

Category #1 – Copy Resistance: Microprint signature line*

Category #2 – Modification / Erasure Resistance: Border characteristics (dispense and refill # bordered by asterisks AND spelled out)

Category #2 – Modification / Erasure Resistance: Printed on “toner-lock” paper

Category #3 – Counterfeit Resistance: Listing of security features

*Microprint Line viewed at 5x magnification

*__This is an original prescription__

Example B

The Center for Women's Health
555 Pennsylvania Ave, Washington CT 20001
202-222-2222 (Fax) 202-222-1111

(1) Rx

Name Jane Q Public
Addr 123 Main Street
City Washington, CT 06597

Date 06/29/2008
DOB 07/04/1960
Ph: 860 -555-5555

HYDROCHLOROTHIAZIDE 12.5 MG One (1) tab by mouth each morning
Generic: HYDROCHLOROTHIAZIDE

Disp ***30*** THIRTY (2)
Refill ***3*** THREE

Security features include: (*) bordered and spelled quantities, a void pantograph and reverse Rx (when copied – the prescription will say "COPY" and the "Rx" in the upper right corner will NOT be visible), and this description of features.
(3)

John Smith, MD
NPI# 1111111111

Category #1 – Void/Illegal/Copy Pantograph with or without Reverse Rx

Category #2 – Modification / Erasure Resistance: Border characteristics (dispense and refill # bordered by asterisks AND spelled out)

Category #2 – Modification / Erasure Resistance: Printed on "toner-lock" paper for laser printed prescriptions, and on plain bond paper for inkjet printer prescriptions

Category #3 – Counterfeit Resistance: Listing of security features

Appendix R
Copayments for Certain Services

Effective with dates of service July 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 99499) including the ophthalmologic services procedure codes (92002 92014) used by physicians or physicians' assistants.

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.

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

i. Pregnant women

ii. Nursing facility residents

iii. Hospice care members

iv. Members under 21

Women diagnosed with breast or cervical cancer and receiving Medicaid under the Women's Health Medicaid Program, aid categories 245 and 800 only.

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

i. Dialysis

ii. Emergency services

iii. Family Planning services (must bill with medical diagnosis)

iv. Waiver 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 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.

C. 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(H) of CMS 1500 claim form:

i. P = Pregnant

ii. S = Nursing facility members

iii. H = Hospice

iv. E = Emergency services

v. FP = Family Planning

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

Pharmacy Services

Refer to Pharmacy Service Manual for current policy and copayment requirements.

Appendix S
Telemedicine and Telehealth

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

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

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

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

For specific information regarding services, coverage, and limitations for Telemedicine Services, please see the Georgia Telemedicine Handbook, and relevant Banner Messages available online at www.mmis.georgia.gov.

Appendix T
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. Additionally, every physician and health care provider who provides prenatal care of a pregnant woman during the third trimester of gestation shall offer to test such pregnant woman for HIV and syphilis at the time of first examination during that trimester or as soon as possible thereafter, regardless of whether such testing was performed during the first two trimesters of her pregnancy. Please refer to the Independent Lab Services Manual for a list of covered procedure codes for HIV and syphilis.

A. HIV PRE-TEST COUNSELING

i. Discuss With Pregnant Women

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

B. INFORMED CONSENT FOR HIV BLOOD TEST

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:

1. Discuss the meaning of the test results:
2. Discuss availability of medical care including prophylaxis for opportunistic infections and antiretroviral therapy:
3. 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:
4. Discuss partner/contact notification; offer assistance:
5. Encourage referral of partners and children for HIV testing:
6. 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
7. Provide or refer to needed medical support and services:

Note: 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.

i. Before Prescribing Any Regimen:

1. 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:
2. Discuss patient concerns:
3. Obtain ZDV use history:

Appendix U
Statement of Participation

The new Statement of Participation

is available in the Provider Enrollment Application Package.

Written request for copies should be forwarded to:

Provider Enrollment

Access on-line at www.MMIS.georgia.gov

OR

Phone your request to:

1 (800) 766-4456

Appendix V
Gainwell Technology

Provider Correspondence

Gainwell Technology

P.O. Box 105200

Tucker, GA 30085-5201

Provider Enrollment

Gainwell Technology

P.O. Box 88030

Atlanta, GA 30356

Prior Authorization & Pre-Certification

Alliant

P.O. Box 105329

Tucker, GA 30348

(800) 766-4456 (Toll Free)

Electronic Data Interchange (EDI)
1-800-267-8785

Asynchronous
Web portal
Physical media
Network Data Mover (NDM)
Systems Network Architecture (SNA)
Transmission Control Protocol/
Internet Protocol (TCP/IP)

Provider Inquiry Numbers:

800-766-4456 (Toll free)

The web contact address is

http://www.mmis.georgia.gov

Appendix W
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?

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

1. All Medicaid healthcare providers and
2. 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. 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.

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?

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

1. Paper claims submission (CMS 1500)
2. Resubmission of electronic claims on paper
3. Submission of web claims
4. IVR System inquiries

(a) Provider authentication

(b) All claim inquiries

(c) All other inquiries

5. Telephone inquiries

(a) Provider authentication

(b) All claim inquiries

(c) All other inquiries

6. Provider authentication

(a) Requests

(b) Inquiries

7. Referrals

(c) Requests

(d) Inquiries

8. Medicaid forms

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

i. Adding a location to my Provider record

ii. Changing my Provider information

iii. Written inquiries and correspondence

iv. E-mail and 'Contact Us' inquiries

Refer to the Part I Policy and Procedure Manual for Medicaid and PeachCare for Kids, Billing Manual, for a list of provider types, categories of service (COS), specialty codes, and specialty descriptions for Georgia Medicaid. (Rev 07/07)

Appendix X

Provider Preventable Conditions, Never Events, and Hospital Acquired Conditions

Effective July 1, 2012, the Centers for Medicare and Medicaid Services (CMS) directed all state Medicaid agencies to implement its final rule outlined in 42 CFR 447.26, regarding PROVIDER PREVENTABLE CONDITIONS (PPCs), NEVER EVENTS (NEs), and HOSPITAL ACQUIRED CONDITIONS (HACs) acquired in ALL hospital settings and other non-inpatient health care settings.

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

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

Claims will be subject to retrospective review in accordance to 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 Y
New CMS 1500 Claim Form

HEALTH INSURANCE CLAIM FORM

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

PICA　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　PICA

CARRIER

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

PATIENT AND INSURED INFORMATION

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

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

SAMPLE

The following table outlines the revised changes on the above CMS 1500 claim form version 02/12:

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Number 1	anged "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	anged "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Number 1	anged "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Number 1	anged "(ID)" to "(ID#)" under "OTHER.'
Number 8	leted "PATIENT STATUS" and content of field. Changed title to "RESERVED FOR NUCC USE."
Number 9b	leted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "RESERVED FOR NUCC USE."
Number 9c	leted "EMPLOYER'S NAME OR SCHOOL." Changed title to "RESERVED FOR NUCC USE."
Number 10d	anged title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **R DCH/Gainwell:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
n Number 11b	leted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier

Appendix Z
Georgia Families & NEMT

A. Georgia Families and Non-Emergency Medical Transportation

For information on the Georgia Families, Georgia Families 360, or Non-Emergency Medical Transportation program, please access the overview document at the following link:

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

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