PART II

POLICIES AND PROCEDURES
for
FEDERALLY QUALIFIED HEALTH CENTER SERVICES (FQHC) AND RURAL HEALTH CENTER RHC



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

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Policy Revision Record
from January 2025 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
01/01/2026	APPENDIX I	Updated to include 2026 HCPCS/GAMMIS updates	M	N/A
11/1/2025	APPENDIX I	Updated to include 90834 and 90837	M	N/A
10/01/2025	N/A	No changes were made this quarter	N/A	N/A
08/01/2025	APPENDIX I	H0038 added for Certified Peer Specialist	A	Addition required by CMS per the Consolidated Appropriations Act of 2023
07/01/2025	N/A	No changes were made this quarter	N/A	N/A
4/1/2025	N/A	No updates made this quarter	N/A	N/A
1/1/2025	Appendix L, N, and O	Deleted Georgia Families, Georgia Families 360 and Non-Emergency Transportation	D	
1/1/2025	Appendix L	Georgia Families, Georgia Families 360 and Non-Emergency Transportation added links	M	
10/1/2024	601.2.5, 602.2.5, 901.1.5.1	Edited to include provider types of Licensed Marriage and Family Therapists (LMFT), Certified Peer Specialists, and Licensed Professional Counselors as approved providers in FQHC/RHC facilities.	A	Addition required by CMS per the Consolidated Appropriations Act of 2023

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

601. Rural Health Clinic (RHC)

601.1. Rural Health Clinics (RHCs) were established by the Rural Health Clinic Service Act of 1977 to address an inadequate supply of physicians serving Medicare beneficiaries in underserved rural areas, and to increase the utilization of nurse practitioners (NP) and physician assistants (PA) in these areas. RHCs have been eligible to participate in the Medicare program since March 1, 1978, and are paid an all-inclusive rate (PPS) per visit for qualified primary and preventive health services. (Rev. 04/2015)

601.2. RHCs are defined in section 1861(aa) (2) of the Social Security Act (the Act) as facilities that are engaged primarily in providing services that are typically furnished in an outpatient clinic. RHC services are defined as:

601.2.1. Physician services

601.2.2. Services and supplies furnished incident to physician's services

601.2.3. NP, PA, certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services; and

601.2.4. Services and supplies furnished incident to an NP, PA, CNM, CP, or CSW services.

601.2.5. Services provided by Licensed Marriage and Family Therapists (LMFT), Certified Peer Specialists, and Licensed Professional Counselors

601.3. RHC services may also include nursing visits to homebound individuals furnished by are registered nurse (RN) or a licensed professional nurse (LPN) when certain conditions are met.

601.4. To be eligible for certification as a RHC, a clinic must be in a non-urbanized area, as determined by the U.S. Census Bureau, and in an area designated or certified within the previous 4 years by the Secretary, Health and Human Services (HHS), in any one of the four types of shortage area designations that are accepted for RHC certification.

601.5. In addition to the location requirements, an RHC must:

601.5.1. Employ as an NP or PA

601.5.2. Have an NP, PA, or CNM working at the clinic at least 50% of the time the clinic is operating as an RHC Have an NP, PA, or CNM working at the clinic at least 50% of the time the clinic is operating as an RHC

601.5.3. Directly furnish routine diagnostic and laboratory services

601.5.4. Have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC

601.5.5. Have available drugs and biologicals necessary for the treatment of emergencies

601.5.6. Meet all health and safety requirements

601.5.7. Not be a rehabilitation agency or a facility that is primarily for mental health treatment

601.5.8. Furnish onsite all the following six laboratory tests:

601.5.8.1. Chemical examination of urine by stick or tablet method or both

601.5.8.2. Hemoglobin or hematocrit

601.5.8.3. Blood sugar

601.5.8.4. Examination of stool specimens for occult blood

601.5.8.5. Pregnancy tests; and

601.5.8.6. Primary culturing for transmittal to a certified laboratory.

601.5.9. Not be concurrently approved as a FQHC, and

601.5.10. Meet other applicable State and Federal requirements.

601.6. RHCs can be either independent or provider based. Independent RHCs are stand-alone or freestanding clinics and submit claims to a Medicare Administrative Contractor (MAC). They are assigned a CMS Certification Number (CCN) in the range 3800-3974 or 8900-8999. They are assigned a Georgia Medicaid Category of Service of 542.

601.7. For detailed information on Georgia Medicaid's certification requirements for Free-Standing Rural Health Services, see Georgia Medicaid Contract 542, Free-Standing Rural Health Services Program, located on the Provider Enrollment tab of the Georgia MMIS website, located at www.mmis.ga.gov.

601.8. Provider-based RHCs are an integral and subordinate part of a hospital (including a critical access hospital (CAH), skilled nursing facility (SNF), or a home health agency (HHA). They are assigned a CCN in the range 3400-3499, or 3975-3999, or 8500-8899. They are assigned a Georgia Medicaid Category of Service of 541.

601.9. For detailed information on Georgia Medicaid's certification requirements for Hospital-Based Rural Health Services, see Georgia Medicaid Contract 541, Hospital-Based Rural Health Services Program, located on the Provider Enrollment tab of the Georgia MMIS website, located at www.mmis.ga.gov.

601.10. The statutory requirements for RHCs are found in section 1861(aa) (2) of the Act. Many of the regulations pertaining to RHCs can be found at 42 CFR 405.2400 Subpart X and following and 42 CFR 491 Subpart A and following.

602. Federally Qualified Health Center (FQHC)

602.1. Federally Qualified Health Centers (FQHCs) were established in 1990 by section 4161 of the Omnibus Budget Reconciliation Act of 1990 and were effective beginning on October 1, 1991. As with RHCs, they are also facilities that are primarily engaged in providing services that are typically furnished in an outpatient clinic and are paid a PPS for qualified primary and preventive health services.

602.2. FQHC services are defined as:

602.2.1. Physician services

602.2.2. Services and supplies furnished incident to a physician's services

602.2.3. NP, PA, CNM, CP, and CSW services

602.2.4. Services and supplies furnished incident to an NP, PA, CNM, CP, or CSW services

602.2.5. Services provided by Licensed Marriage and Family Therapists (LMFT), Certified Peer Specialists, and Licensed Professional Counselors; and

602.2.5.1. Outpatient diabetes self-management training and medical nutrition therapy for beneficiaries with diabetes or renal disease.

602.3. The statutory requirements that FQHCs must meet are in section 1861(aa) (4) of the Act. An entity that qualifies as a FQHC is assigned a CCN in the range 1800-1989, and 1000-1199. They are assigned a Georgia Medicaid Category of Service of 540.

602.4. FQHC services also include certain preventive primary health services. The law defines Medicare-covered preventive services provided by FQHC as the preventive primary health services that a FQHC is required to provide under section 330 of the Public Health Service (PHS) Act.

602.5. There are 3 types of organizations that are eligible to enroll in Medicare as FQHCs:

602.5.1. Health Center Program Grantees: Organizations receiving grants under section 330 of the Public Health Service (PHS) Act, including Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers

602.5.2. Health Center Program Look-Alikes: Organizations that have been identified by HRSA as meeting the definition of "Health Center" under section 330 of the PHS Act, but not receiving grant funding under section 330; and

602.5.3. Outpatient health programs/facilities operated by a tribe or tribal organization (under the Indian Self-Determination Act) or by an urban Indian organization (under Title V of the Indian Health Care

Improvement Act).

NOTE: Information in this chapter applies to FQHCs that are Health Center Program Grantees and Health Center Program Look-Alikes. It does not necessarily apply to tribal or urban Indian FQHCs.

602.6. A FQHC must:

602.6.1. Provide comprehensive services and have an ongoing quality assurance program

602.6.2. Meet other health and safety requirements

602.6.3. Not be concurrently approved as an RHC; and

602.6.4. Meet all requirements contained in section 330 of the Public Health Service Act, including:

602.6.4.1. Serve a designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP)

602.6.4.2. Offer a sliding fee scale to people with incomes below 200% of the federal poverty level; and

602.6.4.3. Be governed by a board of directors, of whom a majority of the members receive their care at the FQHC.

602.7. Additional information on these and other section 330 requirements can be found at http://bphc.hrsa.gov/. For detailed information on Georgia Medicaid's certification requirements for Federally Qualified Health Centers, see Georgia Medicaid Contract 540, Federally Qualified Health Centers Program, located on the Provider Enrollment tab of the Georgia MMIS website.

602.8. Per 42 CFR 413.65(n), only FQHCs that were operating as provider-based clinics prior to 1995 and either a) received funds under section 330 of the PHS Act or b) were determined by CMS to meet the criteria to be a look-alike clinic, are eligible to be certified as provider-based FQHCs. Clinics that do not already have provider-based status as a FQHC are no longer permitted to receive the designation.

603. RHC Location Requirements

603.1. To be eligible for certification as a RHC, a clinic must be in 1) a non-urbanized area, as determined by the U.S. Census Bureau, and 2) an area designated or certified within the previous 4 years by the Secretary, HHS, in any one of the four types of shortage area designations that are accepted for RHC certification as listed in section 605.

603.2. A clinic applying to become a Georgia Medicaid certified RHC must meet both the rural and underserved location requirements. RHCs that plan to relocate or expand should contact their Medicare Regional Office to determine their location requirements.

603.3. For detailed information on Georgia Medicaid's certification requirements for Hospital-Based Rural Health Services, see Georgia Medicaid Contract 541, Hospital-Based Rural

Health Services Program, located on the Provider Enrollment tab of the Georgia MMIS website. For detailed information on certification requirements for Hospital-Based Rural Health Services, see Georgia Medicaid Contract 542, Free-Standing Rural Health Services Program, located on the Provider Enrollment tab of the Georgia MMIS website, located at www.mmis.ga.gov.

603.4. Satellite locations must be licensed and certified separately, with a Medicaid provider number obtained and used for each location.

604. Non-Urbanized Area Requirements

604.1. The U.S. Census Bureau determines if an area is an urbanized area (UA). Any area that is not in a UA is considered a non-urbanized area. A clinic located in an area that is not a UA would meet the RHC requirement for being in a non-urbanized area. Information on whether an area is in an urbanized area can be found at http://factfinder.census.gov; or http://www.raconline.org; or by contacting the appropriate CMS Regional Office (RO) at http://www.cms.gov/RegionalOffices/.

605. Designated Shortage Area Requirements

605.1. The HRSA designates areas as MUAs/MUPs and/or Health Professional Shortage Areas (HPSAs). To be eligible for RHC certification, a clinic must be in an area that has one of the following types of shortage area designations:

605.1.1. Geographic Primary Care HPSA

605.1.2. Population-group Primary Care HPSA

605.1.3. MUA (this does not include the population group MUP designation); or

605.1.4. Governor-Designated and Secretary-Certified Shortage Area. No other type of shortage area designation is accepted for purposes of RHC certification.

605.2. The designation cannot be more than 4 years old to meet the requirement of being in a currently designated area. For RHC purposes, the age of the designation is calculated as the last day of the year 4 years from the date of the original designation, or the date the area was last designated. For example, a clinic that is located in an area that was most recently designated or updated on June 1, 2010, would be considered as meeting this location requirement through December 31, 2014.

605.3. Areas that are listed as "proposed for withdrawal" are considered designated. The designation date is the date that the area was last updated, not when the area was proposed for withdrawal. To determine the designation date of an area that is listed as "proposed for withdrawal", contact HRSA's Shortage Designation Branch at sdb@hrsa.gov or call 1-888-275-4772.

606. FQHC Location Requirements

606.1. FQHCs may be in rural or urban areas. FQHCs that are Health Center Program Grantees or Look-Alikes must be in or serve people from a HRSA-designated MUA or

MUP.

607. RHC Staffing

607.1. In addition to the location requirements, an RHC must:

607.1.1. Employ an NP or PA; and

607.1.2. Have an NP, PA, or CNM working at the clinic at least 50% of the time the clinic is operating as an RHC.

607.2. The employment may be full or part-time. The following are examples of situations that would NOT satisfy this requirement:

607.2.1. An NP or PA who is employed by a hospital that has an ownership interest in the RHC but is not physically present and working in the RHC

607.2.2. A CNM who is employed by the RHC; or

607.2.3. An NP or PA who is locum tenens

607.3. An RHC practitioner is a physician, NP, PA, CNM, CP, or CSW. At least one of these practitioners must be present in the RHC and available to always furnish patient care when the RHC is in operation. A clinic that is open solely to address administrative matters or to provide shelter from inclement weather is not considered to be in operation during this period and is not subject to the staffing requirements.

607.4. An NP, PA, or CNM must be available to furnish patient care at least 50 percent of the time that the RHC is open to provide patient care. This requirement can be fulfilled through any combination of NPs, PAs, or CNMs if the total is at least 50 percent of the time the clinic is open to provide patient care. Only the time that an NP, PA, or CNM spends in the clinic is counted towards 50 percent and does not include time spent furnishing services to a patient in a location outside the clinic (e.g. home, SNF, etc.).

607.5. A clinic located on an island that otherwise meets the requirements for RHC certification is not required to employ an NP or PA, although it is still required to have an NP or PA at least 50% of the time that the RHC is in operation (OBRA ’89, Sec 4024). An island is a body of land surrounded by water, regardless of size and accessibility (e.g., bridges).

607.6. RHCs are not paid for services furnished by contracted individuals other than physicians (42 CFR 405.2468(b) (1)). Therefore, non-physician practitioners must be employed by the RHC, as evidenced by a W-2 form from the RHC. If another entity such as a hospital has 100 percent ownership of the RHC, the W-2 form can be from that entity if all the non-physician practitioners in the RHC receive their W-2 from this owner. It is the responsibility of the RHC to assure that all staffing requirements are met and that RHC practitioners provide services in accordance with State and Federal laws and regulations.

608. Temporary Staffing Waivers

608.1. An existing RHC may request a temporary staffing waiver if the RHC meets the staffing requirements before seeking the waiver, and either or both of the following occur:

608.1.1. An NP or PA is not currently employed by the RHC.

608.1.2. An NP, PA, or CNM is not furnishing patient care at least 50% of the time the clinic operates.

608.2. To receive a temporary staffing waiver, an RHC must demonstrate that it has made a good faith effort to recruit and retain the required practitioner(s) in the 90-day period prior to the waiver request. Recruitment activities should begin as soon as the RHC becomes aware that they will no longer be in compliance with this requirement. Good faith efforts can include activities such as advertising in an appropriate newspaper or professional journal, conducting outreach to an NP, PA, or CNM school, or other activities.

608.3. Staffing waivers are for a period not to exceed 1 year. The waiver cannot be extended beyond 1 year, and another waiver cannot be granted until a minimum of 6 months has elapsed since the prior waiver expired. RHCs should continue their recruitment activities during the waiver period to avoid termination when the waiver period ends.

608.4. A RHC will be terminated if any of the following occur:

608.4.1. The RHC does not meet the staffing requirements and does not request a temporary staffing waiver

608.4.2. The RHC requests a temporary staffing waiver, and the request is denied due to a lack of good faith effort to meet the requirements

608.4.3. The RHC does not meet the staffing requirements and is not eligible for a temporary staffing waiver because less than 6 months have passed since the expiration of the previous waiver

608.4.4. The RHC reaches the expiration date of the temporary staffing waiver and has not come into compliance; or

608.4.5. Other non-compliance issue.

609. FQHC Staffing

609.1. FQHCs must have a core staff of appropriately trained primary care practitioners and meet other clinical requirements. It is the responsibility of the FQHC to assure that all staffing requirements are met and that FQHC practitioners provide services in accordance with State and Federal laws and regulations. Additional information on statutory requirements can be found at: http://bphc.hrsa.gov/about/requirements/index.html.

610. FQHC and RHC Visits

610.1. A FQHC or RHC visit is defined as a medically necessary, face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more FQHC or RHC services are rendered. A Wellness Visit (Health Check/EPSDT) or Transitional Care Management (TCM) services can also be considered an FQHC or RHC visit.

610.2. A FQHC or RHC visit can also be a visit between a home-bound patient and an RN or LPN under certain conditions. See section 906.1 and adjust to the correct section of this chapter for information on visiting nursing services to home-bound patients.

610.3. Under certain conditions, a FQHC or RHC visit also may be provided by qualified practitioners of outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) when the FQHC or RHC meets the relevant program requirements for provision of these services.

610.4. A FQHC or RHC patient includes:

610.4.1. Individuals who receive services at the FQHC or RHC

610.4.2. Individuals who receive services at a location other than the FQHC or RHC (see location information below) for which the FQHC or RHC bills for the service or are financially responsible for the provision of the service; or

610.4.3. Individuals whose cost of care is included in the cost report of the FQHC or RHC.

611. Location

611.1. A FQHC or RHC visit may take place in the FQHC or RHC, the patient's residence, an assisted living facility, a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, §20.1.1), or the scene of an accident. RHC and FQHC visits may not take place in either of the following:

611.1.1. an inpatient or outpatient hospital, including CAHs, or

611.1.2. a facility which has specific requirements that preclude FQHC or RHC visits (e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.).

611.2. Qualified services provided to a FQHC or RHC patient in a location other than the FQHC or RHC facility are considered FQHC or RHC services if:

611.2.1. the practitioner is compensated by the FQHC or RHC for the services provided

611.2.2. the cost of the service is included in the FQHC or RHC cost report; and

611.2.3. other requirements for furnishing services are met.

611.3. This applies to full and part time practitioners, and it applies regardless of whether the practitioner is an employee of the FQHC or RHC, working under contract to the FQHC or RHC, or is compensated by the FQHC or RHC under another type of arrangement. FQHCs or RHCs should have clear policies regarding the provision of services in other locations and include this in a practitioner's employment agreement or contract. FQHCs or RHCs providing FQHC or RHC services in locations other than the FQHC or RHC facility must continue to meet all certification and cost reporting requirements. Services in other locations may be subject to review by, including but not limited to, the Georgia Department of Community Health Office of Inspector General.

611.4. FQHC or RHC practitioners that are compensated by the FQHC or RHC for services furnished in other locations may not bill Medicare Part B for these services. If the FQHC or RHC includes the costs of these services on their cost report, the services may not be billed to Medicare Part B. Services furnished to patients in any type of hospital setting (inpatient, outpatient, or emergency department) are statutorily excluded from the FQHC/RHC benefit and, if appropriate, the service may be billed to Medicare Part B. Services that are billed to Medicare Part B cannot be claimed as a FQHC or RHC cost.

611.5. Except for hospital settings, services furnished in a location other than the FQHC or RHC (either during the posted hours of operation or during another time), and services furnished to FQHC or RHC patients (either those seen previously in the FQHC or RHC or those not previously seen), are billed as a FQHC or RHC visit when the FQHC or RHC includes the practitioner's compensation for these services in the FQHC or RHC cost report and other certification and cost reporting requirements for furnishing services are met. If the cost of a service is not included on the FQHC or RHC cost report, the service may be billed to Part B if appropriate. Only compensation paid for FQHC or RHC services can be claimed on the cost report.

612. Hours Of Operation

612.1. FQHCs and RHCs are required to post their hours of operations at or near the entrance in a manner that clearly states the days of the week and the hours that FQHC or RHC services are furnished, and days of the week and the hours that the building is open solely for administrative or other purposes. This information should be easily readable, including by people with vision problems and people who are in wheelchairs. Qualified services provided to a FQHC or RHC patient other than during the posted hours of operation, are considered FQHC or RHC services when both of the following occur:

612.1.1. the practitioner is compensated by the FQHC or RHC for the services provided, and

612.1.2. The cost of the service is included in the FQHC or RHC cost report.

612.2. Services furnished at times other than the FQHC or RHC posted hours of operation to Georgia Medicaid beneficiaries who are FQHC or RHC patients may not be billed to Medicaid if the practitioner's compensation for these services is included in the FQHC/RHC cost report.

612.3. This applies to both full and part-time practitioners and to practitioners who are employees, working under contract to the FQHC or RHC, or are compensated by the

FQHC or RHC under another type of arrangement. FQHCs and RHCs should have clear policies regarding the provision of services at other times and include this in a practitioner's employment agreement or contract.

613. Multiple Visits on Same Day

613.1. Except as noted below, encounters with more than one FQHC or RHC practitioner on the same day, or multiple encounters with the same FQHC or RHC practitioner on the same day constitute a single FQHC or RHC visit, regardless of the length or complexity of the visit, the number or type of practitioners seen, or whether the second visit is a scheduled or unscheduled appointment. This would include situations where an FQHC or RHC patient has a medically necessary face-to-face visit with a FQHC or RHC practitioner and is then seen by another FQHC or RHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another FQHC or RHC practitioner (including a specialist) for evaluation of a different condition on the same day.

613.2. More than one medically necessary face-to-face visit with a FQHC or RHC practitioner on the same day is payable as one visit, except for the following circumstances:

613.3. For a new patient:

613.3.1. The new patient has a well visit (health check) billed with CPT 99381 – 99385 and an office visit CPT 99202 – 99205 will be reimbursed 1 PPS rate.

613.4. For an established patient:

613.4.1. The established patient has a well visit (health check) billed with CPT 99391 – 99395, Modifier EP, 25 and an office visit CPT 99211 – 99212 will be reimbursed 2 PPS rates.

613.4.2. The established patient has a well visit (health check) billed with CPT 99391 – 99395, Modifier EP, 25 and an office visit CPT 99213 – 99215 will be reimbursed 1 PPS rate and a DEF rate as listed on the Physician Fee Schedule.

614. Global Billing

614.1. Surgical procedures delivered in a FQHC or RHC by a FQHC or RHC practitioner are considered FQHC or RHC services, and the FQHC or RHC is paid based on its PPS for the face-to-face encounter associated with the surgical procedure. The global billing requirements do not apply to FQHCs and RHCs.

614.2. Global Billing is a global surgical package that includes preoperative and postoperative visits with the surgical procedure.

614.3. Surgical procedures delivered at locations other than FQHCs or RHCs may be subject to global billing requirements. If a FQHC or RHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the FQHC or RHC must determine if these services have been included in the surgical global billing.

FQHCs and RHCs may bill for a visit during the global surgical period if the visit is for a service not included in the global billing package. If the service delivered by the FQHC or RHC was included in the global payment for the surgery, the FQHC or RHC may not also bill for the same service.

614.4. To the extent possible, Georgia Medicaid follows Medicare for services not included in the global surgical package, which are listed in Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 40.1.B, and include (but are not limited to): initial consultation by the surgeon to determine the need for major surgery; visits unrelated to the diagnosis for which the surgical procedure is performed (unless the visit occurs due to complications of the surgery); treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery; etc.

614.5. For additional information on global billing, see http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/clm104c12.pdf.

Chapter 700- Special Eligibility Conditions

701. Provider Eligibility

701.1. A non-profit organization that receives a grant under Sections 329, 330 or 340 of the Public Health Service Act is automatically eligible for Federally Qualified Health Center (FQHC) provider status. The FQHC must submit a copy of its grant letter or other documentation from HHS showing enrollment eligibility. In addition, other nonprofit organizations that are determined by the Secretary of Health and Human Services to meet the requirements for receiving such a grant may qualify as an FQHC provider. Such determination is made based on the recommendation of the Health Resources and Services Administration within the Public Health Service, and the requirements defined in Chapter 600.

701.2. A medical facility located in a rural underserved community which is a rural location defined as a non-urbanized area by the U.S. Bureau of Census is automatically eligible for Rural Health Clinic Provider status, in addition to the requirements listed in Chapter 600.

702. Member Eligibility

702.1. There are no special eligibility conditions which members must meet to receive Federally Qualified Health Center or Rural Health Clinic services other than those stipulated in Part I, Section 107 of the Policies and Procedures Medicaid/ PeachCare for Kids manual.

Chapter 800- Prior Approval or Precertification

801. "Core" Services Requirements

801.1. There are no prior approval requirements for "core" services described in Section 900 of this manual. However, clinics should contact the fiscal agent inquiry line at 1-800-766-4456 prior to providing services that may not fall within the scope of primary. The Department may require prior authorization of all, or certain procedures based on the findings or recommendations of the Department, its authorized representatives, or contractual agents. This action may be invoked by the Commissioner as an administrative recourse in lieu of, or in conjunction with an adverse action described in Part I, Section 400 of the Policies and Procedures Medicaid/ PeachCare for Kids manual. In such instances, prior notice shall be provided.

802. Instances Requiring Prior Approval or Preadmission Certification

802.1. As a condition of reimbursement, the Department requires that certain services be approved prior to the time they are rendered. Prior approval from the Department pertains to medical necessity only; the patient must be Georgia Medicaid eligible at the time the service is rendered. If the service is to be performed in an inpatient hospital setting, preadmission certification is required. Selected services performed in an outpatient hospital or ambulatory surgical center (ASC) setting also require preadmission certification. Preadmission certification does not include approval for reimbursement of professional services that require prior approval.

802.2. The Department may require prior approval of all, or certain procedures performed by a specified physician or group of physicians based on the findings or recommendations of the Department, its authorized representatives or agents, the Secretary of the U. S. Department of Health and Human Services or the applicable State Examining Board. This action may be invoked by the Commissioner as an administrative recourse in lieu of, or in conjunction with an adverse action described in Part I, Section 400 of the Policies and Procedures Medicaid/ PeachCare for Kids manual. In such instances, prior notice shall be provided.

Chapter 900- Scope of Services

901. RHC Services

901.1. RHC services include:

901.1.1. Physicians' services, as described in section 903

901.1.2. Services and supplies incident to a physician's services, as described in section 903.

901.1.3. Services of NPs, PAs, and CNMs, as described in section 904

901.1.4. Services and supplies incident to the services of NPs, PAs, and CNMs, as described in section 904

901.1.5. CP and CSW services, as described in section 905

901.1.5.1. Licensed Marriage and Family Therapists (LMFT), Certified Peer Specialists, and Licensed Professional Counselors

901.1.6. Services and supplies incident to the services of CPs and CSWs, as described in section 905; and

901.1.7. Visiting nurse services to the homebound as described in section 906.

901.2. RHC services also include certain preventive services when specified in statute or when established through the National Coverage Determination (NCD) process and not specifically excluded. These services include, but are not limited to:

901.2.1. Influenza, Pneumococcal, and Hepatitis B vaccinations, and

901.2.2. Wellness Visit (Health Check/EPSDT).

902. FQHC Services

902.1. FQHC services include all the RHC services listed in section 901 of this chapter. While the following services may also be furnished in a RHC, the statute specifically lists certain services like FQHC services, including but not limited to:

902.1.1. Screening mammography

902.1.2. Screening pap smear and screening pelvic exam

902.1.3. Prostate cancer screening tests

902.1.4. Colorectal cancer screening tests

902.1.5. Diabetes outpatient self-management training (DSMT) services

902.1.6. Diabetes screening tests

902.1.7. Medical nutrition therapy (MNT) services

902.1.8. Bone mass measurement

902.1.9. Screening for glaucoma

902.1.10. Cardiovascular screening blood tests; and

902.1.11. Ultrasound screening for abdominal aortic aneurysm.

903. Emergency Services

903.1. RHCs provide outpatient services that are typically furnished in a physician's office or outpatient clinic and are not set up for emergency care. Neither independent nor hospital-based RHCs are subject to Emergency Medical Treatment and Active Labor Act (EMTALA) regulations.

903.2. However, RHC practitioners are required to provide medical emergency procedures as a first response to common life-threatening injuries and acute illnesses and to have available the drugs and biologicals commonly used in life-saving procedures. The definition of a "first response" is a service that is commonly provided in a physician's office.

903.3. If a patient presents at the clinic with an emergency when the clinic is not open for patient care because a physician, NP, PA, CNM, CP, or CSW is not present, other staff may attend to the patient until the care of the individual can be transferred. Any care provided in this situation must be within the individual's ability, training, and scope of practice, and in accordance with State laws, and would not be considered an RHC service.

903.4. During their regular hours of operations, FQHC practitioners are required to provide medical procedures as a first response to common life-threatening injuries and acute illnesses and to have available the drugs and biologicals commonly used in life-saving procedures. After their operating hours, FQHCs must provide telephone access to an individual who has the qualifications and training to exercise professional judgment in assessing a patient's need for emergency medical care, and if appropriate, to refer the patient to an appropriate provider or facility that is open.

904. Non-FHC/RHC Services

904.1. FQHCs or RHCs may furnish services that are beyond the scope of the FQHC or RHC benefit. If these services are covered under a separate Medicaid benefit category, the services must be billed separately to the appropriate Category of Service under the vac rules that apply to the service. (Specific to behavioral health services, it is recognized that same day billing by another provider through COS 440 is allowable). All costs associated with non- FQHC or RHC services, such as space, equipment, supplies, facility overhead, and personnel, must be identified and removed from allowable costs on the Medicare FQHC or RHC cost report. Examples of non FQHC/RHC services include:

904.1.1. Services that are prohibited by law or Departmental policy

904.1.2. All procedure codes listed in the CPT as "unlisted procedures" which end in "99"

904.1.3. Services or procedures that are not performed in compliance with policies contained in this Manual

904.1.4. Services normally provided free-of-charge to patients

904.1.5. Center visits for photographs

904.1.6. Medcosonolator or medotherm

904.1.7. Experimental procedures

904.1.8. Services that are not medically necessary

904.1.9. Substance Abuse Center Services

904.1.10. Vaccines, for members younger than nineteen years of age that are available through the VFC program; or

904.1.11. Consultation Services.

905. Description of Non-FQHC/RHC Services

905.1. Certain services are not considered FQHC or RHC services either because they 1) are not included in the FQHC or RHC benefit, or 2) are not a Medicare benefit. Non-FQHC/RHC services are included, but are not limited to:

905.2. Durable Medical Equipment - In accordance with the Affordable Health Care for All Americans Act, Section 6407, and in addition to required compliance with other applicable Medicaid policy, a face-to-face encounter with patients is required before physicians may certify eligibility for durable medical equipment (DME) under the Georgia Medicaid. It is a condition of reimbursement that providers evaluating, prescribing, providing or in any other manner supplying durable medical equipment must comply with the Medicaid policy requirements and documentation standards for face-to-face encounter for initial and replacement equipment, supplies and modifications. For further clarification and specific details of policy and coverage under the DME program, refer to the DME manual.

905.3. Ambulance services

905.4. Hospice Services

905.5. Vaccines - Effective October 1, 1994, vaccines given to Medicaid eligible children will be covered only in accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). To receive reimbursement for the administration of the free vaccines, the physician must enroll in the VFC program. Medicaid will not reimburse the cost of any vaccine covered for children under the VFC program. Refer to the Health Check Services manual for appropriate billing codes and modifiers related to these services.

905.6. Flu Vaccine/COVID-19 Vaccines- Physicians are to bill for the administration of the Flu vaccine and COVID-19 vaccines (as of 12/2020). Reimbursement will be determined by the assigned cost effective in GAMMIS. For COVID-19 vaccines (0001A,0002A,0003A,0011A,0012A,0013A) are reimbursed at the rate of $40.00 as of 04/01/2021.

906. Physician Services

906.1. The term "physician" includes a Doctor of Medicine, osteopathy, dental surgery, dental medicine, podiatry, or optometry who is licensed and practicing within the licensee's scope of practice, and meets other requirements as specified.

906.2. Physician services are professional services furnished by a physician to a FQHC or RHC patient and include diagnosis, therapy, surgery, and consultation. The physician must either examine the patient in person or be able to visualize directly some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization includes review of the patient's X-rays, EKGs, tissue samples, etc.

906.3. Except for services that meet the criteria for a TCM visit, telephone or electronic communication between a physician and a patient, or between a physician and someone on behalf of a patient, are considered physicians' services and are included in an otherwise billable visit. They do not constitute a separately billable visit.

906.4. Services that are not medically appropriate (e.g., appendectomy, etc.) or not commonly furnished in an outpatient clinic setting are not considered physician services in a FQHC or RHC.

906.5. Qualified services furnished at a FQHC or RHC by an FQHC or RHC physician are payable only to the FQHC or RHC. FQHC and RHC physicians are paid according to their employment agreement or contract (where applicable).

906.6. Office E/M services rendered after hours are billable using After Hours codes 99050 and 99051 as Add On codes to Evaluation and Management (E/M) codes 99211–99215 and 99202–99205.

907. Dental, Podiatry, and Optometry Services

907.1. Dentists, podiatrists, and optometrists are defined as physicians in Medicare statute and can provide FQHC or RHC services that are within their scope of practice and not excluded from coverage.

907.2. FQHCs and RHCs are required to primarily provide primary health care. Since dentists, podiatrists, optometrists, are not considered primary care physicians, they do not meet the requirements to be either i) a physician medical director or ii) the physician or non-physician practitioner (NP, PA, or CNM) that must always be available when the clinic is open. Therefore, a dentist, podiatrist, or optometrist can provide a medically necessary, face-to-face visit with an FQHC or RHC patient only when the statutory and regulatory staffing requirements are otherwise met.

907.3. For additional information on these services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 on Covered Medical and Other Health Service at

http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/bp102c15.pdf.

908. Treatment Plans or Home Care Plans

908.1. Treatment plans and home care oversight provided by FQHC or RHC physicians to FQHC or RHC patients are considered part of the FQHC or RHC visit and are not a separately billable service.

909. Services and Supplies Furnished Incident to Physician's Services

909.1. Services and supplies that are an integral, though incidental, part of the physician's professional service:

909.1.1. Commonly rendered without charge or included in the FQHC or RHC bill

909.1.2. Commonly furnished in an outpatient clinic setting

909.1.3. Furnished under the physician's direct supervision; and

909.1.4. Furnished by a Georgia Medicaid qualified contracted member of the FQHC or RHC staff.

909.2. Incident to services and supplies are included in the PPS rate, and include the following:

909.2.1. Venipuncture (except for a member under the age of 18, see the Health Check/EPSDT manual for more information)

909.2.2. Bandages, gauze, oxygen, and other supplies; or

909.2.3. Assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under the supervision of the physician.

909.3. Drugs that must be billed to the Physician's Administered Drug List (PADL) are not included.

909.4. Payment for Georgia Medicaid drugs that are not usually self-administered and are furnished by a RHC or FQHC practitioner to an enrolled Georgia Medicaid patient are included in the RHC and FQHC PPS. However, Section 1861(s)(2)(G) of the Act provides an exception for RHCs when a physician prepares a specific formulation of an antigen for a patient if the antigen is "forwarded to another qualified person (including a rural health clinic) for administration to such patient…, by or under the supervision of another such physician." A RHC practitioner (physician, NP, PA, or CNM) acting within their scope of practice may administer the drug and the cost of the administration may be included on the RHC's cost report as an allowable expense. The cost of the antigen prepared by a physician outside of the RHC is not included in the RHC PPS.

910. Provision of Incident to Services and Supplies

910.1. Incident to services and supplies can be furnished by auxiliary personnel. All services and supplies provided to a physician's visit must result from the patient's encounter with the physician and be furnished in a medically appropriate timeframe.

910.2. More than one incident to service or supply can be provided because of a single physician visit. Incident to services and supplies must be provided by someone who has an employment agreement or a direct contract with the FQHC or RHC to provide services. Services or supplies provided by individuals who are not employed by or under direct contract with the FQHC or RHC, even if provided on the physician's order or included in the FQHC or RHC's bill, are not covered as incident to a physician's service. An example of services that are not considered incident to include the services of an independently practicing therapist who forwards his/her bill to the clinic for inclusion in the entity's statement of services, services provided by an independent laboratory or a hospital outpatient department, etc.

910.3. Services and supplies furnished incident to physician's services are limited to situations in which there is direct physician supervision of the person performing the service. Direct supervision does not mean that the physician must be present in the same room. However, the physician must be in the FQHC or RHC and immediately available to help and direct throughout the time the practitioner is furnishing services.

911. Payment for Incident to Services and Supplies

911.1. Services that are covered by Georgia Medicaid but do not meet the requirements for a medically necessary visit with a FQHC or RHC practitioner (e.g., blood pressure checks, allergy injections, prescriptions, nursing services, etc.) are considered incident to services. The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit. Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe.

911.2. Incidental services or supplies must represent an expense incurred by the FQHC or RHC. For example, if a patient purchases a drug and the physician administers it, the cost of the drug is not covered and cannot be included in the cost report.

911.3. If a drug listed on Georgia Medicaid's Physician Injectable Drug List is furnished by a FQHC or RHC practitioner to a Georgia Medicaid patient, the drug is covered and paid for as a FQHC or RHC service. The cost of the drug is an allowable cost and is part of the clinic's PPS calculation.

912. NP, PA, and CNM Services

912.1. Professional services furnished by an NP, PA, or CNM to a FQHC or RHC are services that would be considered covered by physician services under Medicaid (see section 610), and which are permitted by State laws and clinic or center policies. Services may include diagnosis, treatment, and consultation. The NP, PA, or CNM must directly examine the patient, or directly review the patient's medical information such as X-rays, electrocardiogram (EKG) and electroencephalograms, tissue samples, etc. They do not constitute a separately billable visit.

913. Requirements

913.1. Services performed by NPs, PAs, and CNMs must be:

913.1.1. Furnished under the medical supervision of a physician

913.1.2. Furnished in accordance with FQHC or RHC policies and any physician medical orders for the care and treatment of a patient

913.1.3. A type of service which the NP, PA, or CNM who furnished the service is legally permitted to furnish the service

913.1.4. Furnished in accordance with Georgia Composite Medical Board restrictions as to setting and supervision

913.1.5. Furnished in accordance with written FQHC or RHC policies that specify what services these practitioners may furnish to patients; and

913.1.6. A type of service which would be covered by Georgia Medicaid if furnished by a physician.

914. Physician Supervision

914.1. FQHCs and RHCs which are not physician-directed must have an arrangement with a physician that provides for the supervision and guidance of NPs, PAs, and CNMs. The arrangement must be consistent with Georgia law and Georgia Composite Medical Board restrictions.

915. Services and Supplies Incident to NP, PA, and CNM Services

915.1. Services and supplies that are incident to an NP, PA, or CNM service must be:

915.1.1. A type of service commonly furnished in an outpatient clinic setting

915.1.2. Furnished as an incidental, though integral, part of professional services furnished by an NP, PA, or CNM

915.1.3. Furnished under the direct supervision of an NP, PA, or CNM; and

915.1.4. Furnished by a member of the FQHC or RHC staff who is an employee of the RHC or FQHC.

915.2. The direct supervision requirement is met in the case of an NP, PA, or CNM who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the FQHC or RHC. Services and supplies covered under this provision are generally the same as described in section 915 as incident to a physician's services and include services and supplies incident to the services of an NP, PA, or CNM.

916. Clinical Psychologist (CP) and Clinical Social Worker (CSW) Services

916.1. A CP is an individual who:

916.1.1. Holds a doctoral degree in psychology, and

916.1.2. Is licensed or certified by the State of Georgia, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

916.2. A CSW is an individual who:

916.2.1. Possesses a master's or doctor's degree in social work

916.2.2. Is licensed or certified as a clinical social worker by Georgia to perform; or, in the case of an individual in a State that does not provide for licensure or certification, meets the requirements listed in 42 CFR 410.73(a)(3)(i) and (ii).

916.3. Services may include diagnosis, treatment, and consultation. The CP or CSW must directly examine the patient, or directly review the patient's medical information. Telephone or electronic communication between a CP or CSW and a patient, or between such practitioners and someone on behalf of a patient, are considered CP or CSW services and are included in an otherwise billable visit. They do not constitute a separately billable visit.

916.4. Services that are covered are those that are otherwise covered if furnished by a physician or as incident to a physician's professional service. Services that a hospital or SNF is required to provide to an inpatient or outpatient as a requirement for participation is not included. Services performed by CPs and CSWs must be:

916.4.1. Furnished in accordance with FQHC or RHC policies and any physician medical orders for the care and treatment of a patient

916.4.2. A type of service which the CP or CSW who furnished the service is legally permitted to furnish by the State in which the service is rendered; and

916.4.3. Furnished in accordance with State restrictions as to setting and supervision, including any physician supervision requirements.

917. Services and Supplies Incident to CP and CSW Services

917.1. Services and supplies that are incident to a CP or CSW service must be:

917.1.1. A type of service or supply commonly furnished in a CP or CSW's office

917.1.2. Furnished as an incidental, though integral, part of professional services furnished by a CP or CSW

917.1.3. Furnished under the direct supervision of the CP or CSW; and

917.1.4. Furnished by an employee of the clinic or center.

917.2. The direct supervision requirement is met in the case of a CP or CSW who supervises the furnishing of the service only if such a person is permitted to exercise such

supervision under the written policies governing the FQHC or RHC.

917.3. Services and supplies covered under this provision are generally the same as described in section 907 as incident to a physician's services and include services and supplies incident to the services of a CP or CSW.

918. Visiting Nurse Services

918.1. Description of Services

918.1.1. The FQHC or RHC may provide visits to homebound members when the following conditions are met:

918.1.1.1. There is not a home health agency located within twenty-five (25) miles of the member's home that accepts Medicaid.

918.1.1.2. An RN or LPN renders the services under a written plan of care approved and reviewed every sixty (60) days by the physician supervising the FQHC or RHC.

919. Telehealth Services

919.1. FQHCs and RHCs may serve as an originating site for telehealth services, which is the location of an eligible Medicare beneficiary or enrolled Medicaid member at the time the service being furnished via a telecommunications system occurs. FQHCs and RHCs that serve as an originating site for telehealth services are paid an originating site facility fee.

919.2. FQHC's and RHC's are authorized to serve as a distant site for telehealth services and may bill the cost of the visit. Please refer to the Telemedicine Handbook, located at www.mmis.ga.gov

919.3. FQHCs and RHCs cannot bill an originating site fee and distant site fee for telehealth services on the same encounter.

919.4. For more information on telehealth services, please refer to the Telemedicine Handbook, located at www.mmis.ga.gov.

Chapter 1000- Reimbursement

1001. Freestanding and Hospital-Based Rural Health Clinic Services

1001.1. In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, reimbursement is provided for "core" services and other ambulatory services as listed in Appendix G at a PPS per encounter visit. Each RHC`s per visit is based on its reasonable cost of providing Georgia Medicaid-covered services including other ambulatory services cost during FY 1999 and FY 2000. This baseline rate, effective January 2001, is utilized as the basis for rates in succeeding years. Annually, each RHC's per visit rate is calculated by adjusting the prior year's rate by the Medical Economic Index (MEI). MEI is announced in Recurring Update Notifications (RUNs) issued by Centers for Medicare and Medicaid Services (CMS) in November or December each year.

1001.2. The baseline rates effective January 1, 2001, will be adjusted by the Medicare Economic Index (MEI), effective for dates of service on and after October 1, 2001, based on the MEI and for changes in the RHC's scope of services during January 1, 2001, through September 30, 2001. For the Federal Fiscal Year (FFY) 2002 and FFYs thereafter, the per visit rate will be calculated by adjusting the previous year's rate by the MEI for primary care, and for changes in the RHC's scope of services during the prior FFY.

1001.3. For newly qualified RHCs and FQHCs that participate in FY 2000 only, the Department will use the FY 2000 cost for calculating the baseline PPS rate effective January 1, 2001. Clinics that qualify after fiscal year 2000 will have their initial rates established by a statewide average for similar centers. After the initial year, payment will be set using the MEI and change of scope methods used for other clinics.

1001.4. FQHCs and RHCs that qualify after fiscal year 2000 will have their initial rates established by a statewide average of similar clinics. After the initial year, payment will be set using the MEI and change of scope methods used for other clinics.

1002. FQHC and RHC Patient Charges, Copays

1002.1. Please refer to Appendix D.

1003. Changes in Scope of Services

1003.1. A change in scope of services for FQHC and RHC is defined as a change in the type, intensity, duration and/or number of services. It is the clinic's responsibility to recognize any changes in their scope of services and to notify the Department of those changes and to provide the Department with documentation and projections of the cost and volume impact of the change.

1004. Contracting with Care Management Organization (CMO)

1004.1. When an FQHC or RHC provide services listed in Appendix H pursuant to a contract between the clinic and a Care Management Organization (as defined in Social Security

Act section 1932(a) (1) (B)), the State shall perform a reconciliation if the State determines it is necessary, to ensure that CMO payment equivalent to the amount calculated under the PPS rate. The State shall provide a supplemental payment (only the portion, if any, that State is responsible based on the contract between the department and CMO) equal to the amount by which the PPS rate exceeds the amount of the payments provided by the CMO on an aggregate annual basis. Any such supplemental payments shall be made pursuant to a payment schedule agreed to by the State and the clinic.

1005. Alternative Payment Methodology

1005.1. RHCs located at Critical Access Hospitals

1005.1.1. An alternative payment methodology is established for services furnished in Rural Health Clinics located at Critical Access Hospitals. The reimbursement methodology will follow the provisions established in the State Plan. All clinics affected by this methodology have agreed that their payments will at least equal the amount they would have received under the PPS methodology.

1005.2. Statewide average PPS rate

1005.2.1. Effective July 1, 2013, FQHC that have a PPS rate less than the statewide average will have their PPS rate increased to be equal to the statewide average PPS rate.

1006. Cost Reports

1006.1. January 1, 2001, The Benefits Improvement and Protection Act (BIPA) of 2000 eliminated the requirement for the submission of the annual cost report. However, if the Department determines it has a continued need for cost reports or other accounting methods, it has the flexibility to require such reports.

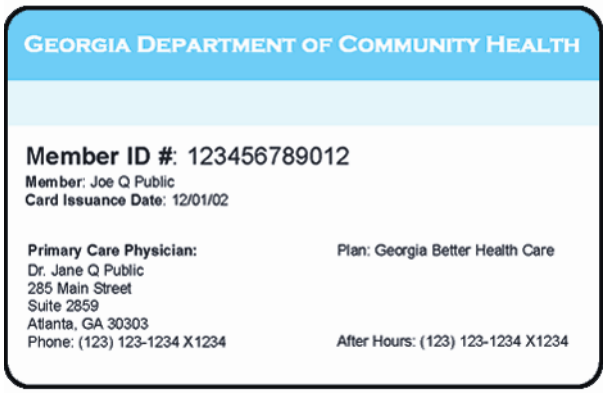
1007. Members with Medicaid Only

1007.1. The appropriate claim form for reimbursement of Rural Health Clinic Services provided to patients covered only by Medicaid is the Physician/or Other Service Invoice (CMS-1500) for freestanding rural health clinics, and the UB-04 claim form for hospital-based rural health clinics. Clinics should complete the appropriate form and forward it to the Department's fiscal agent after each date of treatment.

1008. Members with Medicare and Medicaid

1008.1. If a member is eligible for both Medicaid and Medicare, all claims must be sent to the Medicare carrier first. Medicare upper limits of reimbursement will apply for all services covered by Medicare. Policies and procedures for billing those services are described in Part I, Chapter 300.

Appendix A
Medical Assistance Eligibility Certification
Medicaid & Peachcare for Kids Member Identification Card Sample





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

Appendix B
Explanation of Benefits

A. Definition of an FQHC and RHC Visit PPS rate Encounter

An FQHC and RHC visit is defined as a face-to-face encounter between a center patient and a health care professional, defined as either a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, clinical psychologist, licensed clinical social worker or a visiting nurse. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. For the FQHC and RHC per visit rate to be paid as a PPS visit one of the CPT procedure codes listed in Appendix H must be recorded on a claim.

i. The exception is that two visits may be billed in the following instances:

1. When a patient, after the first visit, suffers illness or injury that requires another health diagnosis or treatment

2. When a patient is seen by a provider and receives dental services on the same day from a dentist

3. When a patient is seen by a provider and receives mental health services on the same day from a clinical psychologist or clinical social worker

4. When a patient is seen by a provider and receives family planning services on the same day from a family planning provider

5. When a patient is seen by a provider and receives optometry services on the same day by an optometrist

6. When a patient is seen by a provider for EPSDT service and receives outpatient/ office services for a medical condition on the same day by the same provider, the provider should bill for the PPS rate and the E & M visit with Modifier 25

7. When a patient is seen by a provider for preventative service and receives outpatient/ office services for a medical condition on the same day by the same provider, the provider should bill for the PPS rate and the E & M visit with Modifier 25

8. DME, OP, PADL, Pharmacy is not included in the PPS rate and should be billed if appropriately provided.

Face-to-face encounters with more than one health care professional and multiple encounters with the same health professional on the same day at a single location constitute a single visit for billing purposes. However, if the patient suffers illness or injury on the same day requiring additional diagnosis or treatment after the initial visit, another visit may be billed. In addition, separate FQHC and RHC per visit payments can be made for “core” services versus other ambulatory services provided on the same day by different types of qualified health care professionals for different procedure and diagnostic codes.

Example:1 A patient visits the center in the morning and sees the nurse practitioner. The nurse practitioner believes an adjustment in medication is needed but wishes the physician to check the determination in the afternoon. The patient sees the physician in the afternoon and an adjustment is made. In this situation, the program is billed for one visit.

Example 2: A patient visits the center in the morning and sees the nurse practitioner. The nurse practitioner orders laboratory tests and x-rays and asks the patient to return in the afternoon to see the physician. The program is billed for a single visit at the all-inclusive rate and the laboratory and x-ray services are listed on the claim.

Example 3: A patient is seen in the morning in the center by a physician. A non-center visit (home) is made in the afternoon by the nurse practitioner. Two visits may be billed.

Example 4: A patient is seen in the morning in the center by a physician assistant. The patient returns to the center in the afternoon because of an injury that occurred after the a.m. visit and is unrelated to the morning visit. Two visits may be billed.

Example 5: A 17-year-old patient is seen in the center by a physician for the treatment of a broken arm. The patient is also seen in the center by a clinical social worker for a school behavioral problem and suicidal tendencies, and the service rendered constitutes a valid psychotherapy visit per the procedure codes listed in Appendix H. Two visits may be billed. Be mindful of all NCCI procedure to procedure guidelines.

Example 6: A patient is admitted to the hospital and the physician provides hospital care to the member during the period of hospitalization. The FQHC and RHC per visit rate is paid for each day the physician sees the patient in the hospital regardless of the number of times the patient is seen each day.

Appendix C
Co-Payment

Effective with dates of service July 1, 2005, the Division is implementing a tiered member copayment scale as described in 42CFR447.54 on all evaluation and management procedure codes (99202-99499) including the ophthalmologic services procedure codes (92002-92014) used by physicians or physicians' assistants.

The tiered co-payment amounts are as follows:

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

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

The copayment 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 Women's Health Medicaid Program, aid categories 245 and 800, only.

The copayment does not apply to the following services:

Dialysis Services

Emergency services

Family Planning services

Waiver 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 co-payment. The Eligibility Certification has been modified to include a co-payment column adjacent to the date-of-birth section. When "yes" appears in this column for a specified member, the member may be subject to the co-payment.

The Department may not be able to identify all members who are exempt from the copayment. Therefore, providers should identify the members as documented below:

To identify members receiving Family Planning services for FQHC (COS 540 & 542), all of the following criteria must be met.

The rendering provider COS equals to 540 & 542,

Enter “FP” in item 24H on the CMS-1500 claim form,

Billable procedure code from CPT 99202 through 99215

The appropriate diagnosis code,

GHP will automatically deduct the copayment amount from the provider’s payment for claims processed with dates of service July 1, 2003, and after. Do not deduct the copayment from your submitted charges. The application of the copayment will be identified on the remittance advice. A new explanation of benefit (EOB) code will indicate payment has been reduced due to the application of copayment.

LARC

To identify members receiving Family Planning services for Long-Acting Reversible Contraceptive (LARC) in FQHC and RHC (COS 540, 541 & 542), all the following criteria must be met.

COS 540 & 542:

The rendering provider COS equals to 540 & 542,

Enter “FP” in item 24H on the CMS-1500 claim form,

Enter appropriate J code (J7296, J7297, J7298, J7300, J7301, or J7307) with FP modifier

Bill appropriate J code at acquisition cost

E & M billable codes are CPT 99202 through 99215 with FP modifier (based on level of evaluation rendered during the encounter)

Insertion and/or removable procedure codes (11981, 11982, 11983, 58300 and 58301) with FP modifier

Bill with an appropriate diagnosis code as listed below

(ICD-10: Z30.430, Z30.431, Z30.432, Z30.433, Z30.49)

COS 541:

The rendering provider COS equals to 541

Enter “FP” in item 42 on the UB-04 claim form,

Enter appropriate J code (J7296, J7297, J7298, J7300, J7301, or J7307) with rev code 250

Bill appropriate J code at acquisition cost

E & M billable codes are CPT 99202 through 99215 with FP modifier (based on level of evaluation rendered during the encounter)

Insertion and/or removable procedure codes are (11981, 11982, 11983, 58300 and 58301) with FP modifier

Bill with an appropriate diagnosis code as listed below

(ICD-10: Z30.430, Z30.431, Z30.432, Z30.433, Z30.49)

Adult Preventive Visit

Effective January 1, 2016, the Department of Community Health will implement one adult preventive visit for members 21 years of age and older. Providers may bill ONE (1) preventive health visit (993XX) for a member annually (between January and December of the CY). Providers must use one of the following ICD-10 diagnosis and a medical diagnosis code when billing the preventive health visit code: Z00.00 or Z00.01 (Encounter for adult examination).

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

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

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

99387 or 99397 - (Adults 65 years and older)

Appendix D
Vaccine For Children Program

A. Immunization - Vaccines for Children (VFC)

Providers who wish to obtain enrollment information or general information regarding the VFC Program should refer to the Health Check Services Manual on-line at www.hp.georgia.gov, or call (404) 657-5013 or 1 (800) 848-3868.

Appendix E

A. Early Elective Deliveries- Early Elective Deliveries (EED) and Elective Inductions Policy

i. Effective October 1, 2013, the Medicaid Division within the Department of Community Health changed its benefit coverage for non-medically necessary cesarean deliveries prior to 39 weeks gestation. Claims submitted for ANY labor inductions or cesarean sections on or before 39 weeks gestation that are not properly documented as medically necessary will be denied in the Georgia Medicaid Management System (GAMMIS). Gainwell Technology's current MMIS will be updated later for claims processing of this benefit coverage for early elective deliveries (EED) including non-medically necessary cesarean deliveries and early inductions. This policy was approved as a mandate by the 2013 Georgia legislature in Georgia's SFY 2014 budget bill. Grand

1. Hospital UB 04 Claims

ii. There are no proposed changes to the current billing process of inpatient claims for induction/delivery services when processed through the claims adjudication process for payment. Hospitals are strongly encouraged to collaborate with their physicians privileged to provide obstetric services in order to develop guidelines and protocols (i.e., a scheduling protocol or Hard Stop Policy and/or establish documentation standards) for deliveries prior to 39 weeks gestation. Hospitals are also encouraged to enforce those guidelines and protocols. Child

1. Professional 1500 Claims

iii. Practitioners are to continue billing obstetric procedure codes on their professional 1500 claim forms for payment: 59400, 59409, 59410, 59514, 59510, 59515, 59610, 59612, 59614, 59618, 59620, and 59622, along with one of the three (3) satells (UB, UC, or UD) appended to the billed delivery procedure code. GAMMIS will be configured with system edit(s) for the delivery claims that do not append one of the required EED modifier and/or that do not meet the approved guidelines of billing certain clinical indications. Delivery claims that are submitted with medical conditions that do not warrant an exception prior to 39 weeks gestation will post the EED edit requiring medical review by our state's peer review organization, Georgia Medical Care Foundation (GMCF). Clinical justification and the proper documentation must be submitted to GMCF for review of the denied obstetric delivery claim. Also, ALL Medicaid practitioners' claims for elective inductions/C-sections must include EITHER the last menstrual period (LMP) or the estimated date of confinement (EDC) or the estimated delivery date (EDD) in field locator 14 of the CMS 1500 paper/electronic form.

Delivery Modifiers for Professional 1500 Claims

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

(a) UB—Medically-necessary delivery prior to 39 weeks of gestation

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

For inductions or cesarean sections that meet the ACOG or approved medically necessary guidelines, the appropriate ACOG Patient Safety Checklist must be completed and maintained for documentation in the GA enrolled member's file, or

For inductions or cesarean sections that do not meet the ACOG or approved guidelines, the appropriate ACOG Patient Safety Checklist must be completed. Additionally, the enrolled provider must obtain approval from the state's peer review organization, Georgia Medical Care Foundation (GMCF), and maintain this checklist in the enrolled member's file. The practitioner must submit to GMCF the clinical justification and documentation for review along with the Patient Safety Checklist.

(b) UC—Delivery at 39 weeks of gestation or later

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

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

For deliveries less than 39 weeks gestation that do not meet ACOG or approved guidelines or are not approved by the Georgia Medical Care Foundation as medically necessary with clinical justification. Examples of unacceptable medical reasons include patient choice, physician going out of town, history of a fast labor, etc.

NOTE: Obstetric delivery claims that are submitted without one of the required modifiers listed above will be denied. To avoid claim denials, the two-digit modifier is required whenever billable obstetrical procedure codes are submitted for payment either for vaginal deliveries or cesarean sections.

iv. Documentation Requirements

Providers should utilize medical standards before performing cesarean sections, labor inductions, or any delivery following labor induction. The documents required for peer review are the member's history and physical, admission notes for the delivery, operative report, if applicable, for cesarean sections, physician progress notes, labor and delivery report, discharge summary, and the ACOG Patient Safety Checklist or an appropriate checklist that meets national guidelines. There are medically necessary conditions that may warrant clinical justification with the proper documentation for an early induction or cesarean section (refer to links in references) for some approved exceptions of medical conditions for deliveries prior to 39 weeks. The list of conditions is not meant to be exclusive.

References

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

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

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

Appendix F

A. BILLING INSTRUCTIONS AND CLAIM FORMS

i. Detailed information and instructions for completion and submittal of claim forms can be found in this section. Claims must be filed on the required form with appropriate information in specific blocks for payment. Claim form for Federally Qualified Health Center Services and Rural Health Center Services is:

1. Health Insurance Claim Form (CMS–1500- Claim (s) must be submitted within (6) months from the month of service. Claim (s) with third party resource(s) must be submitted within twelve (12) months from the month of service.

(a) Medicaid/Medicare Crossover CMS-1500

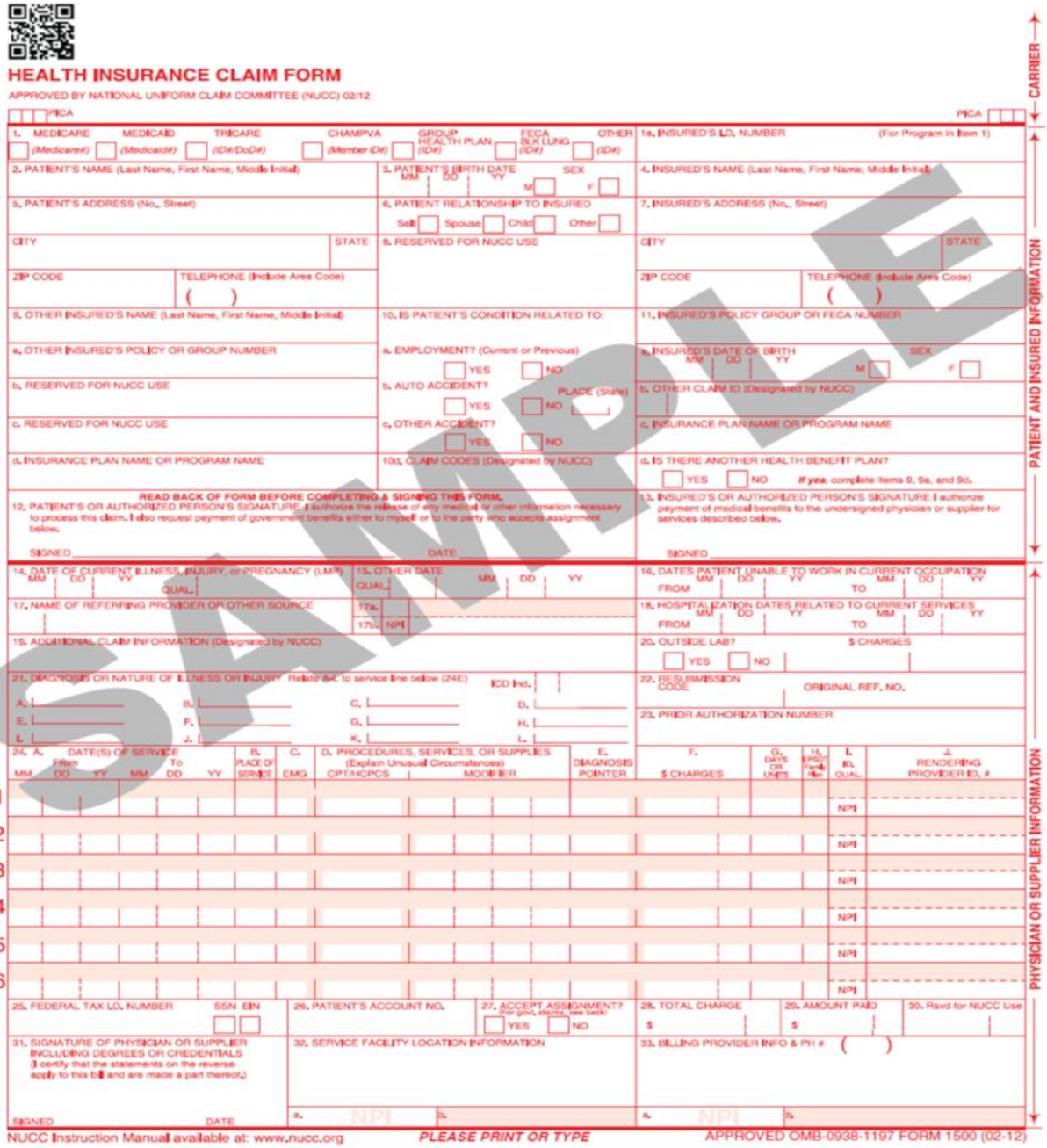
A special crossover claim form is no longer required when billing Medicaid/Medicare crossover. Claim (s) must be submitted in the same format as they are submitted to Medicare. This claim must have an Explanation of Medicare Benefits (EOMB) from Medicare for Medicaid payment. Claim (s) must be submitted within twelve (12) months from the month of service.

For specific Medicare crossover claims instructions and tips for submitting crossover claims, FQHC providers should refer to the "Medicaid Secondary Claims User Guide" located on-line at www.ghp.georgia.gov under Medicaid Provider Manuals.

(b) The Billing Manual has been added to Part 1 of the Policies and Procedures for Medicaid/PeachCare for Kids Manual. Please refer to this Billing Manual for general billing instructions, questions, and the appeals process.

Note: Appendix G should be referred to by FQHC and RHC providers for specific billing instructions.

Appendix G
CMS 1500 Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? 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 TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added “(NUCC)” after “APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE.”
Header	Replaced “08/05” with “02/12”
Item Number 1	Changed “TRICARE CHAMPUS” to “TRICARE” and changed” (Sponsor’s SSN)” to “(ID#/DoD#).”
Item Number 1	Changed “(SSN or ID)” to “(ID#)” under “GROUP HEALTH PLAN”
Item Number 1	Changed “(SSN)” to “(ID#)” under “FECA BLK LUNG.”
Item Number 1	Changed “(ID)” to “(ID#)” under “OTHER.’
Item Number 8	Deleted “PATIENT STATUS” and content of field. Changed title to “RESERVED FOR NUCC USE.”
Item Number 9b	Deleted “OTHER INSURED’s DATE OF BIRTH, SEX.” Changed title to “RESERVED FOR NUCC USE.”
Item Number 9c	Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “RESERVED FOR NUCC USE.”
Item Number 10d	Changed title from “RESERVED FOR LOCAL USE” to “CLAIM CODES (Designated by NUCC).” Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC. FOR DCH/Gainwell: 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 Federally Qualified Health Center Services and Rural Health Clinic Services Combined Manuals Published Oct 1, 2024, G-4 the right-hand side of the field. Added “QUAL.” with a dotted line to accommodate a 3-byte qualifier.” FOR DCH/Gainwell: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date).
Item Number 15	Changed title from ‘IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE” to “OTHER DATE.” Added “QUALIFIER.” with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – Used by Medicare for identifiers for provider roles: Ordering, Referring and Supervising. FOR DCH/Gainwell: Use the following Ordering Provider, Referring, Supervising Qualifiers (effective 4/01/2014): Ordering = DK; Referring = DN or Supervising = DQ.
Item Number 19	Changed title from “RESERVED FOR LOCAL USE” to “ADDITIONAL CLAIM INFORMATION (Designated by NUCC).” FOR DCH/Gainwell: 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

	ICD - 10 diagnoses (CM) codes = value 0.
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from “MEDICAID RESUBMISSION” to “RESUBMISSION.” The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. FOR DCH/Gainwell: 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).”

NOTE: Reimbursement for Federally Qualified Health Center Services is based on an actual clinic encounter or visit (office, emergency room or hospital) even though other services are rendered at the same time. Federally Qualified Health Center Services are reimbursed according to the clinic’s assigned “all inclusive” rate. Please refer to Appendix C of this manual for clinic encounter explanation.

Appendix H
UB-04 Form Completion of the National Uniform Billing Claim Form (UB-04)

FL 1	Provider Name, Mailing Address, and Telephone Number Enter the name of the provider submitting the bill, the complete mailing address, and telephone number.
FL 3	Patient Control Number Enter the patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual case records and posting of payment.
FL 4	Type of Bill Enter code 711 to indicate the specific type of bill. Type of Facility Always use '7' for rural health services. Bill Classification Must be '1' (Rural Health) Frequency The only acceptable rural health clinic frequency is "1".
FL 6	Statement Covers Period Enter the beginning and ending service date of the period included on this bill.
FL 12	Patient Name Enter last name, first name, and middle initial of the patient. If the name on the Medicaid card is incorrect, the member or the member's representative should contact the local DFCS to have it corrected immediately.
FL 13	Patient Address Enter the full mailing address including street number and name of post office box number or RFD, city name: state name; zip code.
FL 14	Patient Birth Date Record date of birth exactly as it appears on the Medicaid card. An unknown birth date is not acceptable. If the date on the Medicaid card is incorrect, the member or the member's representative should contact the DFCS to have it corrected immediately.
FL 15	Patient Sex Enter the sex of the patient as "M" for male or "F" for female. If the sex on the Medicaid card is incorrect, the member or the member's representative should contact the DFCS to have it corrected immediately.

FL 17	Admission Date For outpatient services, the date of admission is considered to be the date services began for the period being billed on the claim form.
FL 18	Admission Hour Enter the hour (00-23) during which the patient was seen for care.
FL 23	Medical/Health Record Number Enter the number assigned to the patient's medical/health record by the provider.
FL 24 through 30	Condition codes Enter the appropriate codes(s) used to identify conditions relating to this bill that may affect payer processing. When the clinic is aware that a member is pregnant, and the Department has identified that member is subject to the copayment, condition code 80 must be entered. Health Check/Family Planning If the services were provided as a result of a referral by the Health Check (formerly EPSDT) Program, enter A1. The Health Check Program is only for individuals under twenty-one years of age. If Family Planning services are provided, enter A4
FL 39 through 41	Value Codes (Rev. 04/2015) Enter revenue code 250 for Long-Acting Reversible Contraceptive, revenue code 521 for rural health clinic services, revenue code 522 for home visit services, revenue code 527 for Visiting Nurse services, Revenue code 636 for injectable drugs and revenue code 001 for the total charges.
FL 42	Revenue Code (Rev. 10/2015) Enter larcde 250 for Long-Acting Reversible Contraceptive, revenue code 521 for rural health clinic services, revenue code 522 for home visit services, revenue code 527 for Visiting Nurse services, Revenue code 636 for injectable drugs and revenue code 001 for the total charges.
FL 43	Revenue Description (Rev. 10/2017) Enter a narrative description of the related revenue categories included on this bill. Abbreviations may be used. The description and abbreviations should correspond with the revenue codes as defined in the Georgia Uniform Billing Manual. When billing injectable drugs on a UB04, the 11-digit National Drug Code (NDC) for the actual administered drug must be in the Field Locator 43.

	Enter the 2-digit qualifier "N4" as a prefix to the 11-digit NDC number, i.e. N455513028310. The associated code must be entered in Field Locator 44.
FL 44	CPT/HCPCS CPT codes must be entered in the FL 44 adjacent to the appropriate revenue code to identify all services provided. The clinic must select the HCPCS code which best describes the service provided. Revenue codes as described in FL 42 and CPT codes for the appropriate level of encounter/service must be used.
FL 46	Units of Service Units of service must always be a "1".
FL 47	Total Charges (by Revenue Category) Enter the total charges pertaining to the related revenue code for the current billing period as entered in the "statement covers period". Only charges relating to the covered eligibility dates should be included in total charges. The figures in this field add up to a total that is reported in this FL using revenue code 001.
FL 50 A, B, C	Payer A, B, C Enter payer name and carrier code of any liable third-party payer other than Medicare. (*Carrier codes are located in the Third-Party Insurance Carrier Listing.) A reasonable effort must be made to collect all benefits from other third party coverage. Federal regulations require that Medicaid be the payer of last resort. (See Chapter 300 of the Policies and Procedures Manual applicable to all Medicaid providers.) When a liable third-party carrier is identified on the card, the provider must bill the third party.
FL 51 A, B, C	Provider Number Enter the number assigned to the provider by the payer indicated.
FL 54 A, B C	Prior Payments Enter the amount that the hospital has received toward payment of this bill from the carrier
FL 58	Insured's Name Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the Medicaid card. If the name on the Medicaid card is incorrect, the member or the member's representative should contact the local DFCS to have it corrected immediately.
FL 60 A, B, C	Certification/SSN/HIC/ID No.

	Enter the Medicaid Member Client Number exactly as it appears on the Medicaid card.
FL 61 A, B, C	Insured Group Name Enter the name of the group or plan through which the insurance is provided to the insured. Medicaid requires the primary payer information on their primary payer line when Medicaid is secondary
FL 62 A, B, C	Insurance Group Numbers Enter the identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.
FL 63 A, B, C	Treatment Authorization Code (Precertification) A number or other indicator that designates that the treatment covered by this bill has been authorized by the DMA. Enter the twelve-digit authorization number as required for inpatient hospital admissions and selected outpatient procedures, if applicable.
FL 63 A, B, C	Employment Status Code Enter the code as defined by the National Uniform Billing Committee used to define the employment status of the individual identified in FL 58.
FL 65 A, B, C	Employer Name Enter employer name that might or does provide health care coverage for the individual in FL 58.
FL 66 A, B, C	Employer Location Enter the specific location of employer of the insured individual identified in FL 58.
FL 67	Principle Diagnosis Code Enter the ICD-10-CM code for the principal diagnosis appearing in FL 76. Codes prefixed in 'E' or 'M' are not accepted by the Department. A limited number of 'V' codes are accepted.
FL 68 through 75	Other Diagnosis Codes Enter the ICD-10-CM diagnosis codes corresponding to additional conditions that co-exist at the time of service and which have an effect on the treatment received. Codes prefixed in 'E' or 'M' are not accepted by the Department. A limited number of 'V' codes are accepted.
FL 76	Admitting Diagnosis Enter the ICD-10-CM diagnosis code provided at the time of admission as stated by the physician when billing for an inpatient hospital visit.
FL 80	Principle Procedure Code and Date Enter the ICD-10-CM code that identifies the principal procedure performed as part of RHC services and the date on which the

	procedure described on the bill was performed. Enter date in MM/DD/YY format.
FL 81 A through E	Other Procedure Codes and Dates Enter the appropriate ICD-10-CM code(s) identifying the procedure(s), other than the principal procedure, and the date(s) (identified by code) on which the procedure(s) were performed.
FL 82	Attending Physician ID Enter the name or number assigned by Medicaid (or the state license) to the practitioner attending the patient.
FL 83	Other Physician ID Enter online A the name or the number assigned by Medicaid (or the state license number) for the physician who performed the principal procedure if different from the attending physician identified in FL 82
FL 85	Provider Representative Signature An authorized signature is required.
FL 86	Date Bill Submitted Enter the date on which the bill is submitted to Medicaid for reimbursement using MM/DD/YY format

NOTE: The medical/health record number is typically used in auditing the history of treatment and can expedite the processing of claims when medical records are required. It should not be submitted for the Patient Control Number (FL #) that is assigned by the provider to facilitate retrieval of the individual financial record.

NOTE: Lines A, B, and C are used for FL 50 through 66 to indicate primary (A), secondary (B) and tertiary (C) payers. For example: If Medicaid is the primary payer listed online A of FL50, Medicaid information must be listed online A through FL 66

Appendix I
Procedure Codes Reimbursable at FQHC and RHC PPS Rate

Evaluation and Management Services	
Office or Other Outpatient Services	99202 - 99205
New Patient	99211 - 99215
Established Patient	99242 – 99245
Consultation	99252 – 99255
Hospital Observation or Inpatient Care Services (Including Admission and Discharge Services)	99234 - 99236
Hospital Inpatient Services	
Initial Hospital Care	99221 - 99223
Subsequent Observation Care	99224 - 99226
Subsequent Hospital Care	99231 - 99233
Hospital Discharge Services	99238- 99239
Emergency Department Services	
New or Established patient	99281 - 99285
Critical Care Services	
Adult (over 24 months of age)	99291 - 99292
Pediatric	99471 - 99473
Neonatal	99468 - 99469
Nursing Facility Services	
Initial Nursing Facility Care	99304 - 99306
Subsequent Nursing Facility Care	99307 - 99310
Other Nursing Facility Services	99315, 99316, 99318
Home Services	
New Patient	99341 - 99345
Established Patient	99347 - 99350
Preventive Medicine Services (Adult & EPSDT/Health Check Preventive Health Visits)	For preventive services for members ages 21 years and older, you must bill place of service 50 (FQHC) or 72 (RHC).
New Patient	99385 - 99387
Established Patient	99395 - 99397
	For preventive services for members under 21 years of age, you must bill place of service 99 (EPSDT/Health Check). For additional billing guidance, please refer to the current EPSDT (Health Check) Manual Tables A and B for billing guidance.

New Patient	99381 - 99385
Established Patient	99391 - 99396
Newborn Care	99460 - 99465
Antepartum and Postpartum Care	
Antepartum Care	59425 - 59426
Postpartum Care	59430
Services of Clinical Psychologists and Licensed Clinical Social Workers	
Central Nervous System Assessment/Test	96101, 96102
Psychiatric Diagnostic or Evaluative Interview Procedures	90791, 90792, 90832
Psychiatric Therapeutic Procedures	90832, 90834, 90837 90846, 90853
Office or Other Outpatient Services	
New Patient	99202 - 99205
Established Patient	99211 - 99215
Certified Peer Specialists	
Self-Help/Peer Services	H0038
Dental Services (One encounter per member per day)	
Procedure Codes Listed in Dental Manual Appendix B and B-1,	
Except the following "incident to" procedures	
D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330, D9610, D9630	
Vision Care Services (One encounter per member per day	
Ophthalmological Services	92002, 92004, 92012, 92014, 92227, 92228, 92250
Office or Other Outpatient Services	
New Patient	99202 - 99205
Established Patient	99211 - 99215
Podiatry Services	
Office or Other Outpatient Services	
New Patient	99202 - 99205
Established Patient	99211 - 99215
Pregnancy –Related Services	99342, 99347, 99348
Perinatal Case Management	T2022

Note: Clinical social workers rendering service within the clinic must use modifier “AJ “with the valid appropriate encounter code that falls in the range of 99202– 99215 in item 24D on the CMS-1500 claim form.

Appendix J
Georgia Health Partnership (GHP)

Gainwell Technology Services
Provider and Member Services
P.O. Box 105200
Tucker, GA 30085-5200

Electronic Data Interchange (EDI)
877-261-8785

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

Provider Inquiry Numbers:
800-766-4456
The web contact address is
http://www.mmis.georgia.gov

Appendix K
Change in Scope of Services

A. Change in Scope of Service is defined in accordance with Section 1000 of this manual and generally represent the following:

i. The addition or deletion of a new category of service as defined in Section 901 and 904 of this Manual; or

ii. The department has granted a request filed by an FQHC that a service has changed in scope as described in Section 1001.2 of this Manual.

iii. "Increase or decrease in the scope of services" means the addition or deletion of a category of service or the department has granted a request filed by an FQHC that a service has changed in scope as specified in Section 1001.2 of this Manual.

B. A change in scope of service may include but is not limited to the following:

i. The addition of a service that has been mandated by a governmental entity such as the centers for Medicare and Medicaid services (CMS) in federal statute, rules, or policies enacted or amended after April 1, 2002.

ii. The addition of an obstetrical-gynecological physician or nurse mid-wife or other advanced practice nurse with a certification in obstetrical-gynecological services to an FQHC site that did not previously offer obstetrical services.

iii. The addition of a physician to a site that only offered nurse practitioner services previously.

iv. An increase in the intensity of services provided.

C. The following situations are not considered a change in scope of services:

i. Wage increases.

ii. Negotiated union contracts;

iii. Renovations or other capital expenditures;

iv. The addition of a disease management program;

v. An increase in the number of staff working in the clinic such as the addition of:

1. A lower-level staff member such a family nurse practitioner when a site employs a family physician;

2. A hygienist when a dentist is employed at the site;

3. A physical therapy assistant when the site employs a physical therapist; and

4. Social service staff;

vi. An increase in office space that is not directly associated with an approved change in scope of service, e.g., the addition of an obstetrical-gynecological physician;

vii. An increase in equipment or supplies that is not directly associated with an approved change in scope of service, e.g., the addition of an obstetrical-gynecological physician;

viii. An increase in patient volume; and

ix. An increase in office hours.

D. An FQHC's request for a rate increases due to a change in scope of service will be granted at the sole discretion of the department. The calculated PPS rate for the service that changed in scope must increase by at least twice the MEI for that year before the department will grant the request for a change in scope of service.

E. A request for review of a change in scope of service must be filed no later than ninety days after the close of one year of operation of the service that has changed in scope.

F. A rate adjustment due to a change in scope shall be granted only once for a particular circumstance for a particular FQHC.

G. A request for rate review due to a change in scope of service must be filed in accordance with the following procedures:

i. The request for review of a change in scope of service must be in writing.

ii. The request for a rate review must indicate that it is due to a change in scope of service.

iii. The request for a rate review must provide a detailed explanation and evidence to prove why a rate adjustment is warranted. The FQHC should demonstrate that by providing either:

1. A community needs assessment shows that population demographic changes warrant the change in scope of service; or

2. A business plan or other similar documentation indicates that the new service is warranted; and

3. Efforts were made to address the problem outside of the rate review process.

iv. If the request is due to a change in the intensity of services provided, the FQHC must provide evidence that the intensity of services has changed and that the increased costs are directly related to the change in intensity of service. This evidence might include a report showing that patients' diagnoses have changed the acuity of care or a report proving that the relative values of the services provided has changed.

H. The department shall respond in writing within sixty days of receiving each written request for a change in scope of service. If the department requests additional information to determine if the rate request is warranted, the department shall respond in writing within sixty days of receiving the additional information.

I. If a request for a rate adjustment due to a change in scope of service is granted, the following provisions will apply:

i. The department will review the FQHC's costs for the service that has changed in scope and will set a rate based on the reasonable cost parameters in Section 1000 of this Manual.

ii. The rate increase shall be the difference between the new rate calculated for the service that has changed in scope minus the rate previously calculated for the prior year for that category of service. The rate increase amount shall be added to the current year's PPS rate for that specific category of service for the FQHC.

iii. The rate adjustment shall be effective on the first day of the first full month after the department has granted the request. Retroactive adjustments will not be made.

iv. The department's decision at the conclusion of the rate review process shall be considered final.

v. A FQHC must notify the department in writing within ninety days of any permanent decrease in a scope of service.

Appendix L
Health Check Codes Separately Billable at Ffs Rate

Inter-periodic Vision Only and Hearing Only Procedure Codes Listed in Health Check Manual Appendix C are not separately reimbursable without an encounter visit.

Immunization and Tuberculin Skin Test Procedure Codes Listed in Health Check Manual Appendix Care Separately Reimbursable with a Health Check encounter visit.

Lead screening codes listed in Health Check Manual Appendix C must be billed separately when Blood Lead screening performed.

Office visit billed with CPT 99202 - 99205 and 99211 - 99215 should be billed with Modifiers EP and 25 and place of service 50 (FQHC) or 72 (RHC) when performed during the same encounter as a Preventive Health check visit.

Developmental screenings are separately reimbursable at the 9-, 18-, and 30-months visits when performed during the same encounter as the EPSDT (Health Check) preventive health visit. Bill the developmental screening with CPT 96110 with EP modifier and place of service 50 (FQHC) or 72 (RHC). Catch-up developmental screenings are billed with the EP and HA modifiers. For further billing guidance, refer to EPSDT (Health Check) Manual.

Appendix M
Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

A. Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

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

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

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

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

Appendix N
Provider Preventable Conditions, Never Events, And Hospital Acquired Conditions

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

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

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

Claims will be subject to retrospective review in accordance to CMS' directive and the State Plan Amendment, Appendix 4.19. When a claim's review indicates an increase of payment to the provider for an identified PPC, HAC, or NE, the amount for the event or provider preventable condition will be excluded from the provider's total payment.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

Appendix O
PeachCare for Kids Co-Payments

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

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

Cost-Based Co-Payment Schedule	
Cost of Service	
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

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