PART II

POLICIES AND PROCEDURES
for
DIAGNOSTIC SCREENING AND PREVENTIVE SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: October 1, 2025

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Policy Revision Record
from 2024 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
10/1/2025	Appendix B	Procedure code 87389 has been added to Appendix B	A	
07/01/2025	Appendix B	CMS terminated procedure codes 0240U and 0241U. Removed from Appendix B	D	
07/01/2025	Appendix A	Replace 1st Care Service with Perinatal Health Partnership	M	
07/01/2025	601.2.11	Replace High-risk infant follow-up with Perinatal Health Partnership	M	
04/01/2025	Appendix B	All vaccine codes are located on the PADL Fee Schedule	M	
04/01/2025	602.1.7	The word “and” was changed to word “or”	M	
04/01/2025	903.8	Updated the administration codes for vaccine	M	
04/01/2025	601.10	Removed pregnancy related	D	
01/01/2025		98016- (Established patient brief communication via telehealth 5-10 mins).	A	

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

601. General

In addition to the general conditions of participation identified in Part I, Section 106, providers enrolled in the Diagnostic, Screening and Preventive Services (DSPS) program must meet the following special conditions:

601.1. The provider agrees to bill only for those diagnostic, screening and treatment services provided personally and directly by licensed practitioners of the healing arts within the scope of their licensure under state law.

601.2. The provider agrees to provide diagnostic, screening and treatment services at an office, clinic, school-based clinic, home, or other similar physical facility within the boundaries of the State of Georgia. The only exception to this condition is the provision of environmental lead investigations, which must be provided at the member's primary place of residence within the boundaries of the State of Georgia. At a minimum, the Diagnostic, Screening and Preventive Services provider must provide the following services:

601.2.1. Antepartum and postpartum care;

601.2.2. Newborn follow-up services;

601.2.3. Immunizations for adults;

601.2.4. Diagnosis and treatment of sexually transmitted diseases;

601.2.5. Hepatitis B management;

601.2.6. Hypertension diagnosis and treatment;

601.2.7. Follow-up and management of tuberculosis; and

601.2.8. Nutritional counseling;

601.2.9. Case management services

601.2.10. Children 1st services

601.2.11. Perinatal Health Partnership

Case management services are only reimbursable for Women's Health Medicaid, Children's Medical Services and High-Risk Infant Follow-Up (Medicaid and Peach Care) eligible.

The services listed above must be provided directly by the enrolled provider. Enrolled providers may not subcontract for the delivery of services.

601.3. The provider agrees to bill the Division the usual and customary fee for each procedure performed. "Usual and customary" is defined as the fee charged to private-paying patients for the same procedure during the same period.

601.4. The provider agrees to maintain records on both Medicaid-eligible and private-paying patients for a minimum of five (5) years. The provider further agrees to furnish the Division, its authorized representatives, or contractual agents, with such information as the Division may request from time-to-time, including information on fees.

601.5. The provider agrees not to bill for any services performed by an independent laboratory or x-ray facility or other health care provider.

601.6. The provider agrees to cooperate with the appropriate guidelines of other Medicaid programs adjunctive to DSPS, such as non-emergency transportation, ambulance, durable medical equipment, orthotics and prosthetics, pharmacy and physician services, family planning and Health Check (EPSDT).

601.7. The provider agrees to notify the Division's Provider Enrollment Unit in writing should any change in enrollment status occur such as: new address and/or telephone number; additional DSPS locations; change in payee; and voluntary termination from the program. Each notice of change must include the date on which the change(s) is to become effective.

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

601.9. The provider agrees to maintain such records as are necessary to demonstrate program compliance and to submit or make such records available upon request for a minimum of five (5) years from the date(s) the service(s) is provided.

601.10. Enrolled Diagnostic, Screening and Preventive Services providers also must be a provider of Health Check (EPSDT), family planning, and perinatal case management services.

601.11. The provider agrees to submit cost and information reports in accordance with the policies and procedures of the Division of Medical Assistance and the Division of Public Health of the Department of Human Resources for the determination of reimbursement rates for covered services.

601.12. The provider agrees to always maintain patient confidentiality

601.13. The provider agrees to assure that there is no duplication of services, i.e., members receive only one type of case management service.

602. Collaboration Between Providers Must Take Place In Order To Avoid Duplication Of Services

Certain members may be eligible for other types of case management services. DCH will reimburse only one provider agency for case management services.

602.1. Children 1st and Case Management

Definitions:
Children 1st is a statewide system for assessing health and socio-environmental risk factors in children from birth to age five (5). It provides a single point of entry to identify risk factors and offer linkages to services to promote early childhood development and improved health for children at risk.

Case Management Services means services which will assist Medicaid eligible individuals to gain access to needed medical, social, educational and other services. Such services include but are not limited to, the following:

602.1.1. Assessment of eligible individuals to determine service needs, including activities that focus on needs identification, to determine the need for any medical educational, social, or other services.

602.1.2. Development of a specific care plan based on the information collected through assessment; that specifies the goals and actions to address the medical, social, educational, and other services needed by eligible individuals.

602.1.3. Referral and related activities to help individuals obtain needed services.

602.1.4. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the individual.

602.1.5. Providers of Children 1st and case management services must:

602.1.6. Have the capacity to provide the full range of services as described in Part I, Section 101 and Chapter 600.

602.1.7. Have full-time trained staff who meet the following qualifications:

A nurse, social worker or nutritionist licensed in Georgia with a minimum of one year of experience working in the delivery of services to children with special health care needs and/or women's health; or

A professional (Bachelor, Masters level) or paraprofessional with one year of human service delivery experience in health and human services. Such staff supports Children 1st or case management services and performs under the supervision of a licensed nurse, social worker, or nutritionist.

602.1.8. Have demonstrated ability to provide and coordinate services to specific population and program category through family assessments, home visits, referrals, and case management.

Chapter 700: Special Eligibility Conditions

701. Eligibility Conditions

There are no special eligibility conditions which members must meet to receive diagnostic, screening and preventive services other than those stipulated in Section 101 of Part 1.

Chapter 800: Prior Approval

801. Prior Approval

The services covered in this Policy Manual do not require approval by the Division prior to their provision. However, the Division may require prior approval of all, or certain procedures rendered by all or certain providers based on the findings or recommendations of the Division, its authorized agents or the Department of Health and Human Services. In such instances, the Division will serve written notice to the provider of this requirement.

Chapter 900: Scope of Services

901. General

The Diagnostic, Screening and Preventive Services (DSPS) program provides reimbursement for a broad range of diagnostic, screening and preventive services, subject to the reimbursement limitations established in this manual.

902. Covered Services

902.1. General

The procedure codes listed in Appendix B of this manual constitute the services covered under the DSPS program. Other program services covered by the Division, such as Health Check (EPSDT) and Family Planning, are not included. Referrals should be made for Family Planning, Health Check, and WIC services. Nutritional counseling for adults who are not eligible for WIC services is covered under the DSPS program provided by a licensed dietician.

902.2. Children 1st and Case Management Services

Children 1st and case management services for Medicaid Peach Care eligible members are covered under the DSPS program provided by a licensed nurse, social worker or nutritionist.

For detailed description, see Appendix A for-Case Management Services and Appendix I for Children 1st Services.

903. Service Limitations

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

903.1. Injectable Drugs

Procedure codes and descriptions for injectable drugs (other than allergy injections) are listed in the Division's Schedule of Maximum Allowable Providers` Administered Drug List, which may be obtained from the Division's web site.

903.2. Laboratory Services

903.2.1. To bill the Division for laboratory services, the provider's laboratory must meet the criteria established in the 1988 Clinical Laboratory Improvement Act (CLIA 88). In addition, the laboratory must meet current OSHA standards.

A copy of the laboratory's most recent certification must be submitted to the Division.

903.2.2. Independent laboratories are enrolled separately in the Medicaid program and must bill the Division directly for their services. When a DSPS provider collects specimens and forwards them to an independent or public laboratory, the DSPS provider may not bill the Division for the collection and handling of the specimen(s) as reimbursement for collection and handling is included in the Evaluation and Management (E/M) code billed.

903.2.3. The Division will not reimburse DSPS providers for laboratory procedures performed by independent, State or public laboratories. DSPS providers must furnish the independent or public laboratory with the member's name and Medicaid number and identify test procedures to be performed. The following procedures are to be sent to the State Laboratory System:

903.2.3.1. Newborn Neonatal Metabolic screening tests;

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

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

903.2.3.4. Hemoglobin solubility test for members over six (6) months of age with HES results that indicate sickle cell anemia or trait;

903.2.3.5. Syphilis Serology

VDRL, RPR; and

903.2.3.6. Precipitation or floculation and Fluorescent Teponema Antibodies (FTA);

903.2.3.7. Tuberculosis Testing

Tubercle culture;

Definitive identification;

903.2.3.8. Salmonella and Shigella Testing; and

The State Laboratory addresses and telephone numbers are listed below:

Decatur Central Public Health Laboratory

Georgia Department of Public Health
Laboratory Services & Supply
1749 Clairmont Road
Decatur, Georgia 30033-4050
(404) 327-7920 FAX (404) 327-7922

Waycross Public Health Laboratory

Georgia Department of Public Health
Laboratory Services & Supply
1751 Gus Karle Parkway
Waycross, Georgia 31503
(912) 338-7050 FAX (912) 338-7061

GA Dept. of Human Resources
1101 Church Street
Waycross, Georgia 31501-3525
(912) 285-6000

Specimen outfits for testing to be done in the Regional Laboratories are available at the above addresses with the exception of Atlanta Central Laboratory. Specimen outfits for Atlanta Central must be obtained from:

Laboratory Services and Supply
1749 Clairmont Road
Decatur, Georgia 30033-4050

903.3. Newborn Services

Preventive health screening of eligible children performed after the newborn examination is covered under the Health Check and Pregnancy Related Services programs only.

The Division has set up a procedure whereby Medicaid-participating hospitals and birthing centers can directly report to Medicaid the birth of a child born to a Medicaid-eligible woman.

Diagnostic, Screening and Preventive Services (DSPS) providers are encouraged to refer pregnant women to DFCS for eligibility determination for the mother and the unborn child and to contact the hospital for Medicaid numbers on newborns.

Please see Part I, Section 101 for information regarding Medicaid eligibility for newborns. See Appendix F for the Newborn Eligibility Form.

903.4. Obstetrical Services

903.4.1. Initial Visit and Prenatal Profile

The Division provides reimbursement for the initial visit to determine

pregnancy separately from any other obstetrical care If a specimen for pregnancy testing is collected for referral to an independent laboratory, a collection and handling fee is not billable separately under CPT code 99000. Reimbursement for collection and handling is included in the E/M code billed. Charges for the clinic visit should be billed immediately after the contact. The initial visit must be billed as a family planning service using diagnosis code "FP."

903.4.2. Antepartum and Postpartum Care--Partial Obstetrical Care Due to Involvement of More Than One Provider During Pregnancy

When billing for services which usually fall under antepartum care only, you must bill the appropriate evaluation and management procedure code per encounter. The visits for antepartum care must be billed with a diagnosis code in the ICD -10 CM range of O02.81 through O92.70, as antepartum visits are not subject to the ten-office visit limitation.

903.4.3. If the same provider began routine antepartum care in the first trimester of pregnancy (on or before 13 weeks gestation) and continued to deliver routine prenatal care through no less than 32 weeks of gestation (by date and/or ultrasound) and did not deliver the child, the provider must bill the appropriate evaluation and management code for ANTEPARTUM CARE.

903.4.4. If the same provider began routine antepartum care later than the first trimester and/or did not continue to deliver routine prenatal care (as outlined above) through the 32nd week of gestation, the provider must bill each prenatal visit with an E/M procedure code.

Routine prenatal care visits should be coded at the appropriate E/M code level, depending on the services rendered.

903.4.5. If a member begins prenatal care late (greater than 28 weeks gestation by dates and/or ultrasound), the provider must bill subsequent prenatal visits under the appropriate E/M Code. The provider may also bill for POSTPARTUM CARE, depending on the services rendered.

903.5. Pregnancy Testing

Pregnancy testing under the DSPS Program must be billed using procedure code 81025. If the pregnancy test is directly related to the patient's contraceptive method, it must be billed under the Family Planning Program. For billing instructions under the Family Planning Program, reference the Policies and Procedures for Family Planning Services manual.

903.6. Clinic Visits

Only one clinic visit per date of service is reimbursable regardless of extenuating circumstances.

903.7. Radiological Services

Radiological services covered for DSPS provided are listed in Appendix B of this manual.

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. For example, three single view frontal chest x-rays performed on the same date of service would be billed as one unit of procedure code 71047.

903.8. Immunizations

Diagnostic, Screening and Preventive Services (DSPS) providers should bill the following vaccine administration codes 90471, 90472, 90473, 90474 associated with a clinic visit along with the covered immunizations given to members over 21 years of age.

903.9. Nutritional Counseling

903.9.1. The Division will reimburse Providers for new patient nutritional assessment, established patient nutritional counseling and nutritional group counseling visits (refer to Appendix B for the appropriate procedure codes).

903.9.1.1. Nutritional counseling (individual or group) can be billed as a single service if it was the only service provided that day.

903.9.1.2. Nutritional counseling (individual or group) rendered in combination with other clinic services on a particular day should not be billed separately.

903.9.1.3. Nutritional counseling for WIC-eligible members must be beyond the first two (2) nutrition education contacts.

903.9.1.4. Nutritional group counseling classes must be specific to member's nutrition-related medical condition and diagnosis.

903.10. Coverage and Limitations

903.10.1. A total of twelve sessions of nutritional counseling services are allowed per member per calendar year.

903.10.2. Only one nutritional counseling session may be billed per day.

903.10.3. The new patient nutritional assessment session, procedure code 99203, is limited to one per member, per calendar year.

903.10.4. The established patient nutritional (individual or group) counseling session, procedure codes 99213, 99211 are limited to eleven per member per calendar year the first year and twelve each subsequent year.

903.10.5. A Group Nutritional Counseling may replace the individual counseling visit and will be billed as 99211.

Procedure Codes 99203, 99211 and 99213 are not reimbursable if done on the same date of service.

903.11. Speech, Language and Hearing Services

903.11.1. The Division provides reimbursement for speech, language and hearing services for members less than twenty-one years of age when rendered by licensed audiologists or licensed speech therapists. Please see Appendix C of this manual for appropriate procedure codes.

Coverage and Limitations

903.11.2. Speech, language and hearing services are limited to eligible Medicaid members under twenty-one years of age.

Procedure code 96105, assessment of higher cerebral functions, is limited to one per member per calendar year (see Appendix C for additional speech, language and hearing service procedure codes).

903.12. Environmental lead investigations are limited to members between the ages of six months and seventy-two months who meet the blood lead level requirements described in Appendix E of this manual.

903.13. Special Services

Diagnostic, Screening and Preventive Services (DSPS) providers may offer additional services that are beyond the scope of services described in Section 901 of this manual.

Providers must seek separate and individual enrollment from the Provider Enrollment Unit for each type of service rendered, including:

903.13.1. Health Check;

903.13.2. Dental Services;

903.13.3. Mental Health Clinic Services;

903.13.4. Vision Care Services;

903.13.5. Family Planning Services;

903.13.6. Nurse Midwifery Services;

903.13.7. Nurse Practitioner Services;

903.13.8. Pregnancy Related Services;

903.13.9. Perinatal Case Management;

903.13.10. Pharmacy; and

903.13.11. Physician Services

The above services are governed by policies and procedures specific to each program. Policies and procedures for DSPS do not apply to these services and billing would be according to program policies and procedures for each program identified above.

903.14. Case Management Services

A licensed nurse, social worker or nutritionist may bill for case management services (refer to Appendix A for appropriate procedure codes).

Levels of acuity for case management interrelated activities are based on the assumption that members will require care coordination of varying levels of intensity depending upon the complexity of medical condition, psycho-social needs, economic and environmental factors.

The case manager will conduct and document a program specific Needs Assessment.

Care Plan based on the Needs Assessment will assign a level of intervention. The Level of Service (Intervention) must not exceed the Level of Need.

All levels of case management services include counseling and/or coordination of care with other providers or agencies consistent with the nature of the problems and the individual and family needs.

903.15. Autism Screening:

CPT 96110 - DEVELOPMENTAL SCREENING is required at ages 18 months and 24 months or any time parents raise a concern:

The screening should be performed with an autism-specific screening tool. The Modified Checklist for Autism in Toddlers (MCHAT) is the recommended tool and downloadable at https://m-chat.org. The M-CHAT is a validated developmental screening tool for toddlers between 16 and 30 months of age and should not be used for children younger than 16 months of age. The M-CHAT is designed to identify children who may benefit from a more thorough developmental and autism evaluation. The M-CHAT can be administered and scored as part of the preventive health visit and can be used by specialists or other professionals to screen for developmental delay and autism. The M-CHAT on-line version features the latest scoring system, Modified Checklist for Autism in Toddlers, Revised with Follow Up (M-CHAT-R/F), making the results more sensitive in detecting developmental concerns.

Documentation:

Evidence of the screening. Documentation in the medical record must include a note indicating the date on which the screening was performed; a copy of the screening tool used; and documented evidence of a screening result or screening score. If indicated,

document the follow-up assessment, therapeutic interventions used, referrals made, and treatments received.

903.16. Children 1st Services

Refer to Appendix I for appropriate procedure codes and reimbursement guidelines.

903.17. High Risk Infant Follow up Services

See Appendix A for details.

903.18. Dental Services in Public Health Clinic

See Part II Policies and Procedures for Dental Services manual Section 909.

904. Non-Covered Services

The following services or procedures are non-covered by the Division under the DSPS program. This list is representative of non-covered services or procedures and is not meant to be exhaustive.

904.1. Nursing home visits;

904.2. Day care center visits;

904.3. Hospital visits;

904.4. Family planning services;

904.5. Radiological procedures performed by a portable x-ray service;

904.6. Drugs used or dispensed in the clinic except those injectables authorized by the Division;

904.7. Health Check screening services;

904.8. Laboratory services;

904.9. Experimental services;

904.10. Educational supplies, medical testimony, special reports, travel by the nurse, no-show or canceled appointments, additional allowances for services provided after clinic hours or between 10:00 pm and 8:00 am or on weekends and holidays;

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

904.12. Services performed outside of protocol or licensure of the specific practitioner;

904.13. The first two nutrition education contacts for WIC-eligible members;

904.14. Speech, language and hearing services for members 21 years of age and older; and

904.15. The initial basic audiometry screening. (Initial screening must be done under Health Check.)

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

904.17. Lead investigations done at sites other than the child's primary place of residence.

904.18. Consultation Services.

905. Health Check referrals are not required for members under 21 years of age.

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 general public for the same service or item on the same date(s) of service, the lowest price charged to other third-party payers, or the statewide maximum allowable reimbursement amount allowed for the procedure code reflecting the service rendered. Effective dates of service October 1, 2003, the
statewide maximum allowable reimbursement is 84.645% of the 2000 Resource Based Relative Value Scale (RBRVS) as specified by Medicare for Georgia Area 1 (Atlanta). All procedure codes recognized and adopted after the 2000 RBRVS are subject to the same level of reimbursement.

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

Reimbursement for services will be contingent on the DSPS provider's enrollment in the program, the patient's eligibility at the time services is rendered, and compliance with any other applicable policies and/or procedures.

1002. National Correct Cording Initiative (NCCI)

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

Georgia Medicaid uses NCCI standard payment methodologies. NCCI Procedure to Procedure edits prevent inappropriate payment of services October 2024 Diagnostic, Screening and Preventive Services X-2 that should not be bundled or billed together and promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUEs) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service provided, including the most appropriate modifier when required.

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

1003. General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18) C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR

provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim cannot be paid.

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

For the NEW CMS-1500 claim form:

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

The Place of Service codes for services provided at the clinic is "71".

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.

For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that captures 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:

1003.1. Access the department's DCH-i newsletter and FAQs at http://dch.georgia.gov/publications

1003.2. Search to see if a provider is enrolled at https://www.mmis.georgia.gov/portal/default.aspx

Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider's last name.

1003.3. Access a provider listing at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Notices/tabId/53/Default.aspx

Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

Appendix A
Case Management Services

The following procedure codes for case management services will be covered for Women's Health Medicaid, Children's Medical Services and "Perinatal Health Partnership (Medicaid and Peach Care) eligible members. Program areas will determine appropriate assessment tools and levels of care for case management services. Cost will be evaluated, and reimbursement adjusted to reflect cost.

99202	99211	99215	99345	99350
99203	99212	99341	99347	
99204	99213	99342	99348	
99205	99214	99344	99349	

A. Medicaid Reimbursement Guidelines

i. Case management services must be completed prior to billing.

ii. The Annual or Comprehensive Assessment can be billed only once per family member per calendar year.

iii. The dates of service for the follow-up visits must be after the date of the Annual or Comprehensive Assessment.

iv. Level I, Case Management Services are limited to a maximum of ten (10) 99211/minimal visits, ten (10) 99202/99212 problem-focused follow-up visits, and one (1) 99347/home visit per year.

v. Level II, Case Management Services are limited to a maximum of ten (10) 99211/minimal visits, ten (10) 99203/99213 expanded-problem focused follow-up visits, and one (1) 99348/home visit per year.

vi. Level III, Case Management Services are limited to a maximum of ten (10) 99211/minimal visits, ten (10) 99204/99214 detailed follow-up visits, and one (1) 99349/home visit per year.

vii. Level IV, Case Management Services are limited to a maximum of ten (10) 99211/minimal visits, ten (10) 99205/99215 comprehensive follow-up visits, and two (2) home visits per year. The Home Visits will be at the 99349 level at a minimum. If indicated, a 99350 Home Visit may be charged after October 1, 2002.

Appendix B
Diagnostic, Screening and Preventive Services (DSPS)Procedure Covered Codes

10060	73110	82947	92587	96159	99385
11020	73130	82948	92588	96164	99386
11102	73140	82962	92650	96165	99387
11103	73501	85013	92651	96167	99396
11104	73502	85018	92652	96168	99397
11105	73503	85025	92653	96573	99401
11106	73521	86328	93005	96574	99406
11107	73522	86480	93010	97151	99407
29700	73523	86580	93041	97152	99408
29705	73551	86769	93050	97153	99409
29710	73552	86794	93264	97154	99415
29720	73560	87070	93792	97155	99416
30300	73592	87081	93793	97156	99421
46900	73610	87164	93986	97157	99422
54050	73650	87205	94010	97158	99451
56501	73660	87210	94150	97535	99452
57061	74018	87220	94617	97750	99458
57150	74019	87389	94618	97763	99473
57452	74021	87426	94664	98016	99747
57454	74712	87428	95004	99050	99491
59430	74713	87662	95017	99051	G0123
65205	76805	87634	95018	99202	G0143
69209	76810	87635	95249	99203	G0144
70350	76815	87636	95863	99204	G0145
70360	76816	87637	96105	99205	G0147
71045	77073	87804	96110	99211	G0306
71046	78265	87811	96112	99212	G0307
71047	78266	87913	96113	99213	Q2036
71048	78830	92537	96121	99214	Q3014
72081	78831	92538	96127	99341	U0001
72082	78832	92551	96133	99342	U0002
72083	78835	92552	96136	99344	0202U
72084	81000	92553	96138	99345	
73020	81002	92557	96139	99347	
73070	81025	92567	96146	99348	
73090	82270	92568	96156	99349	
73092	82271	92582	96158	99350	

For vaccine codes please see the PADL Fee Schedule.

Preventive Service Visits

99385 – New Patient, 18-39 years

99386 – New Patient, 40-64 years

99387 – New Patient, 65 years and older

99395 – Established Patient, 18-39 years

99396 – Established Patient, 40-64 years

99397 – Established Patient, 65 years and older

Nutritional Assessment and Counseling

99203 – New Patient

99211 - Group Nutritional Counseling

99213 - Established Patient

Environmental Lead Investigation

T1028 – Initial Lead Investigation

T1028– Post Hazard Abatement - Modifier U-1

Telehealth

98016 - Established patient brief communication via telehealth 5-10 mins.

Appendix C
Copayments For Certain Services

Effective dates of service October 1, 2005, the Division is implementing a tiered member co-payment scale as described in 42CFR447.54 on all evaluation and management procedure codes (99202 - 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 recipient
$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.

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

- Pregnant women
- Nursing facility residents
- Hospice care members
- 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.

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

Emergency services	Waiver Services
Family Planning services	Dialysis Services

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

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

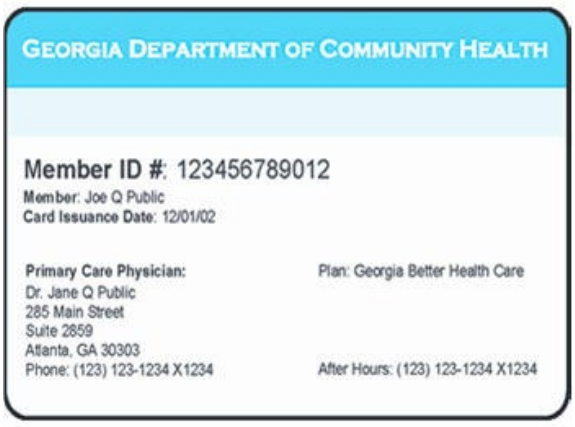
The Division may not be able to identify all members who are exempt from the co-payment. Therefore, providers should identify the members by entering the following indicators in field 24(I) of CMS 1500 claim form:

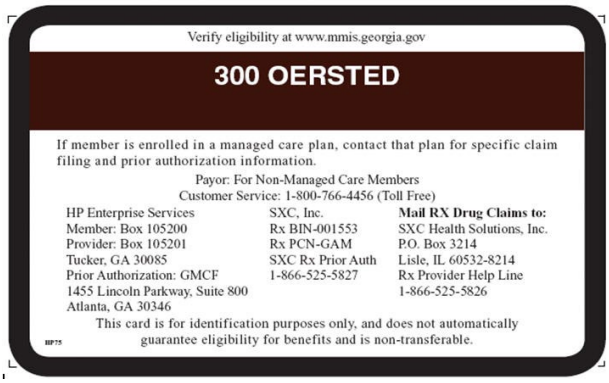
P	=	Pregnant
S	=	Nursing facility members
H	=	Hospice
E	=	Emergency services

Gainwell Technologies will automatically deduct the co-payment amount from the provider's payment for claims processed with dates of service October 1, 1994, and after. Do not deduct the co-payment from your submitted charges. The application for 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, please refer to the Pharmacy Service Manual for current policy and copayment requirements.

Appendix D
Medicaid Member Identification Card Sample





Appendix E
Environmental Lead Investigations

The following procedure codes for environmental lead investigations will be covered for children six months to seventy-two months of age. These codes are limited to one each per member per lifetime. They are covered only for the member's primary place of residence. Prior approval or other consideration for lead investigations done at locations other than the child's primary residence is not available. Rev 10/01/2015

T1028 - Initial lead investigation $229.60 –
T1028 - Post hazard abatement (Modifier U-1) $197.34

LEAD INVESTIGATIONS

A. **MEDICAID REIMBURSEMENT GUIDELINES**

i. This service must be provided in conjunction with a blood lead screening program for Medicaid eligible children

ii. A thorough environmental lead investigation should be conducted within specified time frames for:

All children ages six months to seventy-two months whose blood lead level, as confirmed by either two consecutive lab-analyzed capillary or one venous blood, equal to or greater than 3.5 micrograms per deciliter of blood.

iii. An environmental lead inspection must consist of:

On-site inspections of potential sources of exposure;

Testing of paint using a lead-in-paint analyzer and/or the physical collection of dust, soil, water and paint samples for laboratory analysis;

Analysis and interpretation of data;

Appendix F
Newborn Medicaid Certification

NEWBORN MEDICAID CERTIFICATION
(TEMPORARY)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Division of Public Health

Please mail completed form to

GHP
P.O. Box 105209
Tucker, GA. 30085-5209

NEWBORN MEDICAID ID NUMBER
Certifying provider must contact GHP to obtain a newborn I.D.

NEWBORN'S NAME — *First* | *MI* | *Last* | *Suffix*

DATE OF BIRTH

SEX Male ☐ Female ☐

Mother's Medicaid ID No.

Mother's Social Security No.

Is the mother a U.S. Citizen? YES ☐ NO ☐

MOTHERS NAME — *First Name* | *MI* | *Last*

MAILING ADDRESS — *Number and street* | *City* | *State* | *Zip* | *County* | *Telephone Number*

Date of Request

Parent / Relative Signature

COMPLETED BY — *Please Print*

TITLE — *Please Print*

PROVIDER NAME — *Please Print*

TELEPHONE

PROVIDER SIGNATURE

By signing, I certify to the best of my knowledge that the information above is verified and accurate

DATE COMPLETED

PROVIDER NO.

Please contact GHP to verify the mother's Medicaid eligibility for the month of the newborn's birth, and to obtain the newborn's Medicaid I.D. number.

DMA-550 REV. (07/10)

INSTRUCTIONS TO CLIENTS	INSTRUCTION TO PROVIDERS
This certification can be used to receive medical assistance services for only those persons listed on the reverse side. This certification must be presented to the provider each time medical assistance is requested for any person on the certification. You are responsible for this certification, do not let anyone borrow it. Unlawful use of this certification will result in prosecution. If you lose it, contact your caseworker. If you have other insurance coverage, you must notify the provider when seeking medical assistance. All out-of-state services must be prior approved to ensure payment. For information call: 1-800-766-4456 Hours: 8:00 a.m. – 7:00 p.m. ET. Monday thru Friday Please have your Medicaid client ID number ready when you call.	Medical assistance services are to be provided in accordance with the Department's medical assistance plan up to and including the last day specified on the reverse side. Certification must be requested each time a service is requested. Always check for other proof of identity. Enter the medical assistance claim from the complete case number as shown for the person receiving the service. Contact the Department of Medical Assistance on questions regarding client eligibility. Clients under the age of 21 are exempt from co-payment requirements. Clients of Medicaid in Georgia are not required to pay any portion of those medical bills that are required to be paid by Medicaid. If you have medical bills that should have been paid by Medicaid, please call 1-800-766-4456. You may also write to the Department at: Department of Medical Assistance Member Inquiry Unit 19th Floor 2 Martin Luther King Jr. Dr. SE East Tower Atlanta, Georgia 30334 The Department will inform you within 30 days of receipt of your telephone call or letter of your responsibilities, if any, for payment of the bill.

Appendix G
Georgia Health Partnership

Georgia Health Partnership (GHP)

Electronic Data Interchange (EDI)

1-877-261-8785
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 H
Statement of Participation

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

Phone your request to:

1 (800) 766-4456

Appendix I
Children 1st Family Assessment and Referral Services

A. CHILDREN 1ST FAMILY ASSESSMENT AND REFERRAL SERVICES

The following procedure codes for the Children 1st Family Assessment and referral services will be covered for Medicaid and Peach Care eligible members. Cost will be evaluated, and reimbursement adjusted to reflect cost.

99341	99347	99202	99211	99215
99342	99348	99203	99212	
99344	99349	99204	99213	
99345	99350	99205	99214	

Medicaid Reimbursement Guidelines

i. Children 1st Family Assessment Home Visit is limited to a maximum of one (1) per family unit, per calendar year. If provided to a new client, codes 99341, 99342, 99344 or 99345 are used. If provided to an established client, codes 99347, 99348, 99349 or 99350 are used.

ii. Children 1st Family Assessment clinic Visit is limited to a maximum of one (1) per family unit, per calendar year. If provided to a new client, codes 99202 or 99203 are used. If provided to an established client, codes 99213 or 99214 are used.

iii. Children 1st Optional Follow Up Visit, if indicated, is limited to a maximum of one (1) per family unit, per calendar year. If provided in the home, codes 99347, 99348, 99349 or 99350 are used. If provided in the clinic, codes 99213 or 99214 are used.

iv. Follow-Up /Referral services are limited to a maximum of three (3), contacts per family unit, per calendar year and may be direct or indirect. 99211 is coded when service provider is licensed or non-licensed. 99212 is coded when service provider is licensed

When billing Children 1st assessment and referral services for Medicaid and Peach Care eligible members, use diagnosis code ICD-10-CM R68.89. Children 1st assessment and referral services must be billed under the Diagnostic, Screening and Preventive Services program only.

Appendix J
Case Management Hierarchy

Duplication of Case Management Services

Federal policy and the Department of Community Health (DCH) prohibit the reimbursement for case management services to more than one agency or Medicaid provider that renders case management services to an individual. This policy is set forth according to the federal Requirements and Limits Applicable to Specific Services defined in the State Medicaid Manual, section 4302.

It is the responsibility of the case manager to ensure that the member is not receiving case management services from any other agency. The case manager must obtain from the member information regarding any and all other services that he/she may be receiving prior to enrolling the member in a case management program. If the case manager should learn that the member is enrolled in another case management program, the case manager is advised not to render any case management services until it is verified that his/her case management services are primary. This may require termination of the member from another case management provider before case management from the new provider can be billed. It is the case manager's responsibility to advise the member of the various case management choices available to the member and to allow the member to make an affirmative choice among them.

DCH will reimburse only one provider agency for case management services. The Department has established the case management hierarchy below to define which case management is primary and will be reimbursed the case management provider highest on the hierarchy will be reimbursed if 2 case management providers should submit claims for the same month of service.

COS 830 - (Case Management Organization - CMO) and
COS 851 - (SOURCE Case Management)
COS 100 - (MR Case Management Support) Only participants enrolled in COS 680 or 681
COS 764 - (Child Protective Services Targeted Case Management)
COS 800 - (Early Intervention Case Management)
COS 765 - (Adult Protective Services Targeted Case Management)
COS 760 - (Children At Risk Targeted Case Management)
COS 762 - (Adults with AIDS Targeted Case Management)
COS 763 - (At Risk of Incarceration Targeted Case Management)
COS 100 - (Case Management Support) Only MRDD participants on the Short-term planning list.
COS 960 - (Children Intervention School Service)
COS 790 - (Rehab Services/DSPS)

NOTES: Persons enrolled in hospice have case managers who manage all of their care and may not receive case management from any other program while enrolled in hospice. The Department's hospice lock-in system will automatically cause any other claims for case management to be denied.

Appendix K
PeachCare for Kids Co-Payments

A. Peach Care for Kids® Co-payments:

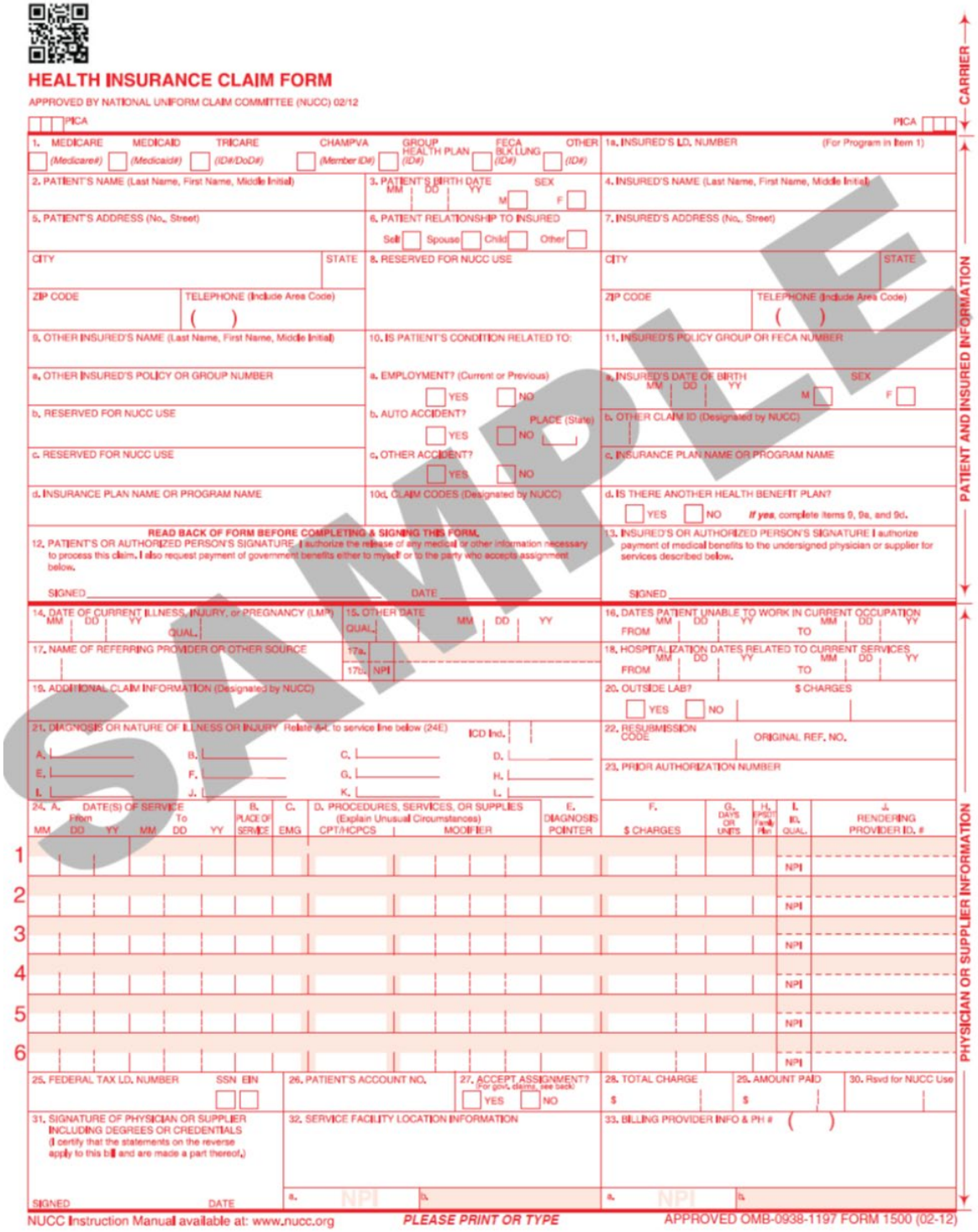
For children ages 6 and over, the following co-payments apply for each CMO:

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

Cost-Based Co-Payment Schedule	
Cost of Service	
$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

*There are no co-payments for children below the age of 6 years old, for children in Foster Care, or for children who are American Indians or Alaska Natives.

Appendix L
New 1500 CMS Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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 MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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

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"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/Gainwell Technologies:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?)
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)." Removed the arrow and text in the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier." **FOR DCH/Gainwell Technologies: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date)**.
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).

Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/Gainwell Technologies:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/Gainwell Technologies:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values ICD -10 diagnoses (CM) codes =
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. **FOR DCH/Gainwell Technologies**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

Appendix M
Health Check and Adult Preventive Visit

A. 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.

B. 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.

NOTE: Please refer to the Health Check Manual for children birth to twenty-one (21) years of age for specific details.

C. Adult Preventive Visit

Effective October 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 99202 - 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/Georgia Medical Care Foundation (GMCF) for review. Providers may bill ONE (1) preventive health visit (993XX) for a member annually (between October 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.
Rev 01/01/2018

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

Adult preventive services provide reimbursement for the following preventive health services:

99385 or 99395 - (Adults 21 through 39 years of age).
99386 or 99396 - (Adults 40 through 64 years of age)
99387 or 99397 - (Adults 65 years and older)

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

Immunization:

Influenza vaccination *

Pneumococcal vaccination*
Tetanus Diphtheria (Td) *
Zoster vaccination
Hepatitis A & B
Measles, mumps, rubella (MMR) *
Meningococcal
Varicella *
Human papillomavirus (HPV) for Women and Men *

Screening:

Breast cancer screening *
Testicular and Prostate screening *
Cervical cancer screening *
Colorectal cancer screening *
Cholesterol screening *
Body Mass Index (BMI) *
Diabetes
Hearing Assessment
Vision (Glaucoma)
Lipid Disorders
Osteoporosis
Smoking Cessation

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

Appendix N
Georgia Families, Georgia Families 360, 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. **Policy Fee Schedule(s):**
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Fee%20Schedules/tabId/20/Default.aspx

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

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

iv. **Non-Emergency Medical Transportation Overview**
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/8/Default.aspx