

PART II

POLICIES AND PROCEDURES
FOR
PODIATRY SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID
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**PART II - POLICIES AND PROCEDURES
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PART II - CHAPTER 600
SPECIAL CONDITIONS OF PARTICIPATION

600. In addition to the general conditions of participation identified in Part I, Section 106, providers in the Podiatry Services Program agree to bill the Division for only those services, which are performed by the podiatrist or under his direct supervision.

For purposes of this policy, only medically necessary, reasonable foot care will be reimbursed. Each of the following must be met:

- a) services must be rendered by medical personnel whom are authorized by law to perform the services and who are qualified by education and training;
- b) the person performing the services must be a salaried employee of the podiatrist or of the podiatrist's group practice as defined below. Podiatrists may not bill for the services of independent contractors who are eligible to bill Medicaid;
- c) the podiatrist must periodically and regularly review the patient's medical records;
- d) the podiatrist must be immediately available on the site at the time the services are delivered; and
- e) a podiatrist may not bill for services rendered by a person(s) not approved to provide that service by Medicaid Policy or applicable licensure, certification or other State or Federal Regulation.

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

In a group practice, each podiatrist must enroll separately and only bill for services they provided using their separate provider number. A group practice is defined as a partnership, a professional corporation, of podiatrists in a space-sharing arrangement . Indiscriminate billing under one podiatrist's name or provider number without regard to the specific circumstances or rendition of the services is specifically prohibited and will be grounds for disallowing reimbursement. Services performed by non-enrolled podiatrists in a group practice are not covered under any circumstances.

The common practice of one physician covering (Locum Tenens) for another will not be construed as a violation of this section. The services furnished by the covering physician is an informal reciprocal arrangement. The regular physician must identify the services as a substitute physician service.

For purposes of this policy, the explanations and limitations contained in Subsection 903.1 shall also apply.

- 601.** The podiatrist agrees not to bill for podiatric services provided in a nursing facility unless the member is specifically referred by his/her attending physician and the referral is documented in the patient's medical record. Standing orders are not sufficient for reimbursement by the Medicaid program.
- 602** The podiatrist agrees to bill the Division the lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date(s) of service, or the lowest price charged to other third party payers for the procedure code most closely reflecting the service rendered. The podiatrist also agrees to maintain records on both Medicaid eligible and private paying patients for a minimum of five years to fully disclose compliance with this Section. The podiatrist further agrees to furnish the Division, its authorized representatives, or contractual agents, with information as requested regarding fees, at no charge.
- 603.** The podiatrist agrees not to bill for any services performed by an independent laboratory or x-ray facility. An independent laboratory or x-ray facility is independent both of the podiatrist office and of a hospital. A laboratory or x-ray facility which is not located in a podiatrist's office or hospital is presumed to be independent unless written evidence establishes that it is owned by the billing podiatrist or a hospital.
- 604.** The podiatrist agrees to cooperate with the appropriate guidelines of other Medicaid Service Programs as necessary.
- 605.** The podiatrist agrees to notify the Division's Provider Enrollment Unit in writing of any changes in enrollment status (e.g., new address, telephone number, additional practice locations, change in payee, closure of an individual practice, dissolution of a group practice causing any change in our records or voluntary termination from our program). Each notice of change must include the effective date.
- 606.** The podiatrist agrees to bill the Division the procedure code(s) which best describe 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.

PART II - CHAPTER 700

SPECIAL ELIGIBILITY CONDITIONS

- 701.** There are no special eligibility conditions which members must meet in order to receive podiatric services other than those contained in Part I, Section 102.

PART II - CHAPTER 800

SCOPE OF SERVICES

800. General

Podiatry services (or foot care services) are defined as the diagnosis, medical, surgical, mechanical, manipulative and electrical treatment limited to ailments of the human foot or legs as authorized within the Georgia statute governing podiatric services. Federal regulations allow the state agency to place appropriate limits on medical necessity and provide utilization controls. If the provider has medical justification for exceeding the limitations set forth in this manual, it must be well documented, made available to the Division upon request, and in some cases require prior approval. Documentation can be requested as a prepayment review or post payment review. Lack of appropriate medical justification will be grounds for denial of service, or reduction or total recoupment of reimbursement.

801. Debridement

Debridement of mycotic nails is covered only if the patient is diabetic, or has a documented history or treatment for peripheral vascular disease. The division utilizes the following current procedural terminology (CPT) codes and descriptions to define debridement procedures:

<u>CPT</u>	<u>Description</u>
11720	Debridement of nail(s) by any method(s); one to five
11721	Debridement of nail(s) by any method(s); six or more
a).	When submitting claims for debridement of mycotic nails the most accurate ICD-10 diagnosis code must be billed and reflect the diabetic or peripheral vascular disease condition, rather than the foot condition.
b.)	When rendering service for a patient in the nursing home or patient's home, a separate fee for a visit is not reimbursable.

802. Evaluation and Management Services

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

802.1. Office or Other Outpatient E/M Services (99201-99215)

The following limitations apply for member's age twenty-one years or older:

- a) Reimbursement for office E/M services is limited to ten per member per calendar year (January 1- December 31), regardless of the number of physicians rendering care.

- b) Only one office E/M service per date of service is reimbursable to the same provider or provider group regardless of extenuating circumstances.
- c) Office E/M services after office hours, during night hours, Sundays and holidays are reimbursed at the same maximum allowable as regular office E/M Services.

802.2. Daily Hospital E/M Services (99221-99233)

If a member is admitted to the hospital as an inpatient, during the course of an appointment, in another site of services (e.g., hospital emergency department, physician's office, nursing facility) the evaluation and management service provided by that physician is considered part of the initial hospital care when performed on the same date as the admission

- a) Initial hospital care CPT codes 99221 through 99223 are only reimbursable to the admitting podiatrist. One unit of any CPT is reimbursable per admission.
- b) Hospital, emergency room, consultations or critical care E/M services on the same date of service are not separately reimbursable to the same podiatrist or group of podiatrists. Only one charge for the most appropriate level of care may be reimbursed for one date of service.
- c) Hospital E/M Services must be documented in the hospital records on the date of each visit. Documentation of service in the podiatrist's office records will not be sufficient for reimbursement of hospital E/M services.
- d) Hospital E/M Services to members awaiting nursing home placement is not reimbursable unless the services are medically necessary.

NOTE: If a physician bills for patient services and later determines that those services should have been billed as an outpatient services, the physician has three months to adjust the claim.

802.3 Consultation

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Consultations are provided by a physician at the request of another physician or appropriate source when an opinion or advice is sought by another physician for a patient. The patient is typically not under the direct care of the physician providing the consultation. The consultation could initiate diagnostic and/or therapeutic services at the same or subsequent visit. Effective 1/1/2014 consultation codes were reinstated for age 21 and under with limitation of one visit for office/outpatient visit limit of one per three years. Effective 7/1/2014 age restriction and visit limitations are removed.

Providers are instructed to bill the consultations codes that described the service they provided e.g. initial hospital care (99251- 99255), or initial office or other outpatient visits (99241- 99245) as applicable.

- a) If a consultation charge is indicated on a claim, the name of the referring physician must also be indicated. In addition, if the referring physician is a Medicaid provider, the Medicaid provider number must also be indicated. If the referring physician is not a Medicaid provider, the physician's Medicare UPIN number must be indicated.
- b) If a procedure is performed in an emergency room by a podiatrist, the proper code for the procedure must be billed, not the consultation code.
- c) Hospital Consultation Services must be documented in the hospital records on the date of each visit. Documentation of service in the podiatrist's office records will not be sufficient for reimbursement of hospital consultation services.
- d) Consultations are covered only if requested by the patient's attending physician, and documented in the medical records.

803. Observation

Observation services are those services by a hospital/physician, including use of a bed and periodic monitoring by a hospital's nursing or other staff, as an outpatient, which are reasonable and necessary to evaluate the patient's condition or determine the need for a possible admission to the hospital as an inpatient. Observation is to determine the need for further treatment or for inpatient admission. A patient in observation may improve and be released or admitted as an inpatient. Observation services are covered only when provided when ordered by a physician or another individual authorized by Georgia state licensure law and hospital staff bylaws to admit patients to the hospital or to order inpatient tests and when provided in compliance with all policies and procedures described in this manual.

Observation services usually do not exceed twenty-four hours. However, some patients may require 48 hour of outpatient observation services. In only rare and exceptional cases do outpatient observation services span more than 48 hours. A maximum of 48 hours of observation services will be reimbursed. 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. If the 48 hour observation limit is exceeded and the patient does not meet the criteria for an inpatient admission, the submitted claim may include the total number of units; but, the facility will only receive reimbursement for 48 hours (or units). The services beyond 48 hours are non-covered.

Providers should not substitute outpatient observation services for a medically appropriate inpatient admission. A person is considered a hospital

inpatient if formally admitted into a hospital and inpatient qualifying criteria designated by Division are met. If a hospital/physician places a patient under observation, but has not formally admitted them as an inpatient, the patient is considered an outpatient. Consequently, an inpatient is not considered discharged if placed in observation status after being admitted as an inpatient. Once admitted, observation status will not be reimbursed.

The availability of outpatient observations does not mean that services, for which an inpatient stay is anticipated, may be performed and billed to the Division on an outpatient basis. For additional information regarding hospital observation status, please review the Part II Policies and Procedures manual for Hospital Services.

804. Nursing Home Services

Podiatrists are able to treat members residing a nursing facility. When a provider performs a procedure in the nursing home setting they must bill the specific procedure or service rendered rather than an E/M visit code. For additional information regarding Nursing Home services please review the Part II Policies and Procedures manual for Nursing Facility Services.

805. Documentation

The podiatrist must maintain legible, accurate, and complete charts and records in order to support and justify the services provided. The chart is defined as a summary of essential medical information on an individual patient. Records is defined as dated reports supporting claims submitted to the Division for services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service shall be entered in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible and shall include but not be limited to:

- a) Date(s) of service
- b) Patient's name and date of birth
- c) Name and title of person performing the service
- d) Chief complaint or reason for each visit
- e) Pertinent medical history
- f) Pertinent findings on examination
- g) Medications, equipment or supplies prescribed or provided
- h) Description of treatment (when applicable)
- i) Recommendations for additional treatments, procedures, or consultations
- j) X-rays, tests, and results
- k) Plan of treatment, care and outcome
- l) The original handwritten personal signature, initial or electronic signature of the person performing the service must be on the patient's medical records. This includes but is not limited to progress notes, radiological and lab reports for each date of

services billed to the Division. The signature on the super bill does not satisfy this requirement. Medical record entries without specified signature may result in recoupment of payment. Electronic signature is defined as “an electronic or digital method executed or adopted by a party with the intent to be bound by or to authenticate a record, which is unique to the person using it, is capable of verification, is under the sole control of the person using it, and is linked to the data in such a manner that if the data are changed the signature is invalidated.” O.C.G.A. § 10-12-3. (1) (1997)

- m) All medical records must be written in Standard English language.

Records must be available to the GA Department of Community Health (all applicable divisions and units) and to the U.S. Department of Health and Human Services upon request. Documentation must be timely, complete, and consistent with the by-laws and medical policies of the office or facility where the service is provided.

806. Auxiliary Personnel

The Division does not enroll or reimburse auxiliary personnel employed by the physician, such as nurses, non-physician anesthetists, unlicensed surgical assistants or other aides. Physicians Assistant (PA) services are reimbursable only under criteria set forth in subsection 601.9 of the Part II Policies and Procedures manual for Physician Services. Services provided by practitioners eligible for enrollment can not 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:

- a) the services are rendered in a manner consistent with the requirements of Section 601.1 of this manual;
- b) the services furnished are “incident to” services performed under the direct supervision of the podiatrist as an adjunct to the podiatrist’s personal services;
- c) the services are services which are “commonly furnished” in the particular medical setting (“commonly furnished” services are those customarily considered incident to the podiatrist’s personal services).

Employed auxiliary personnel performing an incident to services may be part-time or full-time employees of the enrolled physician. In order to satisfy the employment requirement, the auxiliary personnel must be considered an employee of the enrolled physician. The physician must pay the FICA and

issue a W-2 form for the employee.

Services provided by auxiliary personnel not employed by the physician are not covered. Services that are provided on physician's order or included in the physician's bill are not covered as incidents to a physician's service. Part of the podiatrist's personal professional services in the course of diagnosis or treatment of an injury or illness. Such a service could be considered "incident to" when furnished during a course of treatment where the podiatrist performs an initial service and subsequent services which reflect the podiatrist's active participation in and management of the course of treatment. "Direct supervision by the podiatrist" does not mean the podiatrist must be present in the same room; however, the podiatrist must be at the site of these services (i.e., office suite, hospital, clinic, patient's home, nursing home, etc.) and be immediately available to provide assistance and direction throughout the time the services are performed

807. Locum Tenens

It is a long-standing and widespread practice for physicians to retain substitute physicians (called locum tenens) to take over their professional practices when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The locum tenen is typically not an employee of the regular physician and generally has a contract or agreement with the regular physician. During this period the regular physician will bill and receive reimbursement for the substitute physician's services as though he/she rendered the service.

A patient's regular physician may submit a claim and receive payment for services (including emergency visits and related services) rendered by a locum tenen physician if:

- a) The regular physician is unavailable to provide the visit services;
- b) The Medicaid member has arranged or seeks to receive the services from the regular physician;
- c) The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis;
- d) The substitute physician does not provide the visit services to Medicaid patients for a period of time exceeding sixty consecutive days within a twelve (12) month period.
- e) The substitute physician must be an enrolled Medicaid provider.

The locum tenen should have a Georgia Medicaid number. One enrollment and provider number is sufficient. The regular physician should place the locum tenens provider number in 24k on the 1500 claim form. Physicians should be aware that the services furnished by the substitute physician should be identified in the member's medical record held by the regular physician, which is available for inspection.

Reimbursements will be for services for which the regular physician (or group) is entitled to submit. A physician or other person who falsely certifies any of the above requirements may be subject to possible civil and criminal penalties for fraud.

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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 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 will not be paid.**

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

For the NEW CMS-1500 claim form:

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

For claims entered via the web:

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

For claims transmitted via EDI:

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

808. Medicare Deductible/Coinsurance

If a member is eligible for both Medicaid and Medicare, all claims must be sent to the Medicare carrier first. Medicare upper limits of reimbursement will apply for all services covered by Medicare. Policies and procedures for billing these services and detailed coverage limitations are described in Part I, Chapter 300. Please see the Medicare Secondary User Guide for any additional questions regarding dual eligible members.

809. Out-of-State Services

The Georgia Medicaid program will pay for medical services provided to Georgia members while out of state if the claim is received within twelve months from the date of service and if one or more of the following conditions are met:

- a) The service was prior authorized by the Department.
- b) The service was provided as a result of an emergency or life-endangering situation. (If the out-of-state provider believes the medical record supports the existence of an emergency situation but the diagnosis does not justify an emergency, the claim must be submitted with a copy of the medical records.); or
- c) The service was provided in a situation where a delay in treatment would have endangered the health of the individual.

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

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When prior authorizing a procedure or service the referring in-state provider is required to document, in writing, the medical necessity for obtaining services out of state and provide the name and address of the out-of-state medical provider, as well as the procedure or service being requested. The out-of-state provider is required to submit to our Medical Review Agent, Georgia Medical Care Foundation (GMCF), medical documentation to include a care plan and notification of discharge for evaluation of care.

Reimbursement will be determined in accordance with the policies and procedures of the Georgia Medicaid program and is contingent on the patient's eligibility at the time services were rendered. 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:

GMCF
P.O. Box 105329
Atlanta, Georgia 30348
1-800-766-4456

810. Radiological Services

Radiological codes can be billed as the complete procedure, for the professional component only or for the technical component only. All procedures do *not* have all three components; however, in general, the following rules should apply:

- a) Radiology services should be billed as the professional component (with the 26 modifier) when:
 - 1) The podiatrist provides only the professional service for the procedure; or
 - 2) The service is provided in a hospital; or
 - 3) The technical portion of the service is performed by someone other than the podiatrist's salaried employee.
- b) Radiology services should be billed as the technical component (with the TC modifier) when:
 - 1) The podiatrist is providing the technical portion of the service only. This component has very limited application under current Medicaid policy.
- c) Radiology services should be billed as the complete radiological procedures when the podiatrist provides both the professional and technical component. This includes charges for actually processing and developing the x-ray (technical component), and evaluating the x-ray (professional component).
 - 1) The provider should submit the codes as defined in the CPT *without* a modifier.

When billing for multiple identical radiology services performed on the same date of service, charges must be placed on only one line of the claim form with the number of x-rays taken being placed in the "unit" space. For example, three single view chest x-rays performed on the same date of service would be billed as three (3) units of procedure code 71010, at \$10.00 per unit to equal \$30.00 for the line charge. To bill for identical bilateral procedures where there is not an all-inclusive code, bill the procedure code with a "50" modifier on one line indicating one unit of service. Use of the "50" modifier will ensure correct payment for both procedures using the one code. However, if there is an all-inclusive procedure code for a bilateral procedure, the one charge for such procedure will be reimbursed at the lower of 100% of the allowed amount or the submitted charge.

810.1 Computerized Tomography - (CAT SCANS)

The Division reimburses for all medically necessary CAT scans.

810.2 Magnetic Resonance Imaging (MRI)

Medically necessary MRI services are covered by the Department 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.

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

811. Reduced Services

Under certain circumstances a service or procedure can be partially reduced or eliminated at the physician's election. The 52 modifier is to be used to signify that services were reduced. Reimbursement will also be reduced accordingly. For example: When a CPT code states that all codes in a section are for bilateral procedures, the 52 modifier must be utilized if only a unilateral service was provided. Failure to use the 52 modifier when documentation identifies that services were reduced can result in an overpayment which is subject to recovery.

812. Site of Service Differential

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

813. Supplies and Materials

Office medical supplies, except for drugs and certain supplies associated with performing the procedures listed in Appendix D of this manual, will be considered to be practice expenses which are included in the payment for the service to which they are incidental. No additional reimbursement will be made. For procedures in Appendix D, a supply expense will be added in the amount of \$32.89 when the procedure is performed in the podiatrist's office.

814. Surgery

Foot care for members twenty-one (21) years of age and older is limited to essential care, such as but not restricted to, treatment for trauma or complications related to a chronic disease, such as diabetes.

Elective surgeries for members twenty-one (21) 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 Departments Medical Review Agent.

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

814.1 Major Surgery

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

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

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

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

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

fee will include services such as dressing changes, local incision care and removal of operative packs; removal of cutaneous sutures, staples, and removal of urinary catheters, routine peripheral intravenous lines, and nasogastric and rectal tubes; and change and removal of Tracheostomy tubes. Procedures with a 90-day post-operative follow-up period which are subject to the major global surgery policy are listed in the current Federal Register.

814.2 Minor Surgery and Nonincisional Procedures

In addition to the major global surgeries in the surgery section of the CPT manual, there are a number of minor surgeries. These relatively minor surgical services are not traditionally paid using a global surgery policy. There are also diagnostic and therapeutic endoscopic procedures that are frequently performed by non-surgeons and may (or may not) involve actual surgery. These procedures also are not paid using a global surgery policy.

For minor surgeries and endoscopic procedures, no payment will be made for an E&M visit billed on the same day as the minor surgical procedure or endoscopy. Provisions will be made if the two services are separately identifiable (see the description for utilizing modifier 25).

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

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

814.3 Bilateral Procedures

If a procedure is performed bilateral (during the same operative Session) the first will be reimbursed at the lower of 100% of the allowed amount or the submitted charge, while the second will be reimbursed at the lower of 50% of the allowed amount or the submitted charge. To bill for bilateral procedures that do not have an all-inclusive code, bill the procedure code with a "50" modifier on one line indicating one unit of service. Use of the "50" modifier will ensure correct payment for both procedures using the one code.

However, if there is an all-inclusive procedure code for a bilateral procedure, one charge for the procedure will be reimbursed at the lower of 100% of the allowed amount or the submitted charge.

814.4. Multiple Procedures

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

- 1) the first or major procedure will be reimbursed the lower of 100% of the maximum allowed amount or the submitted charge.
- 2) the second thru the fifth procedure will be reimbursed the lower of 50% of the maximum allowed amount or the submitted charge. A non-related second major procedure may be reimbursed at 75% of the maximum allowed amount.
- 3) the subsequent procedures will be reimbursed the lower of 25% of the maximum allowed amount or the submitted charge.

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

814.5 Incidental Procedures

Additional charges for incidental procedures performed at the time of other services are not covered unless substantiated by medical documentation. Such incidental procedures would include an incidental appendectomy, incidental excision of scars, and lysis of adhesions. A diseased appendix surgically removed at the same time as another surgery will be reimbursed under the multiple surgery reimbursement policy. Another example of incidental services that may require medical documentation for separate reimbursement is E&M codes billed with a minor procedure.

814.6. Surgical Team

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

814.7. Co-Surgeons

Co-surgeons will be reimbursed one-half of 125% of the global fee and payment (equally divided between the two surgeons). No

payment will be made for an assistant-at-surgery in these cases. Providers will need to bill with the '62' modifier to denote services were performed by co-surgeons.

814.8. Surgery and Follow-up Care Provided by Different Physicians

The sum of all allowances for all practitioners who furnish parts of the services included in a global fee (bill using modifiers 54 and 55) must not exceed the total amount of the reimbursement that would have been paid to a single practitioner under the global fee for the procedure.

Each physician will be paid directly for the portion of the global surgery services furnished, providing all parties utilize the respective modifiers appropriately. It is expected that the surgeon always furnishes the usual and necessary pre and intra-operative services, and in-hospital post operative services with few exceptions. It is recognized that there are cases when the surgeon turns over the out-of-hospital recovery care to another health care provider. Reimbursement will be adjusted to accommodate these cases and will be made in accordance with the weighted percentages for post-operative care as published in the November 25, 1991, Federal Register. If the surgeon refers the patient to another provider for follow-up the surgeon agrees to accept the reduced reimbursement for the surgery (less the post operative care). The surgeon must file the surgical procedure with the '54' modifier. The follow-up care can not be reimbursed until the surgery has been billed and reimbursed. The physician providing the follow-up care must bill the surgery code with the '55' modifier. If the surgery is non-covered the follow-up care is also non-covered.

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

NOTE: Failure to file with the 54 modifier on the surgery claim will prevent payment to the provider rendering post-operative care.

815. Ambulatory Surgical Center Services

Certain freestanding ambulatory surgery centers are eligible to enroll in the Department's Ambulatory Surgical Center (ASC) Program and should be considered for certain surgical procedures. The Division encourages the use of ASCs as a less costly alternative to hospital surgery. ASCs are limited to certain covered surgical procedures that are furnished which otherwise would be covered if performed in a hospital. For additional information regarding

ASCs please review Policies and Procedures manual for Ambulatory Surgical and Birthing Center services.

816. Non-Covered Services

The following services or procedures are non-covered by the Department. This list is representative of non-covered services and procedures and is not meant to be exhaustive or all inclusive:

- a) Cosmetic Surgery.
- b) Evaluation and non-surgical treatment of a flatfoot condition regardless of the underlying pathology.
- c) Evaluation of subluxation of the foot and non-surgical measures to correct the condition or to alleviate symptoms.
- d) Routine foot care for ambulatory or bedridden patients including: cutting or removal of corns, warts or callouses; trimming nails and other hygienic and preventive maintenance care; self-care such as cleansing and soaking and the use of skin creams.
- e) Orthopedic shoes other than shoes that are an integral part of a brace.
- f) Orthotic foot devices such as arch supports or biomechanical orthotics.
- g) Vitamin B-12 injections to strengthen tendons, ligaments, etc. of the foot.
- h) Preventive health care (Members under age twenty-one may receive this care through the Health Check screening process)
- i) Drugs used in the podiatrist's office or dispensed by the podiatrist, except those injectables contained in the Division's Physicians Injectable Drug List.
- j) Acupuncture.
- k) All procedures listed in the CPT as "unlisted procedure".
- l) Educational supplies, medical testimony, special reports.
- m) Travel by the podiatrist, 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 and holidays.
- n) Calls, visits or consultations by telephone and other related services.
- o) Routine lab and x-ray services required on hospital admissions.
- p) Biofeedback or hypnotherapy.
- q) Services provided free of charge to Medicaid members by county health departments or state laboratories.
- r) Experimental services or procedures or those which are not recognized by the profession or the United States Public Health Service as universally accepted treatment.
- s) Anesthetic agents other than local therapeutic agents.
- t) Portable x-ray services.
- u) Assistant surgeon for podiatric services.

- v) Anesthesia services of podiatrists other than local J codes (Injectables).
- w) Surgical suite.
- x) Amputation performed in a site other than a facility permitted and regulated as a hospital or ambulatory surgical center under Article 1 of Chapter 7 of Letter 31.
- y) Any amputation performed by a podiatrist that is not certified by the Georgia State Board of Podiatry examiners to perform such amputations.

PART II - CHAPTER 900
PRIOR APPROVAL - HOSPITAL PRECERTIFICATION

900. Services Which Require Prior Approval or Hospital Precertification

As a condition of reimbursement, the Department requires that certain services be approved prior to the time they are rendered. Prior approval from the Department pertains to medical necessity only; the patient must be Medicaid-eligible at the time the service is rendered. If the service is to be performed in an inpatient hospital setting, precertification is required. Selected services performed in an outpatient hospital or ambulatory surgical center (ASC) setting also require precertification and may also require Prior Approval.

All inpatient hospital admissions require precertification. The attending (admitting) podiatrist is responsible for obtaining the precertification of the hospital admission. The podiatrist's failure to obtain the precertification number will result in denial of payment to all providers billing for services, including the hospital and the attending podiatrist. Procedures performed in the office setting do not require precertification but may require Prior Approval.

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

The medical treatments and services listed in the following sections must be approved prior to the delivery of the service. In emergent, life-threatening situations, the provider must document the emergent condition and forward the claim together with the documentation to the Division's fiscal agent, or obtain precertification or prior approval within thirty (30) calendar days, whichever is applicable.

- a) All hospital admissions excluding normal deliveries
- b) Selected procedures performed in an outpatient hospital ASC.
- c) All procedures listed in the Physician Services manual as needing Prior Approval

900.1 Prior Authorization

(ICD-10 eff 10/15)

All surgical procedures listed in appendix - and all surgeries performed in a nursing facility or patient's home (except for the following) require prior authorization:

- 1) Debridement of mycotic nails or a paring or curettement:
CPT codes: 11055, 11056, 11057, 11720, 11721, 17000, 17003 and 17004 with diabetic or peripheral vascular disease diagnosis codes
- 2) Incision and drainage of abscess with documented cellulitis:
CPT codes 10060, 10061, 10140, 10160.
- 3) Surgical debridement of stasis, perforating, or decubitus ulcers; CPT codes 11000 with covered diagnosis codes.
- 4) Incision and drainage of hematoma: CPT codes 10140 or 10160 with covered diagnosis codes.
- 5) Foreign body removal to prevent infection formation: CPT codes 10120 or 10121 with covered diagnosis code.
- 6) Emergency relief of pain and infection, which is fully documented. However, all other procedures involving soft tissue or bone surgery performed in a nursing home or the patient's home in CPT code ranges of 10000 - 11646 and 11750 - 64907 must have prior approval before they are rendered.

901. Procedures for Obtaining Prior Approval

If the service is to be performed in an inpatient hospital, outpatient hospital or ASC setting, precertification is required. If the procedure is to be performed in a podiatrist's office, the attending podiatrist's request for prior approval must be submitted to the Department's medical review agent, Georgia Medical Care Foundation.

The request for prior approval must be submitted at least one week prior to the planned surgery. Surgeries must not be performed prior to receipt of an approved request.

Physicians should seek Prior Approval on any service for which reimbursement might be questionable. The ordering physician is responsible for obtaining the Prior Approval. The physician's failure to obtain prior approval will result in denial of payment to all providers billing for services including the facility.

Reimbursement for services is contingent on the podiatrist's enrollment in the Medicaid program, the patient's eligibility at the time services are rendered, and compliance with all other applicable policies and procedures.

902. Precertification

Hospital Pre-certification is required for all inpatient hospital and selected services performed in an outpatient hospital or ambulatory surgical center setting. Please see Appendix H for a complete listing of the outpatient services which require pre-certification. In the event of an emergency admission, certification must be obtained within thirty (30) calendar days of the admission. Certification acknowledges only the medical necessity and appropriateness of the setting and does not guarantee payment.

Requests should be initiated at least one (1) week prior to the planned admission or procedure. Approval is valid for ninety (90) days from the date of issuance. To obtain pre-certification, please contact the Division's agent at:

Alliant Health Solutions
Prior Authorization & Pre-Certification
P.O. Box 105329
Atlanta, Georgia 30348
Metro area: 404-298-1228 Toll free: 800-766-4456
The web contact address: www.mmis.georgia.gov

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

For patients whom the provider believes may later be determined retroactively eligible for Medicaid, GMCF must be contacted in advance for a reference number which will be good for ninety (90) days. If the patient does, in fact, later receive retroactive Medicaid eligibility, providers must continue the precertification and prior approval process, providing all required forms and documentation. Please note that obtaining a reference number prior to service provision does not guarantee approval for the requested services as the procedures still will be required to meet medical criteria.

Written request must be submitted on the Medicaid Precertification Form available from Alliant Health Solutions (AHS).

When precertification has been obtained or in instances where precertification is not required for an outpatient procedure and during the procedure, it is determined that additional or a different procedure is necessary (for determining timeliness or precertification update requests), the additional or different procedure should be considered an urgent procedure. The physician's request for an update of the precertification file should be considered timely if received within thirty (30) days of the date of the procedure.

When precertification has been obtained for an outpatient procedure and after the procedure has been performed, it is determined that inpatient services are necessary (for determining timeliness of precertification update requests), the admission should be considered an emergency. The podiatrist's request for an update of the precertification file should be considered timely if received within thirty (30) days of the date of the admission.

903. Drugs

Effective January 1, 2007, Systems Excellence Healthcare Solutions, Inc. (SXC), is responsible for all outpatient pharmacy services, including but not limited to requests for prior approvals. Prior Authorization requests may be made via telephone, fax, or us postal:

SXC Health Solutions, Inc.

Claims Processing

PO Box 3214

Lisle, IL 60532-8214

PA Phone Number: 888-491-9742

PA Fax Number: 866-525-5827

For detailed information pertaining outpatient pharmacy prior approvals and related pharmacy services, refer to the Part II Policy and Procedure Manual for Pharmacy Services. The Pharmacy Services manual may be obtained by contacting the Georgia Health Partnership (GHP) and is assessable on line at www.mmis.georgia.gov.

CHAPTER 1000 BASIS FOR REIMBURSEMENT

1000. Reimbursement

The Division will pay the lower of the podiatrist's lowest price regularly and routinely offered to any segment of the general public for the same service 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 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 percentage of reimbursement.

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

DXC Enterprises
P.O. Box 105200
Tucker, Georgia 30085-5200

1000.1 NCCI

Georgia Medicaid uses the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) standard payment methodologies. This complies with the Federal Patient Protection and Affordable Care Act, signed into law March 2010. NCCI coding guidelines will be applied to FQHC services when reported.

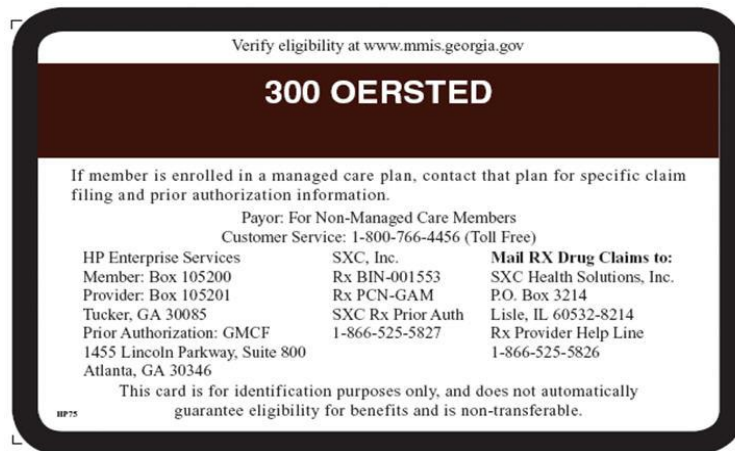
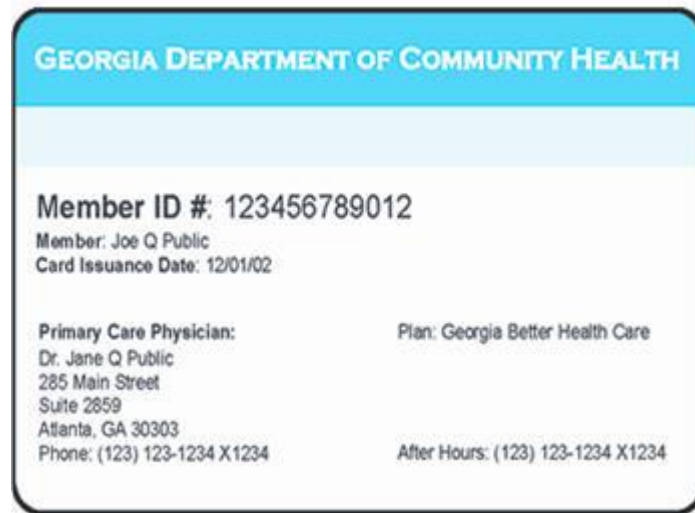
<https://www.cms.hhs.gov/NationalCorrectCodInitEd>

NCCI guidelines will apply when an E/M code is submitted with procedure code. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an 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.

Appendix A

MEDICAL ASSISTANCE ELIGIBILITY CERTIFICATION Medicaid & PeachCare for Kids Member Identification Card Sample

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



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

COPAYMENTS FOR CERTAIN SERVICES

The tiered copayment amounts are as follows:

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 and cervical cancer and receiving

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

- Emergency services,
- Family Planning services
- Waiver Services
- Dialysis Services

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

P = Pregnant S = Nursing facility members

H = Hospice

E = Emergency services

GHP will automatically deduct the copayment amount from the provider's payment for claims processed with dates of service July 1, 2005, and after. Do not deduct the copayment from your submitted charges. The application of the copayment 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 copayment.

Pharmacy Services

Refer to Pharmacy Services Manual for current policy and co-payment requirements.

APPENDIX C

PROCEDURE CODES SUBJECT TO THE SITE OF SERVICE DIFFERENTIAL

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
10040	11406	11740	12046	15120	15851	20615	27640
10060	11420	11750	12047	15121	15852	20650	27641
10061	11421	11752	12051	15130	16000	20670	27645
10080	11422	11755	12052	15131	16020	20694	27647
10081	11423	11760	12053	15135	16025	20900	27648
10120	11424	11762	12054	15136	17000	20910	27650
10121	11426	11765	12055	15150	17003	20922	27652
10140	11440	11900	12056	15151	17004	20220	27654
10160	11441	11901	12057	15152	17106	20500	27656
10180	11442	11920	13100	15155	17107	20501	27658
11000	11443	11921	13101	15156	17108	20520	27659
11001	11444	11922	13102	15157	17110	20525	27664
11010	11446	11950	13120	15200	17111	20550	27665
11011	11450	11951	13121	15201	17250	20551	27675
11012	11451	11952	13122	15220	17260	20552	27676
11041	11462	11954	13131	15221	17261	20553	27680
11042	11463	11971	13132	15240	17262	20600	27681
11043	11470	11976	13133	15241	17263	27603	27685
11044	11471	12001	13150	15260	17264	27604	27686
11055	11600	12002	13151	15261	17266	27605	27687
11056	11601	12004	13152	15271	17270	27606	27690
11057	11602	12005	13153	15272	17271	27607	27691
11100	11603	12006	14000	15273	17272	27610	27692
11101	11604	12007	14001	15274	17273	27612	27695
11200	11606	12011	14020	15275	17274	27613	27696
11201	11620	12013	14021	15276	17276	27614	27698
11300	11621	12014	14040	15277	17311	27615	27700
11301	11622	12015	14041	15278	17312	27616	27702
11302	11623	12016	14060	15570	17314	27618	27703
11303	11624	12017	14061	15572	17315	27632	27704
11305	11626	12018	15002	15574	20005	27619	27705
11306	11640	12020	15003	15576	20100	27634	27707
11307	11641	12021	15004	15600	20101	27620	27709
11308	11642	12031	15005	15610	20102	27625	27712
11310	11643	12032	15040	15620	20103	27626	27715
11311	11644	12034	15050	15630	20200	27630	27720
11312	11646	12035	15100	15650	20205	27635	27722
11313	11719	12036	15101	15731	20206	27637	27724
11400	11720	12037	15110	15732	20600	27638	27725
11401	11721	12041	15115	15734	20605		27726
11402	11730	12042	15116	15736	20610		
11403	11732	12044		15738	20612		
11404		12045					

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
27727	28070	28260	28510	29540			
27730	28072	28261	28515	29550			
27732	28080	28262	28525	29580			
27734	28086	28270	28530	29581			
27740	28088	28272	28531	97012			
27742	28090	28280	28540	97014			
	28092	28285	28546	97016			
		28286	28555	97018			
27750				97022			
27752	28100			97024			
27756	28103	28288					
27758	28104	28289	28570				
27760	28107	28290	28575				
27762	28108	28292	28576	97026			
27766	28110	28293	28585	97028			
27767	28111	28294	28600	97032			
27768	28112	28296	28606	97036			
27769	28113	28297	28630	97039			
27780	28114	28298	28635	97597			
27781	28116	28299	28636	97598			
27784	28118	28300	28645				
27786	28119	28302	28660				
27788	28120	28304	28665				
27808	28122	28305	28666				
27810	28124	28306	28675				
27816	28126	28288	28740				
27818	28140	28289	28750				
27824	28150	28290	28755				
27825	28153	28292	28760				
27830	28160	28293	28820				
28001	28173	28294	28825				
28002	28175	28296	28890				
28003	28190	28340	29305				
28008	28192	28341	29325				
28010	28193	28344	29345				
28011	28200	28345	29355				
28020	28202	28400	29358				
28022	28208	28405	29365				
28024	28210	28430	29405				
28035	28220	28435	29425				
28043	28222	28450	29435				
28045	28225	28455	29440				
28046	28230	28470	29445				
28050	28232	28475	29450				
28052	28234	28490	29505				
28054	28238	28495	29515				
28060	28240	28496	29520				
28062	28250	28505	29530				

**CPT
Code**

APPENDIX D

1

Facility-Based Procedures for which Additional Amount for Supplies May be Payable

(if performed in a Physician's Office)

CPT	DESCRIPTION
20200	MUSCLE BIOPSY
20205	DEEP MUSCLE BIOPSY
20220	BONE BIOPSY, TROCAR/NEEDLE
20225	BONE BIOPSY, TROCAR/NEEDLE
20240	BONE BIOPSY, EXCISIONAL
25111	REMOVE WRIST TENDON LESION
28290	CORRECTION OF BUNION
28292	CORRECTION OF BUNION
28293	CORRECTION OF BUNION
28294	CORRECTION OF BUNION
28296	CORRECTION OF BUNION
28297	CORRECTION OF BUNION
28298	CORRECTION OF BUNION
28299	CORRECTION OF BUNION

APPENDIX E

<u>Procedure Code</u>	<u>Procedures</u> <u>Description</u>
28715	Triple arthrodesis
28725	Subtalar arthrodesis (includes Grice type procedure)

This list is representative of services requiring prior approval for all members, regardless to age, and is not meant to be exhaustive.

11750	Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal;
11752	with amputation of tuft of distal phalanx
27685	Lengthening or shortening of tendon, leg or ankle; single (separate procedure)
27686	multiple (through same incision), each
27687	Gastrocnemius recession (e.g., Strayer procedure) (Toe extensors are considered as a group to be a single tendon when transplanted into midfoot)
27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (e.g., anterior tibial extensors into midfoot)
27691	anterior tibial or posterior tibial through interosseous space
27692	each additional tendon (Add –on Code)
27745	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia
27870	Arthrodesis, ankle, any method
27871	Arthrodesis, tibiofibular joint, proximal or distal
28130	Talectomy (astragalectomy)
28140	Metatarsectomy

28150	Phalangectomy of toe, single, each
28153	Resection, head of phalanx, toe
28160	Hemiphalangectomy or interphalangeal joint excision, toe, single, each
28234	Tenotomy, open, extensor, foot or toe
28238	Advancement of posterior tibial tendon with excision of accessory navicular bone (Kidner type procedure)
28240	Tenotomy, lengthening, or release, abductor hallucis muscle
28250	Division of plantar fascia and muscle ("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 as for resistant clubfoot deformity
28264	Capsulotomy, midtarsal (Heyman type procedure)
28270	Capsulotomy for contracture; metatarsophalangeal joint, with or without tenorrhaphy, single, each joint (separate procedure)
28272	interphalangeal joint, single, each joint (separate procedure)
28280	Webbing operation (create syndactylism of toes) for soft corn (Kelikian type procedure)
28285	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)
28286	for cock-up fifth toe with plastic skin closure, (Ruiz-Mora type procedure)
28290	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)
28292	Keller, McBride or Mayo type procedure

28293	resection of joint with implant
28294	with tendon transplants (Joplin type procedure)
28296	with metatarsal osteotomy (e.g., Mitchell, Chevron, or concentric type procedures)
28297	Lapidus type procedure
28298	by phalanx osteotomy
28299	by other methods (e.g., double osteotomy)
28300	Osteotomy; calcaneus (Dwyer or Chambers type procedure), with or without internal fixation
28302	talus
28304	Osteotomy, midtarsal bones, other than calcaneus or talus;
28305	with autograft (includes obtaining graft) (Fowler type)
28306	Osteotomy, metatarsal, base or shaft, single, with or without lengthening, for shortening or angular correction; first metatarsal
28307	first metatarsal with autograft
28308	other than first metatarsal
28309	Osteotomy, metatarsals, multiple, for cavus foot (Swanson type procedure)
28310	Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
28312	other phalanges, any toe
28313	Reconstruction, angular deformity of toe (overlapping second toe, fifth, toe, curly toes), soft tissue procedures only
28320	Repair of nonunion or malunion; tarsal bones (e.g., calcaneus, talus)

28322	metatarsal, with or without bone graft (includes obtaining graft)
28340	Reconstruction, toe, macrodactyly, soft tissue resection
28341	requiring bone resection
28344	Reconstruction, toes(s); polydactyly
28345	syndactyly, with or without skin graft(s), each web
28360	Reconstruction, cleft foot
28705	Pantalar arthrodesis
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, Medtarsal, tarsal navicular-cuneiform (eg, Miller type Procedure)
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint
28750	Arthrodesis, great toe; metatarsophalangeal joint
28755	interphalangeal joint
28760	Arthrodesis, great toe, interphalangeal joint, with extensor hallucis longus transfer to first metatarsal neck (Jones type procedure)

(For hammertoe operation or interphalangeal fusion, see 28285)

Appendix F

(coincides with Appendix O in the Part II Physician Services Manual)

OUTPATIENT, AMBULATORY SURGICAL CENTER, & HOSPITAL PROCEDURES 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 the Georgia Health Partnership at (404) 298-1228 (Metro Atlanta) or (800) 766-4456 (Toll free).

CPT Code

11721	15650	27630	28090	28288
11750	15740	27635	28092	28340
14001	15750	27637	28102	28341
14020	15756	27638	28103	28344
14021	15758	27656	28107	28360
14041	15760	27680	28110	28810
14060	15770	27681	28111	28820
14061	15840	27685	28112	28825
14300	15841	27686	28113	96000
14350	15842	27687	28114	96001
15002	15845	27690	28116	
15003	17260	27691	28118	
15004	17261	27692	28119	
15005	17262	27700	28120	
15040	17263	27702	28122	
15050	17264	27703	28124	
15100	17266	27705	28126	
15110	17270	27707	28171	
15115	17271	27709	28173	
15130	17272	27712	28175	
15135	17273	27715	28200	
15150	17274	27745	28202	
15152	17276	28008	28208	
15155	17311	28035	28210	
15157	17312	28045	28220	
15200	17314	28055	28222	
15220	17315	28062	28225	
15240	27605	28072	28226	
15260	27606	28080	28230	
15570	27612	28086	28232	
15572	27620	28088	28240	
15574				
15576				
15600				
15610				
15620				
15630				

APPENDIX G

Georgia Families

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

 Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	 CareSource 1-855-202-1058 www.caresource.com
 Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	 WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program

Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All four CMOs are State-wide.**

The Department of Community Health has contracted with four CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan
- WellCare of Georgia

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child

510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB <= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged

227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto – Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind

323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/ GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical)	866-231-1821 www.wellcare.com

		management) www.pshpgeorgia .com	
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Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact DXC at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. DXC will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to DXC in error:

DXC will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- Saves time
- Increases efficiency
- Eliminates duplication of data needed for multiple CMOs
- Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

HP provider reps will provide training and assistance as needed. Providers may contact HP for assistance with

credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to DXC in error:

DXC will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for clean claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. Dental: Checks are mailed weekly on Thursday for clean claims. Vision: Checks are mailed weekly on Wednesday for clean claims (beginning June 7th) Pharmacy: Checks are mailed to pharmacies weekly	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for <u>clean</u> claims that have been adjudicated. <u>Pharmacy:</u> Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for clean claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.	WellCare runs claims payment cycles up to six (6) times each week for clean claims. For further information, please refer to the WellCare website, the WellCare provider manual, or contact Customer Service at 866-231-1821

on Friday (except when a holiday falls on Friday, then mailed the next business day)			
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How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.	Members can change PCPs for any reason within the first 90 days of their enrollment. After the first 90 days, members may change PCPs once every six months.

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24 th day of the month and are effective for the current month. PCP changes made after the 24 th day of the month are effective for the first of the following month.	PCP changes made between the 1st and 10th of the month will go into effect right away. Changes made after the 10th of the month will take effect at the beginning of the next month

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment

services.

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cv.s.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com	866-300-1141 ProspectiveProviderGA@WellCare.com or https://www.wellcare.com/en/Georgia/Become-a-Provider

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	PBM	BIN #	PCN
Amerigroup Community Care	ESI	003858	MA
CareSource	CVS Caremark	004336	MCAIDADV Group: RX0835
Peach State Health Plan	US Script (PBM) Caremark (Claims Processor)	004336	MCAIDADV
WellCare of Georgia	Caremark	004336	MCAIDADV

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through DXC by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. DXC will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes	Yes, you may also use the WellCare subscriber ID

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:
Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
1 (800) 454-3730	1 (855) 202-1058 1(866) 930-0019 (fax)	1 (866) 399-0929	1 (866) 231-1821 1 (866) 455-6558 (fax)

APPENDIX H

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.

Who needs an NPI?

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

- All Medicaid healthcare providers and
- All CMO healthcare providers.

The NPI will be required on electronic claims.

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

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

- Applying to be a Medicaid Provider
- On all electronic claims submission including claims submitted via WINASAP.

When do I need to use my Medicaid Provider Number?

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

- Paper claims submission (CMS 1500)
- Resubmission of electronic claims on paper
- Submission of web claims
- IVR System inquiries
 - Provider authentication
 - All claim inquiries
 - All other inquiries
- Telephone inquiries
 - Provider authentication
 - All claim inquiries
 - All other inquiries
- Prior authorizations
 - Requests
 - Inquiries
- Referrals
 - Request
 - Inquiries
- Medicaid forms

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

- Adding a location to my Provider record
- Changing my Provider information
- Written inquiries and correspondence
- E-mail and 'Contact Us' inquiries

Refer to the Part I Policy and Procedure Manual for Medicaid and PeachCare for Kids for additional information on NPI Requirements.

APPENDIX I

PROVIDER CONTACT

www.mmis.georgia.gov

Provider Correspondence

DXC Enterprise Services
P.O. Box 105200
Tucker, GA 30085-5200

Provider Enrollment

DXC Enterprise Services
P. O. Box 105201
Tucker, GA 30085-5201

Provider Claims Submission

DXC Enterprise Services
P.O. Box 105202
Tucker, GA 30085-5202

Prior Authorization & Pre-Certification

AHS

P.O. Box 105329
Atlanta, GA 30348

Electronic Data Exchange (EDI)

877-261-8785

- Asynchronous
- Web Portal
- Physical Media
- Network Data Mover
- Systems Network Architecture
- Protocol (TCP/IP)

Numbers:

Provider Contact Center

Phone: 800-766-4456 (Toll Free)
Fax: 1-866-483-1044 and 1045

Member Contact Center

Phone: 866-211-0950 (Toll Free)

STATEMENT OF PARTICIPATION

The new Statement of Participation is available in the Provider Enrollment Application Package. Written request for copies should be forwarded to:

DXC Enterprise Services
Provider Enrollment Unit
P. O. Box 105201
Tucker, GA 30085-5201

OR

Phone your request to: 800-766-4456

APPENDIX J



Information for Providers Serving Medicaid Members in the Georgia Families 360SM Program

Georgia Families 360SM, the state's (took out "new") managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system. launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible, through its provider network, for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360SM Every member in Georgia Families 360SM is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov

APPENDIX K

Refer to Part I Policies and Procedures manual for ICD-10 information.

APPENDIX L

New CMS 1500 Claim Form



HEALTH INSURANCE CLAIM FORM

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

☐ PICA

PICA ☐

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☐ (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)		1a. INSURED'S ID. 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 ☐	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.	
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	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		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? \$ CHARGES ☐ YES ☐ NO	
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.	
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. PRIOR AUTH. # I. ID. QUAL. J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER	
1		NPI	
2		NPI	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX ID. NUMBER SSN EIN ☐ ☐		26. PATIENT'S ACCOUNT NO.	
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.)		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	
32. SERVICE FACILITY LOCATION INFORMATION		28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use	
SIGNED _____ DATE _____		33. BILLING PROVIDER INFO & PH # ()	

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/DXC: 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/DXC: 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/DXC: 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/DXC: 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. <u>Use the highest level of code specificity in FLD Locator 21.</u> Diagnosis Code ICD Indicator - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. (Do not bill ICD 10 code sets before October 1, 2015.)
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters

	(A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from “MEDICAID RESUBMISSION” to “RESUBMISSION.” The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. F FOR DCH/DXC: 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).”