PART II

POLICIES AND PROCEDURES
for
ORTHOTIC AND PROSTHETIC SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

MEDICAL ASSISTANCE PLANS DIVISION

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Part II Policies and Procedures Manual for Orthotic and Prosthetic Services

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
07/01/22	Appendix B/G	Removed Outdate P.O. Boxes	D	
07/01/22	Appendix G	Updated Information	M	

PREFACE

This manual contains basic information concerning the Orthotic & Prosthetic program and is intended for use in conjunction with the Part I Policy and Procedure Manual for Medicaid and PeachCare for Kids, which contains the Statement of Participation and encompasses general terms and conditions for receipt of reimbursement.

We urge providers and their administrative and billing staff to become familiar with the contents of this manual and the Part I manual, and to refer to them when questions arise regarding policies and procedures for the proper billing and coding guidelines for these services. Use of the manuals will assist in the elimination of misunderstandings concerning the coverage levels, eligibility, and billing procedures that can result in delays in payment, incorrect payment, or denial of payment.

Amendments to this manual will be necessary from time to time due to changes in federal and state laws and Department of Community Health (the Department), policy. When such amendments are made, they will be posted at www.mmis.georgia.gov, which shall constitute formal notice to providers. The amended provisions will be effective on the date of the notice or as specified by the notice itself, and all providers are responsible for complying with the amended manual provisions as of their effective dates.

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

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PART II - CHAPTER 600

O&P SUPPLIER STANDARDS FOR GEORGIA MEDICAID ENROLLMENT

601. In addition to all conditions of participation in the Medical Assistance Program outlined in Part I, Section 106, Orthotics and Prosthetics providers must:

601.1 A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and agree to adhere to all policies and procedures of the Orthotic and Prosthetic Program.

601.2 A supplier must bill the Division their usual and customary fee for services provided for which a fee schedule amount exists, unless the item is manually priced on the prior authorization, per DCH policy. For manually priced items (miscellaneous codes) the amount submitted must be the amount that has been approved for reimbursement on the prior authorization.

601.3 A supplier must provide binding quotes containing the provider's cost and MSRP attached to the requests for prior authorization for miscellaneous items that require manual pricing. Suppliers must have the purchased invoice correlating to the quote submitted for prior approval of any manually priced item in the patient's file. This documentation must validate that the item provided is exactly the same item that was submitted for reimbursement as evident by the invoice number, pricing, patient information, manufacturer, and serial numbers if applicable.

601.4 A supplier must provide the Division with a valid business license. A business license is considered valid if it is in accordance with the services to be provided. If the local county business codes do not require a business license, then the provider must submit evidence of that effect to Provider Enrollment.

601.5 A supplier must submit proof of comprehensive liability insurance in the amount of no less than $300,000.00 that covers both the supplier's place of business and all customers and employees of the provider. If the supplier manufacturers its own items, this insurance must also cover product liability and completed operations.

601.6 A supplier must be open to the public for business during posted hours of operation (a minimum of thirty (30) hours per week).

601.7 A supplier must submit all information requested by provider enrollment including, but not limited to, the types of services provided with a list of equipment (base codes/additions)/supplies and the associated HCPCS codes, and the location(s) to be serviced.

601.8 A supplier must disclose any person having ownership, financial or control interest in the business.

601.9 A supplier must notify the Provider Enrollment Unit in writing of any change in enrollment status, including changes to the address of the physical location or phone number.

601.10 A supplier must submit proof of accreditation for each location enrolled in the Orthotic & Prosthetic Services Program. All O&P suppliers must be fully accredited by a CMS approved accreditation agency in order to receive and retain a provider billing number from Georgia Medicaid. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment for those specific products and services. Suppliers must remain accredited for the duration of enrollment as a Georgia Medicaid provider.

CMS Excludes a Pharmacy from accreditation if it meets all the following criteria:

- The total billings by the pharmacy for DMEPOS are less than 5 percent of total pharmacy sales;
- The pharmacy has been enrolled as a provider of durable medical equipment, orthotics/prosthetics, and supplies, and has been issued a provider number for at least 5 years;
- No final adverse action has been imposed on the pharmacy in the last 5 years;
- No final adverse action has been imposed on the pharmacy in the past 5 years;
- The pharmacy submits attestation, as determined by CMS. That the pharmacy meets the first three criteria;
- The pharmacy agrees to submit materials as requested during the course of an audit conducted on a random sample of pharmacies selected annually

CMS Approved Accreditation Agencies for DMEPOS Providers Include:

The Joint Commission (TJC)
Commission on Accreditation of Rehab Facilities (CARF)
Community Health Accreditation Program (CHAP)
Healthcare Quality Association on Accreditation (HQAA)
Accreditation Commission for Health Care (ACHC)
The American Board for Certification in Orthotics & Prosthetics, Inc. (ABC)
Board of Certification/Accreditation (BOC)
The Compliance Team, Inc.
National Association of Boards of Pharmacy (NABP)
The National Board of Accreditation for Orthotic Supplies (NBAOS)

Orthotic and Prosthetic suppliers are responsible for selecting the appropriate accreditation organization (AO) for their business.

601.11 A supplier must notify their accreditation agency when a new O&P location is opened and enrolled in Georgia Medicaid to ensure they are accredited or in the process of becoming accredited.

601.12 All physical locations whether owned or subcontracted, must meet the Medicaid Provider Statement of Participation requirements and be SEPARATELY accredited in order to receive a provider ID to be reimbursed by Georgia Medicaid. Any accreditation exceptions made by accrediting organizations where suppliers have more than one location in the same state must be submitted to provider enrollment for verification through the accrediting agency.

601.13 A supplier must have an authorized individual whose signature is binding sign the enrollment application for billing privileges.

601.14 A supplier must have a physical location on an appropriate site that is within the state of Georgia or within fifty (50) miles of the state border and be in an area in which Georgia residents customarily obtain medical services. The location must have a visible with hours of operation posted. The location must be opened to the public, handicapped accessible, and staffed during normal business hours (a minimum of 30 hours per week). This location must have fitting rooms and sufficient space to store medical records and the equipment and supplies they provide.

601.15 A facility must have a fitting room which meets the minimum standards in section **903**.

601.16 An Out-Of-State provider that is enrolled in Medicare may enroll with Georgia Medicaid for the purpose of reimbursement of crossover claims for Georgia residents. Coverage may be extended to Medicaid members in an emergency situation or when prior approval is obtained from the Department before the service is provided.

601.17 A supplier must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking or hold accreditation.

601.18 Suppliers must maintain a complete and accurate patient record in the state of Georgia in accordance with the Conditions of Participation in Part 1, Section 106, Subsection R for no less than five (5) years from the date of service of the most recent claim submitted to Georgia Medicaid for all patients.

601.19 Suppliers must comply with requests for documentation from the Division for any item for which they have attested during the prior authorization process (example: face to face evaluation).

601.20 Suppliers must submit procedure code(s) that most accurately describe the item or service provided when requesting a prior authorization or submitting a claim.

601.21 Suppliers are prohibited from denying services to any eligible Medicaid member based on the inability to pay the copayment, which includes the collection of any unpaid copayments on a later date or time. (Rev. 10/20)

601.22 Suppliers are prohibited from submitting claims for items or services that have not been delivered prior to the claim submission. The record of delivery (delivery ticket) must be kept on file and must provide verification that the item billed was delivered on or before the date the claim was submitted.

601.23 Delivery tickets for all items must be kept on file for a minimum of five (5) years and must be signed by the patient or representative of the patient at the patient's community home. For mail order items (supplies only), a printed confirmation of delivery that contains a tracking number and the patients name and demographic information must be present in the patient chart with a packing order describing the items delivered. Prosthetics (base/additions) must be delivered directly to the beneficiary as the final fitting must be performed.

601.24 A supplier must fill orders and fabricate and fit items from its own inventory or by contracting with other companies for the purchase of items necessary to fill the order. If it does, it must provide upon request copies of contracts or other documentation showing compliance with this standard. A supplier may not contract with any entity that is currently excluded from Medicare or any State Medicaid Program, or from any other Federal Government Executive Branch procurement or non-procurement program or activity. A subcontractor that only performs these services does not need to be accredited.

601.25 A supplier must agree to provide quality items of service and maintain/repair items provided. If complaints are filed with the Division, an investigation and/or review of the provider may be performed by the Division. If the results of this investigation and/or review are unfavorable, the Division will assign the appropriate agency to perform an additional investigation and/or review to establish continuing competency of the provider. If the results of this investigation and/or review are unfavorable, adverse actions as outlined in Part I, Chapter 400, apply.

601.26 A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable state law, and repair or replace free of charge Medicaid covered items under warranty.

601.27 Suppliers must provide a photocopy of the Georgia State license and the certification of the Orthotist or Prosthetist provider required by the Division to provide the services billed. The Division may request a copy of renewal certifications for providers from the appropriate examining board. Providers must describe the type of services to be provided including a list of items by purchase procedure code.

601.28 Suppliers must employ Practitioners with the following accepted certifications: the American Board for Certification in Orthotics and Prosthetics, Inc. (ABC-CP,

ABC-CO, ABC-CPO), the Board for Orthotics and Prosthetics Certification (BOC-CP, BOC-CO, BOC-CPO), ABC Clinical Assistant (ROA/RPA), or the Board for Certification in Pedorthics (C. PEDS), or mastectomy fitters with the ABC 3 – week Mastectomy certification course. An eligible provider participating in the Medicaid program must have, at minimum, one licensed certified practitioner at each location at all times. The type approval requested and the name of each certified practitioner or fitter must be so stated on the application sent for participation to the Division of Medicaid participation.

All enrolled providers must have licensed practitioners. All non-licensed practitioners must be supervised by licensed practitioners. Mastectomy fitters who have successfully completed the three-week ABC mastectomy course may enroll to provide mastectomy services only. **Please see Section 904 Dispensing Fitter (c.) Level III**

Podiatrists may not enroll as providers for the O&P program (COS 330). Please refer to the Part II Policies for Podiatry Services for more information.

601.29 A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll-free number available through directory assistance. The exclusive use of a mobile device, answering machine, or answering service during normal business hours is prohibited.

601.30 A supplier may not directly solicit Medicaid beneficiaries. This excludes (1) members that have given permission for the contact in writing (2) members who previously received a covered item for which the supplier is making the contact (3) telephone contact to a member in regard to an item other than the covered item that was previously furnished if the member has received a covered item from the supplier in the previous fifteen (15) months

601.31 A supplier must permit Georgia Medicaid or its agents to conduct on-site inspections to ascertain the supplier's compliance with supplier standards or to investigate allegations of fraud, waste, and abuse.

601.32 Suppliers are subject to the "Anti-Kickback Statute" which prohibits the exchange (or offer to exchange), anything of value, in an effort to induce (reward) the referral of Federal/State healthcare program business (reimbursement).

601.33 Suppliers must accept returns of substandard (less than full quantity) and /or inappropriate items (items not meeting quality standards, not properly fitted based on height and weight of the patient, or not reasonable and necessary for the patient for which it was provided) that were not appropriate for the member at the time the item was fitted or purchased. Providers must submit a refund to Georgia Medicaid or replace the device promptly when these situations are identified. Constituent complaints resulting in replacement of items by another provider for the correct item (same or similar service) will result in recoupment of the original item.

601.34 **A supplier must accept the Division's payment as payment in full for covered services to a patient accepted as a Medicaid member.** A patient will be deemed accepted as a Medicaid member if (s)he is eligible as a member for those services, the provider represents or demonstrates to the patient that (s)he will treat the patient as a Medicaid member, or the provider bills the Division for covered services. Note: This does not prohibit the provider from receiving reimbursement from liable third parties in accordance with Division policies. See Part 1, Section 303.

601.35 Suppliers are prohibited from filling out any documentation for which they do not hold licensure to complete (PT/OT Evaluations, Prescriptions).

601.36 Suppliers must maintain documentation from the Ordering or Prescribing provider for all services billed to Georgia Medicaid for reimbursement. The ordering or prescribing provider's information must be submitted on all claims submitted to Georgia Medicaid on or after June 1, 2014.

601.37 A supplier must accept responsibility for providing the appropriate orthotic, prosthetic, additions, and/or supplies, fitting, training, and usage of the items supplied. Suppliers are responsible for follow-ups, repairs, and maintenance of the items they provide.

601.38 A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of the contacts. A complaint resolution protocol must be established to address complaints related to these standards. These records must contain the members name, address, phone number, health insurance claim number (HICN), a summary of the complaint and any actions taken to resolve the issue. The complaint and resolution record must be maintained at the physical location and must be made available to the Division upon request.

601.39 Providers must have a completed Certificate of Medical Necessity on file for all items for which one exists. A generic prescription does not replace the requirement for a completed CMN.

601.40 **Per the Rules and Regulations of the State of GA, Rule 360-31-.10 states:**

(1) No person shall work as an assistant to an orthotist, prosthetist or prosthetist orthotist and provide patient care services of fabrication of an orthosis or prosthesis, unless he or she is doing the work under the supervision of a licensed orthotist, prosthetist, or prosthetist orthotist.

a) Patient Care Services is the assessment, measuring, molding, casting, fitting, or delivering a prosthesis or orthoses.

b) Supervision means the supervising licensed orthotist, prosthetist or prosthetist orthotist is physically present in the same building and available to lend assistance if needed.

(2) No person shall work as a technician unless the work is performed under the supervision of a person licensed under this article.

a) Supervision of a technician means the licensed practitioner will give direction and instruction to the technician as to how the device is to be fabricated. The technician will build the device according to the given specifications. The technician will not provide direct patient care services. The licensed practitioner is responsible for the quality of the fabrication of the device that is delivered to the patient.

In addition to the previous standards, providers must fulfill the following requirements, based on the actual provider type:

A) Orthotics Providers

1) A facility must have at least one (1) practitioner who is licensed and certified at the level of the level of certification required by the Division (or a higher level) for each service, to provide and bill the service. For example: a facility providing scoliosis orthosis (L1000 to L1310) must have a practitioner who is ABC-CO. A facility providing services (L2030 TO L2850) must have a practitioner who is ABC-CO) or BOC-CO. A facility providing services (L0174 to L0200) must have a practitioner who is ABC-CO, BOC-CO.

a) Pedorthist

A facility must have at least one (1) practitioner licensed to supervise the practitioner who has Board Certification in Pedorthics (C Ped.). A certified Pedorthist may provide footwear services A5500 to A5513 and L3000 through L3630. A facility must have a fitting room appropriate for proper evaluation and fitting of footwear. Refer to a modification of the standards as outlined in Section 903.

b) American Board for Certification (ABC) Clinical Assistant (ROA/RPA)

A facility must have at least (1) practitioner licensed and certified by ***American Board for Certification*** (ABC) in Orthotics and/or Prosthetics. Under the guidance and supervision of an ABC certified practitioner, the Clinical Registered Assistant may perform orthotic and prosthetic procedures and related tasks. The Clinical Assistant may not use their credential as independent practitioners engaged in unsupervised care.

c) Pharmacy Orthotics

1) A Pharmacy Orthotics provider must have at least one (1)

practitioner who is licensed by the NABP to supervise the fitter. Upon certification, the pharmacy practitioner will be limited to the measuring and fitting of those codes indicated in the SMAP where a fitter is the required certification.

2) A pharmacy provider's facility must also have a licensed practitioner to participate in the O&P Program.

d) Fitter

A facility must have at least one (1) practitioner who is licensed to supervise unlicensed staff. Fitters must obtain certification by successfully completing courses available in their field and mandated by the licensed CO or CP.

A fitter that has successfully completed the three (3) week ABC Mastectomy Fitter course may enroll as a provider and provide mastectomy services only: L8000, L8001, L8002, L8015, L8020 and L8030. **PLEASE NOTE**: **L8035 may only be provided by a facility with a licensed practitioner.**

B) Prosthetics Providers

1. A facility must have at least one (1) practitioner licensed and certified at the level of certification required by the Division, (or a higher certification level), as indicated in Appendix D for each service, to provide and bill the service. For example: a facility providing services L6920 to L7405 must have a practitioner who is ABC-CP. Codes requiring a CP may be a practitioner who is ABC-CP or BOC-CP.

2. A facility must have a fitting room which meets minimum standards as outlined in Section 903.

C) Ocularist Providers

A facility must have at least one (1) practitioner who is certified by the National Examining Board of Ocularists, Inc. A Board Certified Ocularist (BCO) may provide and bill for services V2623 to V2628 only.

D) Hearing Aid Providers

A facility must have at least one (1) practitioner who is certified by the American Speech-Language-Hearing Association. A practitioner holding a Certificate of Clinical Competence-Audiology (CCC-A) credential may only provide L8615-L8699 and V5014-V5299 hearing services for members who are less than twenty-one (21) years of age.

PART II - CHAPTER 700
SPECIAL ELIGIBILITY CONDITIONS

In addition to any eligibility conditions listed in Part I, Section 113, members seeking services under this program must be referred by a licensed physician.

Custom orthotics and prosthetics may be provided for members in an institutional facility. Prior Authorization is required for all requests for members residing in skilled facilities and the prior authorization request must be submitted by a licensed practitioner as per all licensure policies governing the O&P Program. A certificate of medical necessity (CMN) must be included in the request.

PART II - CHAPTER 800
PRIOR APPROVAL

801. General

As a condition of reimbursement, the Division requires that certain services be approved prior to the time they are rendered. Prior approval from the Division pertains to medical necessity only, not appropriateness of service. It does not guarantee payment of submitted charges, or member eligibility.

A CMN is required for ALL submissions for prior approval for the items listed in 802. A generic prescription will not be accepted as sufficient documentation for approval of these items. All information requested on these forms must be fully completed as the required information assists the reviewer in determining medical necessity for the equipment requested and ensures the expeditious review and processing of requests.

802. Services That Require Prior Approval

Providers must review the Schedule of Maximum Allowable Payments for verification of the requirement for a prior authorization.

The Division requires prior approval for the services listed below:

802.1 Orthotics services noted in the SMAP
802.2 Prosthetic services noted in the SMAP
802.3 Hearing services noted in the SMAP
802.4 Any request that is an exception to policy.

803. Procedures for Obtaining Prior-Approval.

Make all requests for prior approval in writing, on the Prior Approval (PA) request form, the DMA 610. Prior approval request forms must be submitted prior to placement of equipment with members. Detailed instructions for completing the PA request form are provided in Appendix C of this manual. Providers must review and follow outlined instructions listed in appendix C. Provider may submit requests via fax, mail, or the web portal by contacting us at:

Alliant Health Solutions PA/UM Department
Fax (678) 527-3032
The web address is the www.mmis.georgia.gov

Select the link below to be directed to the Prior Approval (PA) request for (DMA 610):
https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FORMS/DMA%20610-Prior%20Authorization%20Request%2020170417163115.pdf

Telephone requests for prior authorization will **not** be granted. Direct questions regarding PA request can be answered by contacting Alliant Health Solutions at 800-766-4456.

The attending medical physician's certificate of medical necessity (CMN) must accompany the DMA 610. The physician's handwritten or authenticated electronic signature and date must be on the CMN signature and date stamps are not acceptable. Documents submitted with signatures other than physician signatures will not be accepted. If the item does not have a CMN requirement, then a detailed written order must accompany the prior authorization request. The request form and all attachments must be submitted and received prior to providing the service. Request forms received beyond ninety (90) days from the requested date or service cannot be retrospectively approved. Coordinators, trained in utilization review and URAC standards, will evaluate the request in accordance with DCH and O&P Prior Approval medical review procedure. They will evaluate the medical necessity for the purchase, replacement, or repair of orthotic and prosthetic devices. Decisions will be rendered within 30 calendar days of the receipt of a completed case.

Providers may place code(s) that do not require PA on the DMA 610, if it is part of the device requested. The analyst will review the appropriateness of the request and key the procedure code(s) not requiring the PA into the file. This will allow the provider to bill for all the procedures on the same claim. If a provider lists a purchase procedure code(s) that is not justified in the documentation on the CMN, the analyst will mark through the line and deny the code. The other appropriate procedure code(s) may be approved. The provider must submit another PA form to request the denied procedure code(s). The appropriate "LT" and "RT" modifier must be entered for the following selected purchase procedure codes: mastectomy codes, L3764, L3806, L3808, L3915, L3925, L3029, L3931, L7611, L7612, L7613, and L7614.

803.1 Procedure

1. Each DMA-610 form submitted for prior approval for items specified in Section 802 must be accompanied by a certificate of medical necessity (CMN) signed and dated by the member's attending medical physician. CMNs must not be dated more than ninety (90) days prior to the date a prior approval request is received by the Division.

   The CMN must contain all information listed below:

   a) the member's main diagnosis (including ICD-9 code(s) on or before 09/30/2015 or ICD-10 code(s) on or after 10/01/2015) supporting the medical necessity of the item requested;

   b) HCPCS codes with a detailed description for all items requested which are to be listed with base codes first on the CMN followed by any necessary additions. The physician's signature validates these items are reasonable and necessary, they meet the description of the items intended for the specific member, and the medical necessity is justified;

   c) any specific requested documentation as indicated in 805 (i.e. the functional level of the member for prosthetic codes);

d) if the justification for the device includes growth or a change in weight or size, the practitioner must include the supporting information such as the amount of weight gain or loss, the height and/or the specific measurements, (i.e. stump or socket increase or decrease measurement);

e) the license number of the certified practitioner (the O & P practitioner responsible for the device) handwritten or authenticated electronic signature and certification number;

f) the date the CMN is signed;

g) the physician's handwritten or authenticated electronic signature and date OR attach a separate physician's prescription signed and dated by the physician prescribing the device;

h) a copy of the certified practitioner's certification **must be** attached as well as the Georgia License number.

2. The Review coordinator screens and reviews each request for completeness, timeliness, and clarity and to assure that the requesting O&P Practitioner's certification concurs with the HCPCS code restrictions per DCH policy.

3. The Review Coordinator and the DCH Program Specialist must discuss requests for O&P exceptions to determine appropriate disposition.

4. Incomplete cases are pended and returned to the provider with a written notification of missing data (if any), and the option to submit the missing information within 10 business days. Untimely cases are denied, and the requestor is notified of the option to appeal within 30 calendar days.

5. On complete cases, the Review Coordinator approves the cases that meet InterQual or DCH approved criteria or will identify areas of concern and refer the case to a Medical Consultant.

Providers may appeal any adverse decision per DCH Policy, Part I, Chapter 503.

803.2 Telephone Requests

No telephone requests are accepted. Prior approval must be obtained through written authorization. Requests must be transmitted via the Web portal.

Direct questions regarding Prior Approval (PA) to the Alliant Health Solutions Automated Inquiry Unit. The toll-free number is 1-800-766-4456. Once the inquirer has reached the GHP Inquiry Unit, the caller will be instructed to press a specific number depending on the nature of the inquiry.

804. Billing for Prior Authorized Services

804.1 General

All DMA-610 forms submitted to Alliant Health Solutions will have a prior authorization number assigned. If the requested service(s) is approved by the Division, the assigned prior authorization number must be entered in the appropriate spaces on the claim form when billing for approved services. If this number is not included, the claim will be rejected. Do not bill other items on a claim that contain items that have been prior approved.

804.2 Third Party

Since the Division of Medicaid (Medicaid) is the payor of last resort, "Retroactive" Authorizations may be granted only if another insurer has reimbursed for a portion of the price of the equipment first. When submitting a prior authorization request for possible reimbursement of the balance when third party insurance has reimbursed, submit the prior authorization request form with the explanation of benefits (EOB) attached. The Prior Authorization Request must be received within sixty (60) days of the date of the primary EOB.

If the insurance company has paid the maximum amount the Division of Medicaid (Medicaid) allows, additional reimbursement will not be made.

804.3 Medicaid/Medicare

If the member has part B Medicare and Medicaid, Medicare must decide the medical necessity of supplying the orthotics and prosthetics when the item is a covered item under Medicare. In these instances, Medicaid will not provide reimbursement for any service determined not medically necessary by Medicare.

804.4 Retroactive Eligibility

As outlined in Part I, Section 201.3, claims must be received by the Division within six (6) months from the month in which the determination of retroactive eligibility is made. For services requiring a prior approval (PA), the Certification of Retroactive Eligibility (Form 964) or other official forms issued by the County Department of Family and Children Services (see Billing Manual) must be attached to the PA and must be received within sixty (60) days from the effective date the Division enters the retroactive eligibility data into the system. It is the responsibility of the provider to verify eligibility when providing services. Refer to Part 1 202.2.

805. Special Considerations

805.1 Orthotics

a) Scoliosis codes (L1000 to L1310) require the responsibility of an orthotic practitioner GA licensed and certified by the American Board for Certification in Orthotics (ABC-CO)

b) Helmet Codes A8000, A8001, A8002, A8003 and A8004:

A8000 and A8001 are prefabricated, protective helmets for members that require protective following surgical procedures or trauma or a seizure disorder. These codes do not require a PA.
A8002 and A8003 are "custom" fabricated helmets that require PA and are usually required for members with an unusual cranial shape for the same criteria as the non-custom helmet. This unusual cranial shape may be a birth defect, surgical removal of a part of the skull, or an unusual size.

c) Helmet code: S1040: Diagnoses include: Plagiocephaly, Brachycephaly, Synostosis and Scaphycephaly. Includes all follow-ups. Under twenty-four (24) months of age. The reimbursement is all inclusive for Laser Scanner Data

d) All other orthotic codes requiring prior approval require the supervising practitioner to be licensed and certified by the American Board for certification (ABC-CO) or Board for Orthotist certification (BOC-CO).

e) The certificate of medical necessity (CMN) must be signed and dated by the licensed, certified Orthotist (CO) and must include the certification number of the Orthotist. The physician must sign and date the CMN.

f) A copy of the certification of the Orthotist must be attached to the CMN.

g) There must be a brief description of the item requested highlighting the main procedure codes and a brief medical necessity justification including symptoms which support the procedure codes.

h) The CMN must contain the member's main diagnosis (include the ICD-9 code(s) on or before 09/30/2015 or ICD-10 code(s) on or after 10/01/2015) supporting the medical necessity of the item requested.

i) Certification for repairs and replacement parts for a previously approved device requires the handwritten or authenticated electronic signature and certification of the orthotic practitioner only.

j) The CMN forms provided at the end of this chapter may be copied and used by the physician and/or CO. In addition, any other documentation supporting medical necessity may be attached to assist the reviewer.

805.2 <u>Custom Molded Shoes/ Custom Molded Inserts</u> (L3000 to L3630)

a) These custom molded shoe codes and shoes that attach to a brace (L3000 to L3630) require the responsibility of a certified orthotist (CO) or a Certified Pedorthist (C.Ped.). The service must be supervised by a licensed O&P Practitioner.

b) The CMN must be signed and dated by the CO or C.Ped and must include the license and certification number of the supervising practitioner. The physician may sign and date the CMN.

c) A copy of the certification of the orthotist or pedorthist must be attached to the CMN.

d) There must be a brief description of the custom molded shoe and the medical justification.

e) The CMN form provided at the end of this chapter may be copied and used by the physician and certified/licensed practitioner.

805.3 <u>Therapeutic Shoes for Diabetics</u> (A5500 to A5513)

a) Therapeutic shoes for Diabetics (A5500 to A5513) require a prior approval and the supervision of a licensed practitioner. The certification level is CO or C.Ped. (C.Ped practitioners MUST be SUPERVISED by a licensed practitioner.)

b) The CMN must be signed and dated by the physician managing the member's systemic diabetes condition and the licensed practitioner including the license number. The CO or C.Ped must sign and date the CMN and include his/her certification number. If a second physician or podiatrist is prescribing the shoes, the prescription must also be submitted.

c) A copy of the certification of the Orthotist or the Pedorthist must be attached to the CMN.

d) Diabetic shoes, inserts, and/or modifications to the shoes are covered if the following criteria are met:

1) The patient has diabetes mellitus (ICD-9 diagnosis on or before 09/30/2015 or ICD-10 code(s) on or after 10/01/2015); and

2) The patient has one or more of the following conditions:

i. previous amputation of the other foot, or part of either foot, or
ii. History of previous foot ulceration of either foot, or
iii. History of pre-ulcerative calluses of either foot, or
iv. Peripheral neuropathy with evidence of callus formation of either foot, or
v. Foot deformity of either foot, or
vi. Poor circulation in either foot; and

3) The physician who is managing the patient's systemic diabetes condition has certified that indications 1) and 2) are met and that he/she is treating

the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.

e) One pair of custom molded shoes (A5501), including inserts provided with the shoes and 2 additional pairs of inserts (A5512, or A5513; or one pair of depth shoes (A5500) and 2 pair of inserts (A5512, or A5513) not including the non-customized removable inserts provided with the shoes) is covered within one calendar year.

f) The physician and/or practitioner must describe the type of shoe(s) and/or inserts according to foot (feet) involvement to justify the request.

g) The CMN form provided at the end of this chapter may be copied for use by the physician and certified practitioner.

805.4 Other Footwear (L3000 to L3630)

a) These codes require prior approval.

b) Specific codes describe services for shoes that are an integral part of a leg brace.

c) The shoes must be medically necessary for the proper functioning of the brace.

d) Only a CO or C.Ped. may provide this service and must sign CMN together with physician. Include the licensed practitioner's license number and include ICD-9 code(s) on or before 09/30/2015 or ICD-10 code(s) on or after 10/01/2015).

e) L3204 is for infants/toddlers, a replacement ortho shoe for the Denis Brown bar due to growth. The shoe reimburses per shoe.

f) L3250 is a custom molded shoe code that includes the insert. L3250 can be utilized for diabetics or non-diabetics for missing foot parts or deformities either congenital or traumatic. L3250 cannot be billed with L5000.

805.5 Other Custom Footwear (L3000, L3010, L3020, L3040, and L3250)

a) Require a Prior approval

b) These codes describe services for deformed feet, correctional problems, post-surgical amputation

c) The CMN signed by the certified, licensed orthotist and the pedorthist (if applicable) and must be kept on file by the provider. The physician must sign and date the CMN OR a separate prescription to be kept on file by the provider.

d) The diagnosis (ICD-9 code(s) on or before 09/30/2015 or ICD-10 code(s) on or after 10/01/2015) code must be entered on the claim form.

805.6 Prosthetics

a) Electronic codes (L6920 to L7368) services must be provided by licensed American Board for Certification in Prosthetics (ABC-CP) practitioners only and practitioners who have special training in custom fabricating and fitting these devices. The electronic codes require the physician to document in a separate letter the specific medical and physical limitations and daily activity level (work, school, etc.) of the members which indicates the device is appropriate.

b) All other prosthetic codes requiring prior approval require the practitioner to be licensed and American Board Certified (ABC-CP or Board for Orthotist and Prosthetist certified (BOC-CP).

c) The CMN must be signed and dated by the certified prosthetist CP) and must include the certification number of the prosthetist. The physician must sign and date the CMN.

d) A copy of the certification of the prosthetist must be attached to the CMN and additional documentation of the ABC-CP for codes L6920 to L7368).

e) The CMN must contain the member's main diagnosis code(s) (ICD-9 code(s) on or before 09/30/2015 or ICD 10 code(s) on or after 10/01/2015) must be entered on the claim form supporting the medical necessity of the item requested).

f) There must be a brief description of the item requested highlighting the main procedure codes and a brief medical necessity justification including symptoms which support the procedure codes.

g) The functional level of the member must be documented on the CMN as described below:

Functional Levels:
A determination of the medical necessity for certain components/ additions to the prosthesis is based on the patient's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and ordering physician, considering factors including, but not limited to:

i. the patient's history (including prior prosthetic use if applicable)
ii. the patient's current condition including the status of the residual limb and the nature of any other medical problems; and
iii. the patient's desire to ambulate.

Clinical assessments of patient rehabilitation potential should be based on the following classification levels:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence, typical of the limited and unlimited household ambulator.

Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces (typical of the limited community ambulatory).

Level 3: Has the ability or potential for ambulation with variable cadence (typical of the limited community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion).

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels (typical of the prosthetic demands of the child, active adult, or athlete).

The CMN should document the patient's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case. The Division recognizes within the functional classification hierarchy that bilateral amputees often cannot be strictly bound for functional level classifications.

The diagnosis code(s) (On or before 09/30/2015 report ICD-9-CM codes; On or after 10/01/2015 report ICD-10-CM code(s)) must be entered on the claim form. must be included with the written diagnosis.

h) Certification for repairs and replacement parts for a device previously approved requires the signature and certification of the prosthetic practitioner only.

i) The CMN form provided at the end of this chapter may be copied for use by the physician and CP. In addition, any documentation supporting medical necessity may be attached to assist the reviewer.

805.7 Ocular Prosthetics

a) Ocular prosthetics (V2623 to V2628) require the responsibility of a practitioner certified by the National Examining Board of Ocularists (BCO).

b) The CMN must be signed and dated by the physician **and** (certified ocularist CCC-A) and must include the certification number of the ocularist.

c) A copy of the certification of the ocularist must be attached to the CMN.

d) Documentation of absence of an eye due to trauma or surgical removal must be submitted to support medical necessity.

e) Written diagnoses must include the associated ICD codes (On or before 09/30/2015 report ICD-9-CM codes; on or after 10/01/2015 report ICD-10-CM codes.

f) Replacement is covered every five (5) years unless documentation supports medical necessity of more frequent replacement.

g) Polishing and resurfacing is covered on a yearly basis and does not require prior approval.

h) One enlargement (V2625) or reduction (V2626) of the prosthesis is covered. Additional enlargements or reductions must be supported with additional documentation.

805.8 Hearing Prosthetics

Hearing aids, batteries, repairs and any additional items or services pertaining to hearing aids are only covered for members under twenty-one (21) years of age, this includes external replacement components and repairs for cochlear implants.

Covered Services

Hearing Aids

A first time or initial order for aid is covered for members less than twenty-one (21) years of age if the member does not currently have a hearing aid that meets the functional needs of the member for the ear being fitted for the device. Reimbursement for the hearing aid(s) are limited to one unit per three (3) years. The hearing aid(s) must be dispensed with at least a one (1) year factory warranty.

Georgia Medicaid only provides coverage for new hearing prosthetics. Each new hearing aid must have a manufacturer's warranty and be covered with loss/replacement insurance coverage for no less than three (3) years. All hearing aids, including replacement hearing aids, must be dispensed with replacement/loss insurance coverage. The total cost of insurance for the required three (3) years is considered to be included in the reimbursement of the hearing prosthetic. It is the responsibility of the provider to renew the insurance each year for each member serviced.

If a hearing aid(s) is lost and uninsured, within three years of the purchase of the device, the Division will require the provider to replace the device free of charge. If a hearing aid(s) is lost and replaced through warranty, the provider must purchase replacement insurance on the newly issued device(s). If the hearing aid(s) is lost and replaced through the provider purchased insurance, then the member (family or guardian) should pay for the replacement insurance **before** the provider issues the new hearing aid(s). Providers may request that the member (family or guardian) pay for the new replacement insurance only after the warranty or initial provider purchased insurance has been utilized to replace the lost hearing aid(s).

Prior Authorization for Hearing Aids is contingent upon the following:

a) For new/initial hearing aids; a medical consultation and recommendation by a licensed physician specializing in ear(s), nose, and throat (ENT), and prescribing hearing aids and/or audiograms. The consultation report or certificate of medical necessity (CMN) form must document the member's medical diagnosis and condition supporting the recommendation for the hearing aid(s).

   or

   For replacement hearing aids; a medical consultation and recommendation written by a licensed primary care physician (PCP). The consultation report or certificate of medical necessity (CMN) form must document the member's medical diagnosis and condition supporting the recommendation and necessity for the replacement hearing aid(s).

b) An audiological examination (audiogram) was performed by a licensed audiologist that supports the recommendation for an ENT consultation and the hearing aid(s);
   (*If the audiogram becomes untimely pending an ENT evaluation the audiologist may sign and date a letter stating that repeating the audiogram will not change the outcome and is therefore unnecessary*.)

c) The Georgia licensed audiologist must determine and recommend the most appropriate hearing device through assessment;

d) Only a Georgia licensed audiologist is allowed to evaluate, fit, and dispense the hearing aid(s) for children three (3) years of age or younger;

e) The prescription for repairs must be signed and dated by the licensed audiologist or hearing aid vendor.

f) Providers must keep on file a complete record of all repairs, including the manufacturer's invoice. The Division has the right to request this information.

g) All out of warranty factory or laboratory repairs must be performed by an authorized dealer. The factory and/or laboratory invoice must be attached to the PA form for repairs over $225.00 (per hearing aid). The invoice for repairs must remain in the member's file.

HCPCS Code	DESCRIPTION
V5014	HEARING AID REPAIR/MODIFYING
V5040	HEARING AID, MONAURAL, BODY WORN, BONE CONDUCTION
V5050	HEARING AID, MONAURAL, IN THE EAR
V5060	HEARING AID, MONAURAL, BEHIND THE EAR
V5171	HEARING AID, CONTRALATERAL ROUTING DEVICE, MONAURAL, IN THE EAR (ITE)
V5172	HEARING AID, CONTRALATERAL ROUTING DEVICE, MONAURAL, IN THE CANAL (ITC)
V5181	HEARING AID, CONTRALATERAL ROUTING DEVICE, MONAURAL, BEHIND THE EAR (BTE)
V5211	HEARING AID, CONTRALATERAL ROUTING DEVICE, BINAURAL, ITE/ITE
V5212	HEARING AID, CONTRALATERAL ROUTING DEVICE, BINAURAL, ITE/ITC
V5213	HEARING AID, CONTRALATERAL ROUTING DEVICE, BINAURAL, ITE/BTE
V5214	HEARING AID, CONTRALATERAL ROUTING DEVICE, BINAURAL, ITC/ITC
V5215	HEARING AID, CONTRALATERAL ROUTING DEVICE, BINAURAL, ITC/BTE
V5221	HEARING AID, CONTRALATERAL ROUTING DEVICE, BINAURAL, BTE/BTE
V5244	HEARING AID, DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, CIC
V5245	HEARING AID, DIGITALLY PROGRAMMABLE, ANALOG, MONAURAL, ITC
V5246	HEARING AID, DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, ITE (IN THE EAR)
V5247	HEARING AID, DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, BTE (BEHIND THE EAR)
V5254	HEARING AID, DIGITAL, MONAURAL, CIC
V5255	HEARING AID, DIGITAL, MONAURAL, ITC
V5256	HEARING AID, DIGITAL, MONAURAL, ITE
V5257	HEARING AID, DIGITAL, MONAURAL, BTE
V5258	HEARING AID, DIGITAL, BINAURAL, CIC
V5259	HEARING AID, DIGITAL, BINAURAL, ITC
V5260	HEARING AID, DIGITAL, BINAURAL, ITE
V5261	HEARING AID, DIGITAL, BINAURAL, BTE
V5264	EAR MOLD/INSERT

V5266	BATTERY FOR HEARING DEVICE
V5267	HEARING AID SUP/ACCESS/DEV
V5299	HEARING SERVICE, MISC.

Audiological evaluation (audiogram)

An audiological evaluation and the hearing aid evaluation are included in the reimbursement for the hearing aid(s). It is the responsibility of the enrolled hearing aid provider to obtain the evaluation at no additional cost to the Division.

Fitting and Dispensing Services

The components listed below must be part of the fitting and dispensing services. Steps 3-8 can occur on a subsequent appointment.

1) Selection and fitting of an appropriate hearing aid(s)
2) Ear mold impression of the ear(s)
3) Instruction on the operation and use of the hearing aid(s)
4) Ear mold fitting
5) Other procedures required for the proper fitting of the hearing aid(s)
6) Instruction on the care and maintenance of the hearing aid(s)
7) Wearing period in which the member is encouraged to return as often as necessary to the dispenser for proper counseling and adjusting to the hearing aid(s). This includes being accustomed to wearing the device and adjusting controls.
8) Provision of appropriate information to the member concerning repairs and loss under the warranty insurance and repairs and loss covered by the Medicaid program.

Repairs/Replacements

Repairs/Replacements for hearing aid(s) and cochlear implants are only covered for eligible Medicaid members under 21 years of age. Repairs are covered for all hearing aids, including those not purchased by Medicaid, if they are still being used by the member. Medicaid will *not* provide reimbursement for repairs on a hearing aid(s) worn prior to the purchase of a new hearing aid(s) by the Division. Annual repair cost must not exceed $225.00 per calendar year, per member, per hearing aid. This includes all parts, labor, and delivery. Repairs may be billed starting one year from the initial date of purchase from the Division.

Reimbursement will not be made for the replacement or repair of hearing aid(s) and cochlear implants that are still covered under warranty or an enforceable protection plan (loss insurance, etc.).

Cochlear Implant Speech Processor
Loss insurance must be provided at all times by the enrolled provider to be reimbursed by Georgia Medicaid

A speech processor (L8619) must be insured for loss by the enrolled provider at all times. The reasonable useful lifetime for both the processor and controller is three (3) years. Georgia Medicaid will allow the replacement of these items beginning three years after the date of service for which the items were purchased. The manufacturer/provider may determine if a loss is catastrophic or due to patient negligence. If the loss is catastrophic, a PA request may be submitted for review to determine if the Division will reimburse for the replacement. Replacement devices involving a catastrophic event must contain the appropriate supporting documentation (police report, fire report, etc.). If the loss is determined to be related to patient negligence the provider must submit a claim for the replacement of the device through the loss insurance policy. **In this case the provider may request that the member pay for the loss insurance on the replacement device not to exceed $ 119.00 per replacement device**.

If the loss is not the result of patient negligence or a catastrophic event, the provider must furnish the loss insurance. **The provider may replace the lost processor with a refurbished device.**

L8619 (Cochlear implant, external **speech processor and controller, integrated system**, replacement)
Miscellaneous Items/Additions/Supplies (L8699)

Ear molds, cords or wires, batteries, repairs and labor are covered and reimbursable services by the Division. These items and/or services are not included in the hearing aid reimbursement rate and may be billed separately if they are reasonable and necessary. Providers must refer to the Schedule of Maximum Allowable payments for their respective program for guidelines on replacements and rates of reimbursement.

Effective October 1, 2014, providers must submit a quote invoice from the manufacturer that contains a detailed description of the items for which they are requesting reimbursement, MSRP pricing, and the providers cost. The Division will reimburse miscellaneous items at 40% above the actual provider's cost (not to exceed $500.00). This code may only be submitted for approval with one unit of service that will contain the approved combined price for all items being requested.

Disposal

The State of Georgia retains ownership at all times of hearing aid(s) and accessories purchased by Medicaid. Neither the member nor his family is free to dispose of the aid(s) at his or their discretion. Disposition of the aid(s) will be at the discretion of the Division of Medical Assistance. When the provider

becomes aware that the aid(s) is no longer needed by the member, the provider should contact the Division for instructions as to what and how disposition is to be made.

External cochlear implant components

a) Hearing prosthetics require the responsibility of a practitioner who is certified by the American Speech-Language-Hearing Association as indicated below. A practitioner holding a Certificate of Clinical Competence-Audiology (CCC-A).

EXTERNAL COCHLEAR IMPLANT COMPONENTS

HCPCS Code	DESCRIPTION	Required Certification
L8615	COCH IMPLANT HEADSET REPLC	CCC-A
L8616	COCH IMPLANT MICROPHONE REPLC	CCC-A
L8617	COCH IMPLANT TRANS COIL REPLC	CCC-A
L8618	COCH IMPLANT TRAN CABLE REPLC	CCC-A
L8619	COCH IMP EXT PROC/CONTR RPLC	CCC-A
L8621	REPL ZINC AIR BATTERY	CCC-A
L8622	REPL ALKALINE BATTERY	CCC-A
L8623	LITH ION BATT CID, NON-EARLVL	CCC-A
L8624	LITH ION BATT CID, EAR LEVEL	CCC-A
L8625	COCH IMPLANT EXT BATTERY, RPLC	CCC-A
L8699	PROSTHETIC IMPLANT NOS	CCC-A

805.9 External BAHA- (Bone Anchored Hearing Aids) Initial and Replacement Components (Rev. 01/18, 04/18)

A bone anchored hearing aid is a surgically implanted hearing device that transmits sound directly into the inner ear through bone, by passing the external auditory canal and middle ear. BAHA devices consist of an external sound processor and a titanium implant that is affixed to the temporal bone. The sound processor vibrates the implant, which in turn produces vibrations in the temporal bone which transmits through the other bones to the cochlear of the opposite ear and creates sound.

The BAHA external sound processor (L8691) and the transducer actuator (L8694) will be considered for coverage as a replacement only, as both components are covered through the Orthotics and Prosthetics – Hearing Services Program. Each replacement sound processor must have a manufacturer's warranty and be covered with loss/replacement insurance for no less than three (3) years. The cost of the loss/replacement insurance during this three (3) year period is included in the reimbursement of the device. All replacement components require prior approval.

If an external sound processor for a bone anchored hearing aid is lost and uninsured within three years of the purchase of the device the provider will be

required to replace the device free of charge. If the replacement device(s) is lost and replaced through warranty, the provider must purchase replacement insurance on the newly issued device(s). If the device(s) is lost and replaced through the provider purchased insurance, then the member (family or guardian) should pay for the replacement insurance before the provider issues the new device(s). Providers may request that the member (family or guardian) pay for the new replacement insurance only after the warranty or initial provider purchased insurance has been utilized to replace the lost hearing aid(s).

Description

Bone-anchored hearing aids (BAHAs) are an alternative to conventional hearing aids when physical or medical complications prevent adequate functional improvement in hearing. Sound quality of BAHAs is superior to, and pain/discomfort is largely diminished, when compared to conventional bone conduction devices.

Policy/Criteria

I. The bone anchored hearing aid auditory osseointegrated device, which includes all internal and external components (L8690) will be considered for coverage of the initial aid. The BAHA Softband non osseointegrated device, which includes all external components (L8692) will be considered for coverage of members that have not reached the implantable age. The BAHA external sound processor (L8691) will be considered for coverage as a replacement device. It is medical policy that BAHAs are medically necessary for members with all of the following indications:

BAHAs for any other indication are considered not medically necessary because effectiveness has not been established.

A. Implantable device for age ≥5 years; or head band device for age ≤5 years or for members medically unable to have an implant.
B. Unilateral or bilateral conductive hearing loss; or unilateral or bilateral mixed conductive and sensorineural hearing loss; or unilateral sensorineural hearing loss;
C. Pure tone average bone conduction threshold (measured at 0.5, 1, 2, and 3kHZ) < 70 dBHL (decibels hearing level) and an unaided speech discrimination score not worse than 60%; Pure tone average bone conduction testing results performed within the previous 6 months;
D. An audiological evaluation and the hearing aid evaluation are included in the reimbursement for the hearing aid(s). It is the responsibility of the enrolled hearing aid provider to obtain the evaluation at no additional cost to the Division.
E. One of the following indications:

1. Congenital or surgically induced malformations of the ear canal such that it does not exist or cannot accommodate a standard air-conduction hearing aid,
2. Chronic infection or dermatitis of the middle or outer ear that is exacerbated by a standard air-conduction hearing aid,
3. Allergic reactions to standard air-conduction hearing aids,
4. Single-sided deafness occurred after removal of an acoustic neuroma, from trauma, or from a viral or vascular insult,
5. Tumors of the external canal and/or tympanic cavity.

II. BAHA Softband Indications

1. Chronic Draining Otitis Media which is unresponsive to treatment
2. Congenital malformation of the external auditory canal or middle ear (atresia and/or microtia), moderate to severe conductive or mixed hearing loss with confirmed bone conduction results in the normal to mild hearing range (better than 40 dBHL).
3. Acquired stenosis of the external auditory canal.
4. Ossicular discontinuity or erosion that cannot be repaired by surgery.
5. Confirmed profound hearing loss (greater than 90 dB hearing loss) in one ear with confirmed bone conduction thresholds in the opposite ear of 40 dB hearing loss or better.
6. Age under 5 years or who have contraindication to the use of an implantable device.

BAHAs for any other indication are considered **not medically necessary** because effectiveness has not been established.

Coverage Guidelines:

External replacement components of bone anchored hearing aid(s) will be considered for coverage if all the following criteria are met:

a) The member is under twenty-one (21) years of age
b) The member has an existing BAHA that has been in place for no less than three (3) years and requires the replacement of an external component.
c) A written order from a physician documenting the need for the replacement is on file and submitted during the prior authorization process
d) The device is being provided by a practitioner who is certified by the American Speech-Language –Hearing Association (CCC-A).

Coding Guidelines:

Initial placement, replacement processor(s) for bone anchored hearing aid(s) and supplies will be considered for coverage through the prior approval process. L8690 – L8694 are listed on the schedule of maximum allowed payments (SMAP) for orthotic and prosthetic services and does not require manual pricing. L8699 is manually priced and should not exceed the preestablished limitations.

SMAP	**Website**	**Web Location**
The schedule of maximum allowable payment may be found by visiting Georgia Medicaid Division website	www.mmis.georgia.gov	Provider Information → Fee Schedule → Orthotic and Prosthetic Fee Schedule

HCPCS Codes	Description
L8690	AUDITORY OSSEOINTEGRATED DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS
L8691	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, EXCLUDES TRANSDUCER/ACTUATOR, REPLACEMENT ONLY, EACH
L8692	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, USED WITHOUT OSSEOINTEGRATION, BODY WORN, INCLUDES HEADBAND OR OTHER MEANS OF EXTERNAL ATTACHMENT
L8694	AUDITORY OSSEOINTEGRATED DEVICE, TRANSDUCER/ACTUATOR, REPLACEMENT ONLY, EACH
L8699	PROSTHETIC IMPLANT, NOT OTHERWISE SPECIFIED *(Preestablished Limitations: Battery Pack 1 per year $116.80 each; i-Connect 1 per 6 months $83.20 each; Battery charger kit 1 per 1year ABC-$127.20, Med El $64.00; All external accessories and parts for cochlear implant device with no separate code may be requested with L8699 (i.e. ABC Firefly 1 per year; Cochlear Mic-lock; Ear hooks 1 per year $9.00 (Med El/Cochlear); Repairs 2 per year, all requests for items without capped rates must be submitted an invoice)*

ICD-10-CM Diagnosis Codes

ICD-10-CM Code	Description
C30.1	Malignant neoplasm of middle ear

C47.0	Malignant neoplasm of peripheral nerves of head, face and neck
C49.0	Malignant neoplasm of connective and soft tissue of head, face and neck
C44.201, C44.202, C44.209	Unspecified malignant neoplasm of skin of ear and external auricular canal
C44.211, C44.212, C44.219	Basal cell carcinoma of skin of ear and external auricular canal
C44.221, C44.222	Squamous cell carcinoma of skin of ear and external auricular canal
C44.291, C44.292, C44.299	Other specified malignant neoplasm of skin of ear and external auricular canal
D14.0	Benign neoplasm of middle ear, nasal cavity and accessory sinuses
D21.0	Benign neoplasm of connective and other soft tissue of head, face and neck
D22.20 – D04.22	Melanocytic nevi of ear, benign neoplasm of skin of external auricular canal
D04.20, D04.21, D04.22	Carcinoma in situ of skin of ear and external auricular canal
H61.111, H61.112, H61.113, H61.119	Acquired deformity of pinna
H65.20 – H65.23	Chronic serous otitis media
H65.30 – H65.33	Chronic mucoid otitis media
H65.411 – H65.419, H65.492 – H65.499	Chronic allergic otitis media and other chronic nonsuppurative otitis media
H66.20 – H66.23	Chronic atticoantral suppurative otitis media
H66.3X1 – H66.3X9	Other chronic suppurative otitis media
H66.90 - H66.93	Otitis media and otosclerosis
H80.93	Unspecified otosclerosis, bilateral
H90.0 -H90.2	Conductive hearing loss
H90.11 – H90.12	Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side
H90.2	Conductive hearing loss, unspecified
H90.3	Sensorineural hearing loss, bilateral
H90.41 – H90.42	Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side
H90.5	Unspecified sensorineural hearing loss
H90.6	Mixed conductive and sensorineural hearing loss, bilateral
H90.71 – H90.72	Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side

H90.8	Mixed conductive and sensorineural hearing loss, unspecified
L20.0	Besnier's prurigo
L20.81	Atopic neurodermatitis, flexural eczema, other atopic dermatitis
L23.7	Allergic contact dermatitis due to plants, except food
L24.7	Irritant contact dermatitis due to plants, except food
L25.5	Unspecified contact dermatitis due to plants, except food
L23.0	Allergic contact dermatitis due to metals
L24.81	Irritant contact dermatitis due to metals
L23.9	Allergic contact dermatitis, unspecified cause
L24.9	Irritant contact dermatitis, unspecified cause
L25.9	Unspecified contact dermatitis, unspecified cause
L30.0	Nummular dermatitis
L30.2	Cutaneous autosensitization
L30.8	Other specified dermatitis
L30.9	Dermatitis, unspecified
Q16.1	Congenital absence, atresia and stricture of auditory canal (external)
Q16.3	Congenital malformation of ear ossicles
Q16.4	Other congenital malformations of middle ear
Q17.9	Congenital malformation of ear, unspecified

Limitations:

- Noncovered for members over the age of twenty-one (21) years.
- Abutments and other components of the internal device are noncovered through the Orthotics and Prosthetics program.
- External Processors will not be replaced more than once (1), per three (3) years.
- Devices issued without the required insurance coverage may be subject to recoupment upon post-payment review.

806. Certification for Medical Necessity Forms (CMN)

Forms to assist the provider in obtaining prior approval authorization for orthotic and prosthetic services follow in this chapter. The information requested on these CMN forms assists the reviewer in determining medical necessity for the item requested and is vital in the expeditious review and processing of requests. The provider may copy these forms to be utilized by the physician and certified practitioner to justify the service requested. If the provider or physician has forms that contain this information, they may be used instead of the ones provided. The CMN, signed and dated by the physician and the certified practitioner, must be attached to the Prior Authorization Request Form DMA-610.

The Division reserves the right to request additional documentation of the medical necessity and appropriateness of the service from the certified practitioner, physician or other health care professional involved in the patient's care.

Submit all Prior Authorizations electronically through the Web Portal at the following address; www.mmis.georgia.gov.

Alliant Health Solutions PA/UM Department
Fax (678) 527-3032

Certificate of Medical Necessity for AFO (Ankle Foot Orthosis) / KAFO (AFO above Knee)

Member's Name: _____ Medicaid # _____ Ht: _____ Wt:_____

Report ICD-9-CM on or before 09/30/2015 and ICD-10-CM on or after 10/01/2015

Diagnosis:

- ☐ Arthritis
- ☐ Arthrogryposis
- ☐ Blount's Disease
- ☐ Cerebral Palsy
- ☐ Charcot's arthropathy
- ☐ CVA
- ☐ Fractured Calcaneus
- ☐ Fractured fibula
- ☐ Fractured talus
- ☐ Fractured tibia
- ☐ Guillain-Barre
- ☐ Multiple Sclerosis
- ☐ Muscular dystrophy
- ☐ Myasthenia gravis
- ☐ Myelomeningocele
- ☐ Osteogenesis Imperfecta
- ☐ Osteomyelitis
- ☐ Spina Bifida

Symptoms justifying medical necessity (check **all** applicable):

- ☐ Abduction
- ☐ Abduction
- ☐ Contractures
- ☐ Dorsiflexion
- ☐ Drop foot
- ☐ Equinus deformities
- ☐ Excessive extension
- ☐ Excessive flexion
- ☐ Excessive inversion
- ☐ Gait disturbance
- ☐ Joint hypermobility
- ☐ Muscular weakness, low tone
- ☐ Pronation
- ☐ Spasticity, Hypertonicity
- ☐ Supination
- ☐ Subluxation
- ☐ Talipes equinovarus
- ☐ Tight heelcords
- ☐ Toe Walking
- ☐ Valgus/Varus abnomalities

Orthotic device requested: ☐ Bilateral ☐ Unilateral
L1900 thru L1990 and L2000 thru L2090 List the appropriate code and description

Additions to AFO:
L2200 thru L2860 Enter the appropriate code and description

Are these replacement braces due to growth? ☐ Yes ☐ No If yes, justify with changes in weight and/or measurements.
Change in weight _____ Change in height _____ Change in leg length _____
Are these replacement braces due to growth? ☐ Yes ☐ No If yes, justify with changes in weight and/or measurements.
Change in weight _____ Change in height _____ Change in leg length _____
Are these replacement braces due to growth? ☐ Yes ☐ No If yes, justify with changes in weight and/or measurements.
Change in weight _____ Change in height _____ Change in leg length _____

Signature of certified/licensed orthotist:_____ **Date** of signature _____
Printed name of certified orthotist: _____

Certification number: _____ (**Attach copy of certification) License Number _____**
☐ Check if Rx attached; if so, MD signature not required on this form. **Date**: _____

Printed Name of Physician _____
Signature of Physician _____ **Date** of signature _____

Signature of certified/licensed orthotist:_____ **Date** of signature _____
Printed name of certified orthotist: _____
Certification number: _____ (**Attach copy of certification) License Number _____**
☐ Check if Rx attached; if so, MD signature not required on this form. **Date**:_____

Printed Name of Physician _____
Signature of Physician _____ **Date** of signature _____
Signature of certified/licensed orthotist:_____ **Date** of signature _____
Printed name of certified orthotist: _____
Certification number: _____ (**Attach copy of certification) License Number _____**
☐ Check if Rx attached; if so, MD signature not required on this form. **Date**:_____

Printed Name of Physician _____
Signature of Physician _____ **Date** of signature _____

CERTIFICATION FOR CUSTOM ORTHOTICS OR PROSTHETICS

Alliant Health Solutions PA/UM Department

Member Medicaid Number _____ Date of Birth _____

Member's Full Name _____ HT _____ WT _____

Diagnoses _____ Code(s) _____

Report ICD-9-CM on or before 09/30/2015 and ICD-10-CM on or after 10/01/2015

Describe **in complete detail** all applicable sections:

Ambulatory status _____

Functional level _____ Circle 1 2 3 4

Endurance _____

Neck and head control

Bank _____

Trunk _____

Pelvis/Hips

Upper extremities _____

Lower extremities _____

Skin integrity _____

Activities that require device _____

Description of Device	Medical Justification	Purpose of Device

I certify that this custom orthotic or prosthetic device is medically necessary

MD printed name _____ Practitioner printed name _____

MD signature _____ Practitioner signature _____

MD address _____ Practitioner title _____ Certification # _____

Practitioner License #: _____ Date: _____

CERTIFICATE OF MEDICAL NECESSITY FOR ORTHOTIC OR PROSTHETIC

Member Medicaid Number:_____ Date of Birth: _____

Member Name:_____ Height:_____Weight:_____

Diagnoses _____ Code(s) _____

Prosthetic: _____ Orthotic: _____ Custom Shoes: _____ Other: _____

Rental:___ Purchase:___ Amputee's Intended Functional Level: 1__; 2 __; 3 __; 4 __; 5 __

Low High

Description of Services Requested:

_____

_____

_____

Justification of services:

_____

_____

I certify that these services I have ordered are medically necessary to either restore function or as a corrective treatment.

Practitioner (Print): _____ Certification Number: _____

Practitioner Signature:_____ Date:_____

Practitioner License # _____ Medicaid Provider Number: _____

Date: _____

Physician Name (Print): _____

Address: _____

Phone Number:_____ Fax Number: _____

Signature:_____ Date: _____

(Stamped Signatures and dates are not acceptable)

Certification for Diabetic Shoes

Member Medicaid Number: _____ Date of Birth: _____

Member Name: _____

Member Address: _____

1. This patient has diabetes mellitus – ICD Code: _____
   Report ICD-9-CM on or before 09/30/2015 and ICD-10-CM on or after 10/01/2015

2. This patient has one or more of the following conditions (circle all that apply and expand on the description to justify the shoes as to medical necessity):
   a) History of partial or complete amputation f the foot;
   b) History of previous foot ulceration;
   c) History of pre-ulcerative callus;
   d) Peripheral neuropathy with evidence of callus formation;
   e) Foot deformity;
   f) Poor circulation.

Expand on the above condition: _____

_____

_____

3. I am treating this patient under a comprehensive plan of care for his/her diabetes.

Description of shoes needed: _____

I certify that the diabetic therapeutic shoes are medically necessary.

Physician Name (Print): _____

Phone Number: _____ Fax Number: _____

Address: _____

Signature: _____ Date: _____
(Stamped Signatures and dates are not acceptable)

Orthotist or Pedorthist: _____ Certification Number: _____

Practitioner License # _____ **Date:** _____

Practitioner Signature: _____ Date: _____

Medicaid Provider Number: _____ **Attach Copy of Certification**

PART II - CHAPTER 900
SCOPE OF SERVICES

901. General

The Orthotics and Prosthetics Program reimburses for the purchase of certain orthotic and prosthetic devices for a patient's use in a non-institutional setting. The items must be prescribed by a physician and generally do not have value to patients in the absence of illness or injury. Custom items requiring prior approval, appropriate for use by only one person (the individual the item is customized for) and could not be used by anyone else, may be covered for nursing home/institutional members. All non-custom (off the shelf, prefabricated items) are not covered for members in an institutional/nursing home setting.

902. Definitions

902.1 Orthotic - a rigid and/or semi rigid device or brace which is for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. The orthotic device may be custom fabricated and fitted, prefabricated custom fitted or off-the-shelf prefabricated and fitted.

Leg, arm, back, and neck braces and trusses come within the scope of the definitions of orthotic back braces; also included (but not limited to) are special corsets, sacro-lumbar and dorso-lumbar corsets diabetic shoes, and custom molded shoes.

902.2 Orthotist - a practitioner who provides care to patients with disabling conditions of the limbs and spine by designing, fabricating, and fitting devices known as orthoses. At the request of and in consultation with a physician, the orthotist assists in formulation of prescriptions for orthoses, and examines and evaluates the patients' orthotic needs in relation to their disease entity and functional loss. In providing the orthosis, the orthotist is responsible for formulating its design, including selection of materials; making all necessary casts, measurements, model modifications, and layouts; performing fittings, including static and dynamic alignments; evaluating the orthosis on the patient; instructing the patient in its use; and maintaining patient records; all in conformity with the prescription. The orthotist is expected to keep abreast of new developments concerning orthotic patient care and is required to supervise the functions of support personnel and laboratory activities related to the development of orthoses.

Orthotic practitioners include:

ABC-CO - a practitioner certified by the American Board for Certification in Orthotics.

BOC - a practitioner certified by the Board for Orthotist Certification.

C.Ped. - a practitioner certified by the Board for Certification in Pedorthics.

ABC - Clinical Assistant (ROA) - a registered assistant is certified by the American Board for Certification in Orthotics.

FITTER/TECHNICIAN/FABRICATOR (may be supervised by an Orthotic or Prosthetic Practitioner) - a practitioner certified by any of the above disciplines or has completed a manufacturer's training course. Also includes the mastectomy fitter who has successfully completed the three-week ABC Mastectomy Fitter course. **See Section 904 Dispensing Fitter**.

902.3 Prosthetic - an external device (other than dental or corrective lenses) which replaces all or part of an external body part (including artificial eyes) or replaces all or part of the functions of missing body part or congenital abnormality. The prosthetic device may be custom fabricated and fitted, prefabricated and custom fitted or off-the-shelf prefabricated and fitted.

External prosthetic devices include, but are not limited to artificial limbs, all or part; breast prostheses (including surgical brassiere); and prosthetic eyes and external parts for cochlear implants.

902.4 Prosthetist - a practitioner who provides care to patients with partial or total absence of a limb by designing, fabricating, and fitting devices known as prostheses. At the request of and in consultation with physicians, the prosthetist assists in formulation of prescriptions for prostheses, and examines and evaluates the patients' prosthetic needs in relation to their disease entity and functional loss. In providing the prosthesis, the prosthetist is responsible for: formulating its design, including selection of materials and components; making all necessary casts, measurements, and model modifications, performing fittings, including static and dynamic alignments; evaluating the prosthesis on the patient; instructing the patient in its use; and maintaining patient records all in conformity with the prescription. The prosthetist is expected to keep abreast of new developments concerning prosthetic patient care and is required to supervise support personnel and laboratory activities related to the development of prostheses.

Prosthetic practitioners include:

ABC-CP - a practitioner certified by the American Board for Certification in Prosthetics.

BOC-CP- a practitioner certified by the Board for Prosthetist Certification.

BCO - a practitioner certified by the National Examining Board of Ocularists. BOCs take compulsory CE units three years post examination and are recertified every 6 years.

RPA - a registered assistant certified by ABC in Prosthetics

Prosthetist/Orthotist practitioners include:

ABC-CPO - a practitioner certified by the American Board for Certification in Orthotics and Prosthetics.

BOC-CPO - a practitioner certified by the Board for Prosthetist and Orthotist Certification.

903. Coverage and Requirements for Orthotics and Prosthetics

903.1 The prosthetic device must substitute for all or part of an external body member or including hearing and ocular prosthetics.

903.2 The prosthetic device must replace all or part of the function of a permanently inoperative or malfunctioning external body member.

903.3 Prosthetic accessories, supplies, repairs, adjustments, modifications replacements, must be necessary for the effective use of a prosthetic device.

903.4 The prosthetic and orthotic device provider must design the device, select materials and components, measure, fit, and align the device, and instruct the patient in its use.

903.5 The orthotic device must support or align movable parts of the body, prevent, or correct deformities, or improve functioning.

903.6 Measurement and fitting for orthotics must be performed by a provider with at least one licensed practitioner physically at each location where applicable. The practitioner with the minimum certification (or higher) required by the Division and indicated in Appendix C for each procedure code must supervised by a licensed practitioner. The orthotic provider must submit a copy of the license of the supervising practitioner for the services to be provided. It is the provider's responsibility to submit a new license in the event of change or updates (i.e., change of practitioner or license renewal).

903.7 Providers of orthotics and prosthetics services must obtain a written certificate of medical necessity (CMN) with detailed clinical information supporting the items ordered from a licensed physician before fitting the device, and the certificate of medical necessity must be kept on file by the provider in accordance with the provision of this manual.

903.8 Measurement and fitting for prosthetics must be performed by a provider with at least one licensed practitioner physically at each location required by the Division. The level of certification required is indicated in Appendix D for each procedure code. The prosthetic provider must submit a copy of the required most current certification for the services to be provided. It is the provider's responsibility to submit a new certification in the event of change or updates (i.e., change of practitioner or recertification). All adjustments and fittings are included in the cost of the base orthotic/prosthetic device.

903.9 The required certified and licensed practitioner of orthotics or prosthetics must be physically available during all hours of patient care and to supervise staff providing services. The facility must be accredited by 01/09/09.

904. Provider Licensure/Certification Restrictions

The Division restricts the type of certification required to provide orthotic/prosthetic devices/services as indicated by "Required Provider Certification" in Appendices C and D. The determination to restrict provider certification is based on the Levels of Care concept which determines the competency level of the provider in relation to their Scope of Practice. The Division has measured competency of certification based on the Type of Device/Service requiring specific qualifications and responsibilities or Levels of Care. Competency level includes formal education and experience, clinical assessment, patient evaluation and management, clinical managerial/ supervisory activities and education in technical and biomechanical principles underpinning the design and fitting of the orthosis.

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

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

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.

Levels of Care for Practitioners are as follows, in ascending order of capability:

ABC Clinical Assistant (ROA/RPA) – May perform orthotic and prosthetic procedures and related tasks in the management of patients. Fabricates, repairs, and maintains devices to provide maximum fit, function and appearance under the guidance and supervision of the ABC certified practitioners. May not use their credential as independent practitioners engaged in unsupervised patient care. Obligated to support and conform to professional responsibilities that promote and assure the overall welfare of the patient and the integrity of the profession.

Fabricator - Entry level to moderately qualified. Fabricates devices repetitiously and by rote with little understanding of technical or biomechanical principles. No patient contact.

Technician - Moderately to well qualified. May have training in technical or biomechanical principles as well as training by component or device manufacturers. May have also received formal credentials. Has some patient contact when assisting a caregiver or care manager, particularly if qualified to work with a particular class or type of device (e.g., external power, RGOs).

Dispensing Fitter - Provides Off-the-Shelf, soft goods type devices. May be trained in a manufacturer's workshop but the majority of training/experience is gained on the job. Has little understanding of technical or biomechanical principles. Individuals in this category are likely to also be a technician or to perform clerical/administrative responsibilities.

a) Fitter (Level I) Provides Off-the-Shelf, soft goods type devices. **On the job training only.** Has little understanding of technical or biomechanical principles. Individuals in this category are likely to also be a technician or to perform clerical / administrative responsibilities.

b) Filter (Level II) As Fitter (Level 1) but has also successfully completed a manufacture's training course. Device knowledge is likely to be limited to the product line(s) covered in that course or used in the particular practice setting.

c.) Fitter (Level III) Mastectomy Fitter. Has Level I and II and successfully completed the three weeks ABC Mastectomy Fitter Course. Mastectomy Fitters Level III may enroll to provide services L8000 through L8030. Procedure L8035 is provided through a licensed provider.

Care Giver - Works directly with patients, providing Custom Fitted devices and follow up. Also participates in fabrication activities.

Care Manager/Case Manager - In addition to care giver activities, qualified to provide Custom Fabricated and Fitted devices and to engage in clinical managerial/supervisory activities. Formally trained and qualified to assess and evaluate the needs of patients and to collaborate with other health care providers. Educated in technical and biomechanical principles underpinning the design and fitting of prostheses and orthoses.

Types of Devices are as follows:

Custom Fabricated and Fitted Device - An orthosis or prosthesis fabricated to original measurements and/or a mold for use by a patient in accordance with a prescription and which required substantial clinical and technical judgment in its design and fitting.

Custom-Fitted Device (High) - A prefabricated orthosis or prosthesis sized and/or modified for use by the patient in accordance with a prescription and which requires substantial clinical judgment (involving high Clinical Assessment and Patient Management skills) and substantive alteration (involving medium Technical Implementation skills) for appropriate use.

Custom-Fitted Device (Low) - A prefabricated orthosis or prosthesis sized and/or modified for use by the patient in accordance with a prescription and which requires substantial clinical judgment (involving medium Clinical Assessment and Patient Management skills) and substantive alteration (involving low Technical Implementation skills) for appropriate use.

Off-the-Shelf - A prefabricated prosthesis or orthosis sized and/or modified for use by the patient in accordance with a prescription and which does not require substantial clinical judgment and substantive alteration for appropriate use.

Required Provider Certification
Considering the definitions of the various types of devices and the qualifications and responsibilities of the providers in the levels of care, the Division determined the certification required for each orthotic and prosthetic service.

906. Noncovered Services

Reimbursement for the services listed below will not be made by the Division under the Orthotics and Prosthetics Program.

906.1 Devices not within the scope of the definition of an orthotic or prosthetic device, including but not limited to: elastic stockings, garter belts, and similar devices.

906.2 Dentures or dental examination for the purpose of prescribing, fitting, fabricating, or changing dentures is excluded from coverage. This is a covered service under the Dental Program.

906.3 Augmentative Communication Devices.

906.4 Devices will not be replaced due to member's negligence or abuse. Loss insurance must be provided by the provider at all times. If member negligence is proven, member may be asked to furnish the loss insurance.

906.5 Any services rendered by an assistant/technician who is not being supervised by the O&P licensed professional of the facility. (Reference Section 106.40 for clarification on what constitutes as supervision).

907. Fitting Rooms

Facilities must meet minimum standards as published herein. Facilities certified under Standards for Facility Accreditation published by the American Board for Certification in Orthotics and Prosthetics, Inc. will be deemed to have automatically met the following minimum standards required of all providers:

a) the size of the fitting room must be at least 35 square feet;
b) the room must be easily accessible to the patient, and room must have a closeable door;
c) a fitting table with a padded surface and disposable cover, and a minimum size of 24 X 72 inches, is required;
d) a full-length mirror must be provided;
e) a straight-back chair must be provided;
f) parallel bars must be installed at least 8 feet long; and
g) ramps and or elevators shall be provided for access convenience.

PART II - CHAPTER 1000
BASIS FOR REIMBURSEMENT

1001. Reimbursement Methodology

The maximum reimbursement for providers of orthotic and prosthetic services is limited to the lower of:

a. The actual charges for the item; or
b. 80% of the 2007 CMS DMEPOS rate

The Division defines "usual and customary charge" as the lowest of; the lowest price charged to other third-party payers (including HMO's); or the lowest price regularly and routinely offered to any segment of the general public. Discounts offered to charitable organizations are not included in this definition.

There is a $3.00-member copayment for Orthotics and Prosthetics Services. The $3.00 co-payment is applied to all main component codes or "base" codes.

CHAPTER 1100 PRIOR APPROVAL

1101. General

Each Prior Authorization Request submitted to GHP will have a prior authorization number assigned. If the requested service(s) is approved by the Division, the prior authorization number as must be entered in the appropriate space on the claim form when billing for services that have been authorized. If these numbers are not included, the claim will be rejected. DO NOT BILL OTHER ITEMS ON A CLAIM THAT CONTAINS ITEMS THAT HAVE BEEN PRIOR APPROVED.

1102. Third Party

Since the Division of Medical Assistance is the payer of last resort, "Retroactive" Authorizations may be granted only if another insurer has reimbursed for a portion of the price of the equipment first. When submitting a prior authorization request for possible reimbursement of the balance when another insurance company has reimbursed, submit the prior authorization request form with an explanation of medical benefits (EOB) attached as if the full amount (retail price) was being requested from the Division. The Prior Authorization Request must be received within sixty (60) days of the date of the EOB.

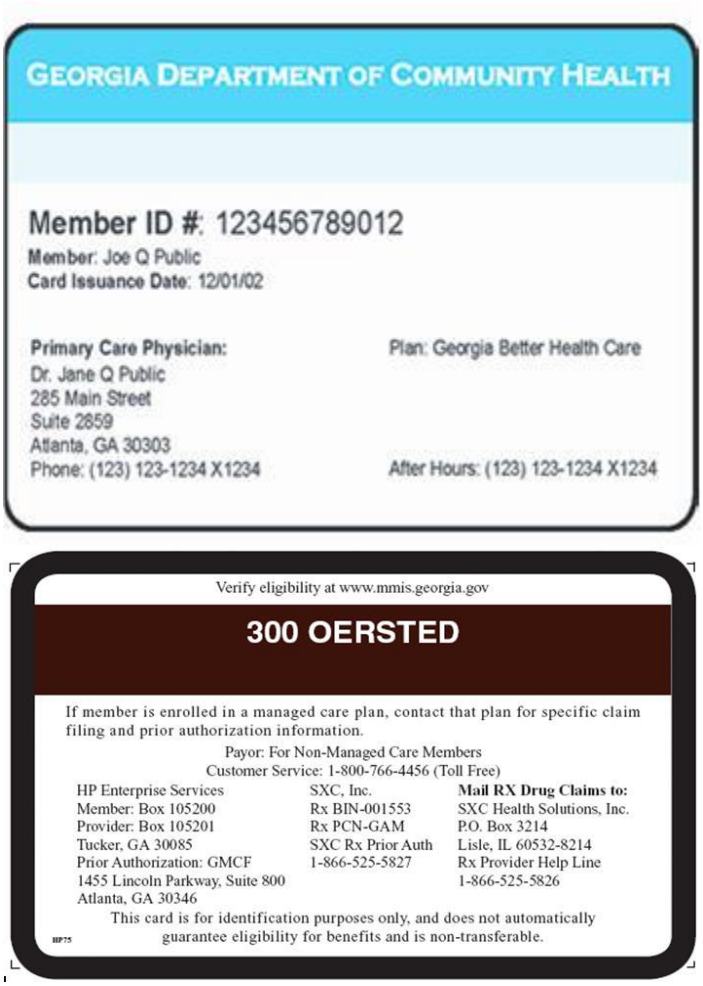
If the insurance company has paid the maximum amount the Division allows, additional reimbursement will not be made.

1103. Retroactive Eligibility

As outlined in Part I, Section 201.3, claims must be received by the Division within six (6) months from the month in which the determination of retroactive eligibility is made. For services requiring a prior approval (PA), the Certification of Retroactive Eligibility (Form 964) or other official forms issued by the County Department of Family and Children Services (see Billing Manual) must be attached to the PA and must be received within sixty (60) days from the effective date the Division enters the retroactive eligibility data into the system. It is the responsibility of the provider to verify eligibility when providing services.

APPENDIX A

Medicaid
Identification Card Sample



APPENDIX B

(Rev. 07/22)

STATEMENT OF PARTICIPATION

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

The Georgia Paperless Initiative was launched on September 1, 2014, between the Georgia Department of Community Health (DCH) and DCH's fiscal agent (partner vendor) Gainwell Technologies (f.k.a. DXC Technology). DCH and Gainwell Technologies teamed up to transition to a paperless system for Medicaid provider enrollment applications, claims filing, appeals and reimbursement.

Effective May 1, 2015: all claims, appeals, forms, prior authorizations (PA), and provider enrollment (PE) documents should be submitted electronically through the GAMMIS web portal at www.mmis.georgia.gov. This includes paper claims, appeals, provider inquiry forms (DMA - 520 /520A), PAs, Medicare and Medicare Advantage claims, Institutional claims, Inpatient Part B only claims, and PE applications.

As of May 1, 2015, the following P.O. Boxes are no longer valid and should not be used:

P.O. Box 105201 - Provider Enrollment / EDI Services / CMS 1500 Claims
P.O. Box 105203 - Crossover Claims
P.O. Box 105204 - UB04 Claims
P.O. Box 105205 - ADA 2006 Dental Claims
P.O. Box 105206 - Adjustments and Voids
P.O. Box 105207 - TPL / Finance / Buy-in

Only the following P.O. Boxes remain open and are to be used as instructed by Gainwell Technologies:

P.O. Box 105200 - Member and Provider Correspondence
P.O. Box 105208 – Retroactive Eligibility Claims, Out of State Claims,
P.O. Box 105209 – Miscellaneous Non-claims documents and Business Reply mail

For additional information on the paperless initiative, refer to the Frequently Asked Questions (FAQs) for Providers that was posted March 18, 2015, on the Georgia Department of Community Health's (DCH) website (www.dch.ga.gov) titled "Transition to Paperless Processes". Access to the DCH-i newsletter and the latest FAQs was posted on March 23, 2015, at the following web address http://dch.georgia.gov/publications.

You may also contact Gainwell Technologies at (800) 766-4456 or through the Georgia Medicaid Management Information System (GAMMIS) at www.mmis.georgia.gov for further guidance.

Thank you for your continued participation in the Georgia Medicaid Program.

APPENDIX C

INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION REQUEST FORM AND CMS-1500 (version 02/12) CLAIM FORM

This section provides detailed instructions for completing the Prior Authorization Request Form and Detailed instructions for completing the CMS-1500 (version 02/12) claim form. This information is also found in the Billing Manual, Section 5.1.2 pages 30 thru 34. The DMA-610 form is found online at www.mmis.georgia.gov. A Physician's Certificate of Medical Necessity (CMN) should always be included with the prior authorization request.

Prior approval can only be obtained through the web at www.mmis.georgia.gov.

Questions regarding covered services and prior approvals should be directed to the Automated Inquiry Unit at 1-800-766-4456. Once the inquirer has reached the inquiry unit, the caller will be prompted to listen to the available options and make selections based on the nature of the inquiry.

Effective December 1, 2014, only electronic submissions will be accepted.

A sample form and a brief explanation of data items follow:

Item 1: Member Name

Enter the name exactly as it appears on the Medical Assistance Eligibility Certification, last name first.

Item 2: Member Case Number

Enter the Medicaid number exactly as it appears on the Medical Assistance Eligibility Certification. (This number may change so it is imperative that you view the Certification during each month of service.) A valid member case number will be formatted in one of two ways as follows:

a. Ten digits ending with the alpha letter P or S (example: 123456789P) or
b. Thirteen digits (example: 123-456789-1C-11)

The entire number, including all zeros, must be placed on the form correctly or it will be rejected.

Item 3: Nursing Home

Yes or No must be indicated.

Item 4-7: Birth date, Sex, Address, and Telephone Number

This information is self-explanatory and should be entered for the member. **Age is a requirement and must be filled in at all times.**

Item 8: Prescribing Physician/Practitioner Name and Address

Enter name and address of physician who prescribed item being requested.

Item 9: Prescribing Physician Provider Number

Enter the ten-digit Medicaid Provider Number. If not enrolled in the Medicaid Program, the State license number should be entered and is the only other acceptable number.

Item 10: Prescribing Physician's Telephone Number

Enter the telephone number of the prescribing physician.

Item 11: Provider of Service(s) Name and Address

Enter current name and address of the durable medical equipment company.

Item 12: Medicaid Provider Number

Enter the ten-digit Provider Number.

Item 13: Provider's Telephone Number

Enter the provider's telephone number.

Item 14: Authorization Period

Rentals - Enter the date the equipment is placed.

Purchases - Enter the date the provider signs this Prior Request Form as the beginning date. If equipment has been issued, enter the date of placement as the beginning date. The Prior Approval staff will enter the "through" date.

Item 15: Description of Services Requested

Enter the general name of the item requested, in this case such as "wheelchair" or "hospital bed".

Item 16: Primary Diagnosis Requiring Service(s)

Briefly list diagnosis and condition of the member as the physician has described on the prescription.

Item 17: Enter the ICD-9-CM (International Classification of Diseases) code(s) related to the service requested on or before 09/30/2015. On or after 10/01/2015 enter the ICD-10-CM code(s) related to the service requested.

Item 18: Justification and Circumstances for Required Services

Enter the justification for the equipment, including any special features, length of time needed, and extraordinary circumstances.

Item 19: Description of Item

List equipment and additions for which authorization is being requested on the CMN**.** Use additional forms if necessary but do not exceed six (6) lines on one form. Mileage one-way charge must be included as a line item.

Item 20: Procedure Code or Equipment Code

Enter the code number for device or procedure (refer to Appendices C and D).

Item 21: Requested or Estimated Retail Price Per Unit

Enter requested reimbursement amount. This amount must be the provider's usual and customary charge, not the Division's maximum reimbursement rate, unless specified in policy, and then enter the rate specified by policy (i.e., amounts that are prorated).

Item 22: Months or Units of Service Requested

Enter the total number of units being claimed for the period of service covered by this prior approval authorization (same as line 23)

Item 23: Units Per Claim

Enter the number of units being requested per claim. Enter number of units requested. For example, the unit for a pair if stated as per pair is one. However, if the unit stated is per shoe, a pair is two (2) units

Item 24: Providers Signature

The provider of services must sign the Prior Authorization Request form and attach a copy of the physician's prescription to it. Delegation of signature must be in writing and on file with the Division.

Item 25: Date

Enter the date the request is sent from the provider's office.

Item 26: Request (DIVISION'S USE ONLY)

Division action will be noted in this section upon receipt of the request. If "Approved as Changed" block is checked, please note any changes in the following areas:

Item 14 - Authorization period may be adjusted.

Item 20 - Procedure code may be changed

Item 21 - Requested amount may be adjusted.

Item 27: Signature (DIVISION'S USE ONLY)

Division of Medical Assistance authorized signature.

Item 28: Date (DIVISION'S USE ONLY)

This date is the date that the request was approved and will be entered by the Division.

Item 29: Explanation (DIVISION'S USE ONLY)

This area is provided for the Division to enter comments concerning the request.

THE PRIOR AUTHORIZATION REQUEST FORM
DMA-610 (Rev. 01/18)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE

PRIOR AUTHORIZATION REQUEST*

CHECK ONE:
☐ DME ☐ O&P ☐ CASE MGMT.

MAIL COMPLETED FORMS TO:
GMCF
P. O. Box 105329
Atlanta, Ga. 30348

1. Member Name (Last, First, M.I.)	2. Medicaid ID No.:	3. Nursing Home: ☐ Yes ☐ No
4. Birth Date:	5. Sex: ☐ Male ☐ Female	6. Address: / 7. Telephone Number:

8. Prescribing Physician/Practitioner Name & Address:		11. Provider of Service(s) Name & Address:	
9. Provider License Number:	10. Telephone (AC / Number):	12. Medicaid Provider Number:	13. Telephone (AC / Number):

14. Requested Dates of Service: From: / / Thru: / /	15. Description of Service(s) Requested	
	16. Primary Diagnosis Requiring Service(s)	17. ICD 9-CM

18. Justification and Circumstances for Required Service(s) (Use separate page if necessary)

STATEMENT OF SERVICE(S)

	19. Description of Procedures, Equipment or Other Services	20. Procedure Code	21. Requested or Estimated Price Per Unit	22. Months of Units of Service Requested	23. Units per Claim
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

24. Provider's Signature:→ | 25. Date Submitted:

**Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program at the time of service.*

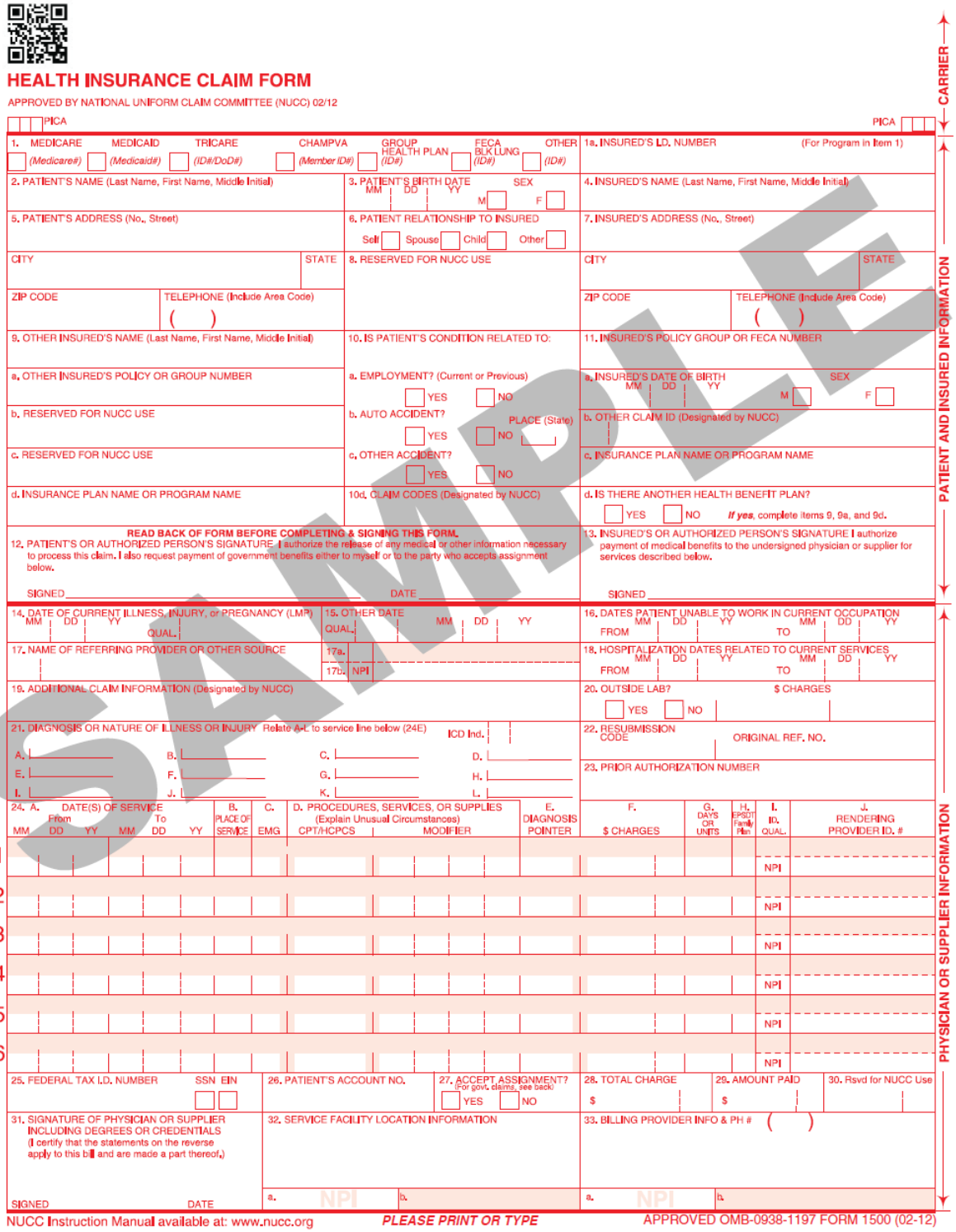
This request is subject to Retrospective Peer Review.

DMA 610 Rev. (07/10)

Please Note: The Prior Authorization Form is found and may be downloaded from the Web Site www.mmis.georgia.gov under Forms for Providers.

NEW CMS 1500 Claim Form (version 02/12) & ZFLD Locator Instructions

General Instructions on filling out the CMS-1500 claim form are found in the Billing Manual on the web: www.ghp.georgia.gov



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
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/HP:** 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/HP: 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/HP:** 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/HP:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values (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/HP**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

APPENDIX D

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APPENDIX E

DOCUMENTATION REQUIREMENTS AND CODING GUIDELINES

PROOF OF DELIVERY

Any item reimbursed by Georgia Medicaid that does not have a signed and dated delivery ticket confirming the actual delivery of the item prior to claims submission will be subject to recoupment. The date of service on a claim must be on or after the date the delivery ticket is signed by the member or caregiver. The document must contain all elements listed below. There are NO exceptions.

Proof of Delivery for Orthotic and Prosthetic Services (Delivery Ticket) MUST include the following:

a) Beneficiary's Name
b) Delivery Address
c) Detailed Description of Items with HCPCS codes for all Prosthetic/Orthotic items (sufficient information to identify the items delivered including brand names, serial numbers, and narrative descriptions for ALL miscellaneous codes)
d) Quantities Delivered
e) Date Delivered
f) Beneficiary or Designee Signature and Date of Signature
g) Relationship of anyone signing the delivery ticket as a representative of the patient
h) There must be a specific statement for the patient to initial stating that they attest that they are satisfied with the way the orthotic or prosthesis device(s) fit and that they were trained on the proper usage and care of the device(s).
i) Signature of the Supplier and date the item was provided to the patient (this signature authenticates that this is the final prosthesis or orthotic which has been fitted and adjusted (if applicable) to conform to the needs of the member for which it was issued.)

Orthotic and Prosthetic Suppliers are required to maintain POD documentation in their files for medical review purposes. Every element required for the approval of the orthotic or prosthetic service (Invoice, Delivery Ticket, CMN, etc.) is considered to be part of the medical record and MUST be kept on file by the provider and available to the Division upon request for no less than five years. This documentation assists in determining correct billing and coding practices for claims submitted for Medicaid reimbursement, and ensures the items reimbursed are the actual items that were delivered to the patient and that they meet the needs of the patient in regard to fitting, adjusting, and user acceptance of the item(s). The reviewing agent must be able to determine from the delivery documentation that the supplier properly coded the item(s) that the item(s) delivered are the same item(s) submitted to Medicaid for reimbursement, and that the items are intended for and received by a specific Medicaid beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the items are prohibited from signing or accepting the item(s) on behalf of a Medicaid beneficiary (i.e., acting as a designee on behalf of the beneficiary).

The signatures and dates on the delivery ticket MUST be complete and legible to submit for and receive reimbursement from the Medicaid program.

1) **PT/OT Evaluations**

   Chart notes do not replace the requirement for a PT/OT Evaluation.
   These notes, when submitted, are considered to be supporting documentation in addition to the actual evaluation. All policy guidelines (PT/OT Evaluation, CMN, etc) must be met in order for prior approval to be obtained. There are no exceptions.

2) **Functional Level Requirements**:

   Medical Record Documentation must support the functional level of the member and the items ordered by the physician and rendered by the provider of Orthotic & Prosthetic Services. Note: Georgia Medicaid does not require providers to submit K0-K4 modifiers at this time, however, the items ordered, and medical record must support any functional level that is documented in the Orthotist/Prosthetist evaluation and submitted for prior authorization and reimbursement. If the functional level is not supported in the medical record the items provided will be subject to recoupment.

   ***All prior authorizations submitted for lower limb prostheses submitted with a functional level of 0 will be denied.**

   Function Levels:

   K0- Lower extremity prosthesis functional level 0- Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

   K1- Lower extremity prosthesis functional level 1- Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at a fixed cadence. ***Typical of the limited and unlimited household ambulator.***

   K2- Lower extremity prosthesis functional level 2- Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. ***Typical of the community ambulator.***
   K3- Lower extremity prosthesis functional level 3- Has the ability or potential for ambulation with variable cadence. ***Typical of the community ambulatory who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.***

   K4- Lower extremity prosthesis functional level 4- Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. ***Typical of the prosthetic demands of the child, active, adult or athlete.***

CODING GUIDELINES

Microprocessor Knees-

Microprocessor knees (L5856, L5857, or L5858) are covered for members who are capable of ambulating at a K3/ K4 level who are not expected to require the use of a power mobility device in the following two years due to any preexisting conditions related to the functionality of either of the lower limbs. Medical necessity and appropriate qualification for the MPK must be documented in the information submitted for prior authorization.

Providers of lower limb prosthetics are expected to provide secure and proper fitting devices that ensure the member is able to safely ambulate and complete all activities of daily living according to their assigned functional level. If a provider issues a lower limb prosthesis that results in an order for a power mobility device or completely new prosthesis within the following two years due to any damage caused by the prosthesis or the inability of the member to functionally use the prosthesis due to poor workmanship, a prosthesis that does not support the members weight at time of issue, or a prosthesis that is not appropriate for the actual functional level of the member (too heave, etc.), then the initial prosthesis will be subject to recoupment.

L5856 - ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE

L5857 - ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE

L5858 - ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE

Use of Miscellaneous HCPCS Codes-

Providers of orthotic and prosthetic services may not use miscellaneous codes to submit for items that are created or manufactured by the provider (Example: Additional shuttle pins) Miscellaneous codes are reserved for items that have been FDA approved and have a published catalogue or pricing sheet containing MSRP pricing. Any item submitted for approval under a miscellaneous code that does not meet this coverage criteria will be denied.

APPENDIX F

COPAYMENT

Effective with dates of service July 1, 2005, and after, there is a Co-payment for Orthotic and Prosthetic services. The $3.00 Co-Pay is applied to all main component codes or "base" codes.

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

- Pregnant women
- Members under 21 years of age
- Nursing facility residents
- Hospice care members
- Women diagnosed with breast or cervical cancer and receiving Medicaid under the BCC Waiver or Presumptive Eligibility (aid categories 245 and 800 Only)

The copayment does not apply to the following services:

- Emergency Services
- Family Planning Services

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

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

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 24i on DMA-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, 1994, and after. Do not deduct the copayment from your submitted charges. The application of the copayment is identified on the remittance advice. A new explanation of benefit (EOB) code will indicate payment has been reduced due to the application of copayment.

APPENDIX G

(Rev. 07/22)

GEORGIA HEALTH PARTNERSHIP (GHP)

Provider Inquiries:

1-800-766-4456 (Toll Free)

Web Address: www.mmis.georgia.gov

Provider Correspondence:

Gainwell Technologies

P.O. Box 105200
Tucker, Georgia 30085-5201

Provider Enrollment:

Gainwell Technologies

P.O. Box 105200
Tucker, Georgia 30085-5201

Electronic Data Interchange (EDI)

1-800-267-8785

- Asynchronous
- Web Portal
- Physical Media
- Network Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol/Internet Protocol (TCP/IP)

Prior Authorization Requests:

Alliant Health Solutions

Web Portal: www.mmis.georgia.gov
1-800-766-4456 (Toll Free)

Member Services:

1-866-211-0950

#1 for Eligibility, Service Limits, Copays
#2 Georgia Families
#3 Requests for New ID Card
#4 Changes to Primary Care Physician
#5 Questions IRS-1095 Form
#6 All Other (Including Pharmacy Benefit)

or visit the following web address:

www.mmis.georgia.gov and select Member Information

APPENDIX H

(Rev. 7/21)

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 three 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 three licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	CareSource 1-855-202-1058 www.caresource.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 three CMOs are State-wide.**

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

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

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
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 management) www.pshpgeorgia.com

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 GAINWELL TECHNOLOGIES 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. GAINWELL TECHNOLOGIES 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 GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES 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 are 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.

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES 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 GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES 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
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 on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: 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.

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan
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.

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
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following 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
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com

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 #	GROUP #	Helpdesk
Amerigroup Community Care	IngenioRx	020107	HL	WKJA	1-833-235-2031
CareSource	Express Scripts (ESI)	003858	MA	RXINN01	1-800-416-3630
Peach State Health Plan	CVS	004336	MCAIDADV	RX5439	1-844-297-0513

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL TECHNOLOGIES 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
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes

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
1 (800) 454-3730	1 (855) 202-1058 1 (866) 930-0019 (fax)	1 (866) 399-0929

APPENDIX I

Information for Providers Serving Medicaid Members
in the Georgia Families 360^{0} SM Program

Georgia Families 360^{0} SM, the state's 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 360^{0}SM 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 360^{0} SM Every member in Georgia Families 360^{0} 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, please visit www.dch.georgia.gov.

APPENDIX J

FREQUENTLY ASKED QUESTIONS (FAQs)

Georgia Medicaid Orthotics and Prosthetics (O&P) Services Frequently Asked Questions

1) How do I bill repairs/labor for Orthotics and Prosthetics so that the labor does not continuously deny?

The repair/part L4210 (orthotic) or L7510 (prosthetic) MUST be entered on line one (as the qualifying procedure) and the labor L4205 (orthotics) or L7520 (prosthetics) MUST be submitted on line 2. Any other sequence will result in a denial of the labor. If the labor codes are submitted with any repair/part other than L4210 or L7510, then the labor will be denied as included in the primary procedure. Any part/repair that has specific HCPCS code includes the labor component.

2) How do I submit miscellaneous codes such as K0108 on the Prior Authorization?

These codes are to be submitted ONE time with ONE unit of service with the invoice for the items that are to be included in this code. The total price for ALL items to be included as miscellaneous/additions etc. are submitted for the price to be approved for the code. Requesting multiple Prior Authorizations for more than 1 unit of service for a miscellaneous code or more than one-line item or unit of service for these types of codes will be denied as incorrect billing.

3) What information should be submitted with a Prior Authorization?

All supporting documentation must be submitted as attachments with the prior authorization requests for a decision to be made for reimbursement. Failure to provide required necessary documentation (Detailed written order, CMN, additional supporting documentation when required) or documentation that does not contain the information required to support the medical necessity (length of need, height/weight, etc) of the items requested will result in a request for this information and will extend the time it takes to complete the request. Failure to comply with requests for additional supporting documentation will result in a denial of the prior authorization request.

4) When the prices for Orthotics and Prosthetics services is updated to only be listed in the Schedule of Maximum Allowable Payments for Orthotic & Prosthetic Services in October 2013 where do I go to find this Fee Schedule?

The prices for these items will be listed in both the O&P Manual and on the SMAP-O&P until October 2013. After this time, you must go to the MMIS website >>Providers>>Fee Schedules and select the Schedule of Maximum Allowable Payments for Orthotic and Prosthetic Services.

5) **What is the reasonable useful lifetime (RUL) for a prosthetic device? Prosthetic devices (limbs) including major components have a reasonable useful lifetime of 3-5 years.** Adults over the age of 21 are expected to have a RUL of at or around 5 years and children/young adults that are still growing may be replaced around 3 years or when determined reasonable and necessary through the PA process.

   Claims submitted for the replacement of items other than specifically designated replacement items or accessories (socks etc.) will be denied if they are billed before the end of the reasonable useful lifetime.

   Custom orthotics have a RUL of 3 years and non-custom (prefab or ots is 1-3 years depending on the item and patient's age)

6) **Where can providers find additional information about ICD-10?**

   Additional information to help with your ICD-10 planning and preparation is available on the following websites:

   - **Centers for Medicare & Medicaid Services (CMS) ICD-10 site**
     http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10
   - **Medicare Learning Network**
     http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/
   - **Workgroup for Electronic Data Interchange (WEDI)**
     http://www.wedi.org/workgroups/icd-10
   - **American Health Information Management Association (AHIMA)**
     http://www.ahima.org/
   - **American Hospital Association (AHA)**
     http://www.aha.com/
   - **American Academy of Professional Coders (AAPC)**
     http://www.aapc.com/icd-10/index.aspx
   - **Center for Disease Control (CDC)**
     http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf