

PART II

**POLICIES
AND
PROCEDURES
FOR
FEDERALLY QUALIFIED
HEALTH CENTER SERVICES**



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAL ASSISTANCE

Published: October 1, 2010

**PART II – POLICIES AND PROCEDURES
FOR
FEDERALLY QUALIFIED HEALTH CENTER SERVICES**

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NOTE: Various sections of this Table of Contents were expanded to allow for quick and easier look-up an access to information contained in this manual.

PART II - CHAPTER 600

SPECIAL CONDITIONS OF PARTICIPATION

- 601.** In addition to the general conditions of participation identified in Part I, Section 106, of the Policies and Procedures Medicaid/PeachCare for Kids manual, providers in the Federally Qualified Health Center Services (FQHC) Program must meet the following special conditions:

601.1 FQHC Provider Status

An FQHC provider must be a non-profit organization that meets the criteria defined for provider eligibility in Chapter 700. All FQHC services provided by qualified individuals employed by or under contract with an FQHC are billed using the organization's provider number (e.g. FQHC's NPI, FQHC's Medicaid ID number for each location) and Tax Identification Number (TIN). At the time of enrollment, the FQHC must submit to the Department the names and provider numbers of all physicians and other practitioners who are center-based. Any changes in provider status must be reported to the Provider Enrollment Unit immediately.

601.2 FQHC Reimbursable Services

The FQHC agrees to provide those primary care services typically included as part of a physician's medical practice. In addition, an FQHC can provide services related to the diagnosis and treatment of mental illness, and, in certain instances, visiting nurse services.

Services and supplies that are furnished by FQHC staff and incident to an FQHC professional service are also considered part of the FQHC service. These FQHC reimbursable services are referred to as core services. Refer to Chapter 900 of this manual for further discussion.

601.3 Provider Staff Requirements

The FQHC agrees that primary care services are to be provided by licensed physicians, licensed physician assistants, nurse practitioners, or nurse-midwives operating under the direct supervision of an FQHC physician and within the scope of the physician extender's licensure or certification and in accordance with the current approved written protocol. The center shall furnish such protocol to the Department, its authorized representatives or contractual agents upon request.

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Direct supervision does not mean that the physician must be in the same room when services are rendered; however, the physician must be

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immediately available (at the least by telephone) to provide direction or assistance when necessary.

Services of licensed clinical psychologists and clinical social workers are not required, but can be considered an FQHC service when these personnel provide diagnosis and treatment of mental illness.

Visiting nurse services must meet licensure requirements, but can only be provided as an FQHC service in areas where there is a shortage of home health agencies (Refer to Section 903.8 of this manual for further discussion).

The FQHC agrees to provide the Provider Enrollment unit a list of all the practitioners providing medical services at the center with their NPI and individual assigned Medicaid provider number if they are enrolled in the Medicaid program. Furthermore, the FQHC must submit all enrollments of any practitioners in any Medicaid category of service other than the FQHC program to the Provider Enrollment unit.

The FQHC also agrees to notify the Provider Enrollment unit of any changes in the above and to keep these lists current in order to avoid loss of reimbursement for services provided by practitioners not identified as FQHC staff.

601.4 **Billing for FQHC Services**

The FQHC agrees to bill the Department its usual and customary charge for each FQHC related service using applicable diagnoses and procedure codes. FQHC services must be billed using the FQHC's NPI and Medicaid provider number assigned to the specific FQHC location and Tax Identification Number (TIN) of the specific FQHC location where the services was provided and/or the rendering provider is based.

“Usual and customary” is defined as the fee charged to private paying patients for the same procedure during the same period of time. Records on both Medicaid eligible and private paying patients must be maintained for a minimum of five (5) years in order to verify compliance with this policy. The FQHC shall also furnish the Department, its authorized representative or contractual agents, with all information that may be requested regarding “usual and customary” fees.

Further, the FQHC agrees to ensure that no staff or contract provider will seek separate reimbursement from the Department for specific services billable under the FQHC program. The FQHC also agrees that laboratory, pathology, radiological, and other services ordered by the FQHC staff, but provided by an organization independent of the FQHC must be billed by the provider of the service and not the FQHC. (See Chapter 1000 of this manual).

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601.5 FQHC Reimbursement Rates

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Regardless of the level of service rendered, the FQHC agrees to accept an all-inclusive PPS rate for each primary medical care per visit with a procedure code listed in Appendix H. The PPS rate was established based on the methodology explained in Chapter 1000 of this manual.

Refer to 601.6 below

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601.6 Other Ambulatory Services Provided by an FQHC

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FQHC's rendering providers who provide additional services that are outside the definition of an FQHC core service, agree that they will obtain separate provider numbers for each category of service that is reimbursable by the Department, and will bill under the specific program for such services when warranted.

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FQHC agrees to accept the all-inclusive PPS rate per visit for the procedure codes listed in Appendix H of such other ambulatory services.

601.7 FQHC Cost Reports

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

PART II - CHAPTER 700

SPECIAL ELIGIBILITY CONDITIONS

701. **Provider Eligibility**

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 non-profit 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.

702. **Member Eligibility**

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

PART II - CHAPTER 800

PRIOR APPROVAL--PRECERTIFICATION

Rev 01/09 801. **Core Services Requirement**

There are no prior approval requirements for core services described in Section 901 of this manual. However, clinics should contact the GHP Inquiry line prior to providing services which may not fall within the scope of primary care or for which reimbursement is unsure. GHP may be called at 1-800-766-4456.

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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 Chapter 400. In such instances, prior notice and justification shall be served.

802. **Instances Requiring Prior Approval or Preadmission Certification**

As a condition of reimbursement, the Department requires that certain services be approved prior to the time they are rendered. Prior approval from the Department pertains to medical necessity only; the patient must be Medicaid-eligible at the time the service is rendered. If the service is to be performed in an inpatient hospital setting, 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.

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 Chapter 400. In such instances, the Department will serve the provider with written notice of this requirement and the grounds for such action.

PART II - CHAPTER 900

SCOPE OF SERVICES

901. FQHC Services

FQHC services are those primary care services provided to patients by providers who are eligible for FQHC provider status as defined earlier in Chapter 700 of this manual. These services are of the type normally provided as part of a primary care physician's practice and include physician services, services provided by physician assistants, nurse practitioners and nurse-midwives. In addition, FQHC services include those provided by clinical psychologists and clinical social workers. In areas where there is a shortage of home health agencies, FQHC services may also include those services provided to a homebound Medicaid patient by a visiting nurse on a part-time or intermittent basis.

The FQHC must provide, either directly or by referral, a full range of these primary diagnostic and therapeutic services and supplies mentioned above which include, but are not limited to:

1. Medical history, physical examination, assessment of health status and treatment of a variety of conditions amenable to medical management on an ambulatory basis by a physician or a physician extender.
2. Evaluation and Diagnostic services:
 - a. Radiological Services
 - b. Laboratory and Pathology Services
3. Services and supplies incident to a physician or a physician extender services:
 - a. Pharmaceuticals
 - b. Supplies
4. Visiting nurse services under the criteria described in Section 903.8 of this manual.

901.1 FQHC Core Services

FQHC Core services include those services described above in Section 901 and those services and supplies incident to these services per Section 901.2 below.

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For reimbursement purposes, a service visit must be provided in order for a provider to be paid a PPS rate. A visit occurs when one of the

procedure codes listed in Appendix H is billed on a claim. A FQHC visit is defined in Appendix C.

Payments specified as the PPS rates are all inclusive of professional, technical and facility charges including evaluation and management, routing surgical and therapeutic procedures and diagnostic testing (including laboratory, pathology and radiology) capable of being performed on site at the FQHC and billed by the facilities' provider ID and TIN.

- a. Laboratory, pathology, radiology and medications administered are not separately reimbursable. To the extent that the provider has the capabilities to provide these services and historically provided these services, the FQHC shall continue to provide such services.
- b. The bundling of therapeutic and diagnostic testing services in the PPS rate is not meant to imply that the FQHC shall vend or refer out such ancillary services to other providers merely for the purpose of maximizing reimbursement.
- c. Health Check visits are reimbursable at the PPS rate only to those FQHCs and their practitioners who are enrolled as Health Check Screening providers. Abnormal Health Check Visits may be paid as a second PPS rate on the same member for the same date of service.

Services listed in Appendix K are separately reimbursed according to a fee schedule or Vaccine for Children applicable rules.

901.2 Services and Supplies Incident to a Service Visit

Services and supplies incident to a service visit include those services commonly furnished in a physician's office and ordinarily rendered without charge or are included in the practice's bill, such as laboratory/pathology services, radiology services, ordinary medications, supplies used in a patient service visit. Services provided incident to a service visit must be furnished by an employee and must be furnished under the direct supervision of an FQHC health care practitioner, meaning the health care practitioner must be immediately available when necessary even by telephone.

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The reasonable costs associated with these services were reported on the FQHC cost report and were considered as part of the FQHC PPS baseline rate calculation. (Refer to Chapter 1000 for more information).

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901.3 **Locations Where FQHC Services Can Be Provided**

FQHC core services can be provided at the, center, a hospital (either inpatient or outpatient setting) at the patient's place of residence (including nursing homes), or other medical facility—refer to Section 906 for details. All care provided at these locations by staff employed by an FQHC are considered FQHC Core services and are all reimbursed on an all-inclusive PPS reimbursement rate per visit based on the PPS rate assigned to the specific center. Refer to Chapter 1000 for more details. An FQHC visit is defined in Appendix C.

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901.4 **Other Ambulatory Services**

In addition to “core” services, an FQHC may provide other ambulatory services as defined in Section 904 of this manual. These services are billed separately by category of service and certain procedure codes of these services listed in Appendix H are reimbursable at all inclusive PPS rate per visit.

The reasonable costs associated with these services were reported on the FQHC cost report and were considered as part of the FQHC PPS baseline rate calculation—refer to Chapter 1000 for more information.

902. **Coding of Claims**

The claim form required by the Department for billing FQHC services is the CMS 1500 form. Refer to Appendix G for billing instructions and claim form.

Provider coding of both diagnosis and procedures is required for all claims. The coding schemes acceptable by the Department are the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9 CM) for diagnosis and the Current Procedural Terminology (CPT) coding manual for procedures. Copies of the CPT and ICD-9 CM code books are available for purchase from the following organization:

American Medical Association
Order Department
P.O. Box 7046
Dover, DE 19903-7046
Ph: 1 (800) 621-8335

Certain codes from these coding schemes are not accepted by the Department and certain modifications to the CPT coding scheme have been made. These are discussed in the following sections.

902.1 ICD-9-CM

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Codes deleted from previous editions of the ICD-9-CM are not accepted by the Department. The special categories of codes that begin with alphabetic characters “E” (E8000-E9999) and “M” (M8000-M9970/1) are not accepted by the Department for billing services rendered in the FQHC. The remaining special category of codes which begin with “V” are acceptable only if the “V” code describes the primary diagnosis and indicates suspected or proven conditions which warrant medically necessary services. In coding the diagnosis on the claim, the code must be placed on the claim form using the identical format (excluding the decimal point) as shown in the ICD-9-CM (e.g., 402; 4020; 40200).

902.2 CPT

The FQHC must select the procedure code(s) that best describes the procedure(s) performed. The following instructions apply to all claims for center services:

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- a. Codes deleted from previous editions of the CPT are not reimbursable and should not be submitted.
- b. Codes for “Unlisted Procedures” which end in “99” are not accepted by the Department and should not be submitted.
- c. CPT modifiers for clarifying circumstances are not accepted by the Department for billing services rendered in the FQHC. The appropriate “Place of Service” codes are located on the back of the CMS 1500 claim form and must be used in lieu of the modifiers. The place of service code for services provided at the center is 50.
- d. Annual updates to the CPT are effective as soon as possible after the month of publication. This applies to deletions, additions, and/or revisions. Centers will be notified on their Remittance Advices as to the effective date of these changes. It is the center’s responsibility to maintain an up-to-date CPT publication.
- e. When billing CPT or HCPC codes, the FQHC should bill the appropriate Place of Service Code on the billing Form.

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903. **Special Instructions**

All core services described in Section 901 which are rendered by a Federally Qualified Health Center under this program must be performed in conjunction with a center visit as described in Appendix C. Several services require special coding or other instructions described below:

903.1 **Family Planning Services**

Centers that provide family planning services must enter “FP” in item 24H on the CMS-1500 claim form. The Center must also enter the appropriate diagnostic code indicating family planning in block 24E on the claim form. Examples of outpatient family planning procedures are examination, IUD insertion and removal, diaphragm fitting, tubal ligation, birth control pills, artificial insemination, norplant, and provision of other contraceptive aides. The CPT procedure codes for family planning visits fall within the range of 99201-99215.

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903.2 **Injectable Drugs and Immunizations**

Procedure codes and descriptions for injectable drugs (other than allergy injections and immunizations) are listed in the Department’s Physicians’ Injectable Drug List, which may be obtained from the Department’s fiscal agent. The codes for injectable drugs are identified with a “J” or “X” prefix and must be used in lieu of CPT codes. Allergy injections and immunizations must be coded from the CPT. Beginning October 1, 2007 the National Drug Code (NDC) number is required along with the injectable drug code on the claim.

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Please refer to the Health Check Manual for billing instructions related to health check codes and modifiers.

903.3 **Laboratory Services**

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Laboratory procedures are defined and listed in the CPT and fall within the procedure code of 80002 through 89399. Laboratory services, furnished by FQHC staff, are not separately reimbursable but must be listed on the claim form in conjunction with an FQHC visit.

Centers referring members to laboratory facilities independent of the center may not bill the Department for such services. Laboratory services completed independent of the center must be billed by the laboratory facility that completes them.

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Centers collecting specimens and forwarding them to an independent or public health laboratory may not bill for the collection and handling, nor can centers bill for the test procedure. Laboratory services are not separately reimbursable. However they must be listed on the claim form whenever performed and must always be in conjunction with an FQHC visit.

With the appropriate CLIA certification, the center must provide to all FQHC members any laboratory procedure that falls within the above procedure code range that the FQHC is capable of providing and which is available at the center to its private paying patients.

There are six of the above wide ranges of laboratory services that are mandatory for FQHC provider status. They are essential to immediate diagnosis and treatment and are as follows:

1. chemical examination of urine, by stick or tablet method or both (including urine ketones);
2. hemoglobin or hematocrit;
3. blood sugar;
4. examination of stool specimens for occult blood;
5. pregnancy tests; and
6. primary culturing for transmittal to a certified laboratory.

Laboratory procedures required to be sent to the State laboratories are not separately reimbursable and must be performed by the State laboratory.

903.4 **Obstetrical Services**

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Federally Qualified Health Centers may be reimbursed for antepartum and postpartum services if and when these services are available at the center. The appropriate CPT codes must be used on the claim form if antepartum and postpartum care services are provided by the FQHC, for which they will be reimbursed at the PPS rate for the FQHC per visit—refer to Appendix H for valid CPT codes.

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The delivery, however, is not considered an FQHC Core service. The physician or nurse-midwife managing and providing the delivery service must bill the Department directly for that service only using his/her individual provider number and the FQHC TIN. The FQHC will be reimbursed at the Fee for Service rate for the applicable delivery only CPT code. Global OB codes should not be billed by the FQHC.

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It is strongly suggested by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) that all pregnant women receive HIV education and counseling as part of their regular prenatal care. HIV testing of consenting pregnant women is also recommended in light of the availability of treatment that significantly reduce HIV transmission from mother to infant, and protects the health of the newborn.

The Centers for Disease Control (CDC) has further stated that knowledge of HIV infection during pregnancy can permit treatment before the onset of opportunistic infections and disease progression, as well as early identification and treatment of HIV-exposed infants.

903.5 Radiology Services

Radiology procedures are defined and listed in the CPT and fall within the range of 70010-79900. Radiology services furnished by the center's staff are not separately reimbursable but must be listed on the claim form whenever performed and must always be in conjunction with an FQHC visit.

Centers referring members to radiology facilities independent of the clinic cannot bill the Department for such services. Radiology services completed independent of the center must be billed by the radiology facility that completes them.

903.6 Newborn Eligibility

All FQHC services provided to newborns must be billed separately from services provided to the newborn's mother and must be billed under the newborn's Medicaid number.

903.7 Pediatric Preventive Health Screening/Newborn Metabolic Screening Procedure

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Preventive health screenings performed on eligible children after the initial newborn examination are governed by the policies and procedures specific to the Health Check Program and billing is according to the policies and procedures specific to the Health Check Program. Health Check visits are reimbursable at the PPS rate to those centers and the center's staff professionals who are enrolled as Health Check screening providers. FQHC may enroll in the Health Check Program by contacting the Department's Provider Enrollment Unit. FQHC must submit to the Provider Enrollment Unit a listing of the names and the Medicaid provider numbers of all staff practitioners that are enrolled in the Health Check Program (Category of Services 600). The FQHC must keep the listing current until the FQHC is enrolled, in order to avoid the loss of reimbursement at the PPS rate for services provided by the practitioners not identified as FQHC staff.

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The procedure codes for Health Check visits that fall within the range of 99381-99385 and 99391-99395 are reimbursable at the PPS rate for each visit. The procedure codes that are listed in Appendix K are reimbursable in accordance with the fee schedule specific to the Health Check Program.

The Georgia Newborn Screening Program under Georgia law (OCGA [31-12-6](#) & [31-12-7](#)) and Rules and Regulations ([Chapter 290-5-24](#)) requires that every live born infant have an **adequate blood test** to screen for 28 disorders. **The law requires that all babies born in Georgia be tested.**

Testing must be done prior to discharge from the hospital regardless of age of the baby or the status of feeding. If the baby is discharged before 24 hours after birth, the baby must be tested again prior to one week of age. Testing may have to be repeated if it is improperly collected, the infant is born premature or with a low birth weight or an abnormal result is found.

903.8 **Visiting Nurse Services**

The FQHC may provide visits to homebound members when the following conditions are met:

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

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903.9 **Universal Newborn Hearing Screening Services**

Effective July 1, 2000, Universal Newborn Hearing Screening services will be covered by the Department.

The American Academy of Pediatrics, The American Speech-Language-Hearing Association, The Academy of Audiology, and the American Academy of Otolaryngology, Head and Neck Surgery have recently endorsed the implementation of universal newborn hearing screenings and recommend that such screenings be performed in all birthing hospitals.

Procedure codes and description for hearing screening services are listed in the CPT and fall within the procedure code range of 92585 through 92588. Universal Hearing Screening services are not separately reimbursable, but must be listed on the claim form in conjunction with FQHC visit.

NOTE: The following are the limitations to these procedure codes:

- 92585 Automated Audiometry Brain Stem Response—2 units/year
- 92587 Evoked Otoacoustic Emissions, Limited—3 units/year

903.10 Vaccines for Children Program (VFC)

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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 Section 600 of Policies and Procedures for Health Check Services manual located on-line at www.ghp.georgia.gov or call (404) 657-5013 or 1 (800) 848-3868 for specific information. (Refer to Appendix F)

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Refer to the Health Check manual for the appropriate billing codes and modifiers related to these services.

904. Other Ambulatory Center Services

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Centers may offer additional services that are beyond the scope of FQHC core services described in Section 901 of this manual. The rendering providers of such services must seek separate and individual provider numbers from the Provider Enrollment Unit for each category of service in which they are providing other Categories of services. Examples include, but are not limited to the following programs:

- Rev 01/09
- a. Early and Periodic Screening, Diagnosis and Treatment (Exception - FQHCs should enroll in the Health Check Program COS 600)
 - b. Dental services
 - c. Vision Care services
 - d. Podiatry services
 - e. Pregnancy-Related services
 - f. Perinatal Case Management

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The above services are governed by Medicaid policies and procedures specific to each program. The policies and procedures for the Federally Qualified Health Center Services program do not apply to these “other” ambulatory services. Billing must be submitted according to the policies and procedures for each program. Service visits will be reimbursed at all-inclusive PPS rate per visit. (Refer to Appendix H for Procedures reimbursable at PPS rate)

905. Physician Services outside the Scope of Primary Care

Referral of secondary or tertiary care may occasionally be needed through the clinic after primary care has been rendered.

The Department will reimburse only one source of care, either the referred secondary or tertiary practitioner or the primary care provider enrolled as an FQHC provider. Coordination of above care between the secondary or tertiary care provider and the FQHC provider is mandatory to avoid duplicate billing and denial of reimbursement.

906. Alternate Places of Service

Federally Qualified Health Center services are reimbursable when furnished to a patient at the center, hospital, or other medical facility. The following restrictions apply to alternate place(s) of service.

a. Hospitals

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Centers may be reimbursed for services rendered in hospitals when such services are included in the procedure codes listed in Appendix H. Services may be provided on either an outpatient or inpatient basis and may be rendered by an FQHC physician or physician extender. Preadmission certification is required according to procedures outlined in Section 802 of this manual.

b. Nursing Homes

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Centers may be reimbursed for services rendered in nursing homes when such services are included in the procedure codes listed in Appendix H and are rendered by an FQHC physician, physician assistant, nurse practitioner or certified nurse-midwife. Such primary care services must be prescribed by the attending and prescribing physician managing the member's tertiary care at the nursing home. If the center staff physician is also the attending and prescribing physician at the nursing home, the member's primary care should be rendered within the scope of the physician's individual practice. Prescribed visits made by physician assistants, nurse practitioners, and nurse midwives are not reimbursable for nursing home services.

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c. Other Clinics

There are no primary care delivery restrictions on the provision of services at a center other than those of the managing center facility if the member and managing facility agree to the services for reasons of their own.

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d. Residential

Centers may be reimbursed for services rendered in a patient's homes when such services are included in the procedure codes listed in Appendix H and are rendered by an FQHC physician, physician assistant, nurse practitioner or certified nurse-midwife, who are compensated under agreement by the center for providing services to center patients in a location other than at the center's facility.

Visits to homebound members by Visiting Nurse are reimbursable when rendered in accordance with Section 903.8 of this manual.

907. Non-Covered Services

The services or procedures listed below are non-covered FQHC services. This list is indicative of non-covered services and is not meant to be exhaustive.

- a. Services that are prohibited by law or Departmental policy
- b. All procedure codes listed in the CPT as "unlisted procedures" which end in "99"
- c. Services or procedures that are not performed in compliance with policies contained in this Manual
- d. Services normally provided free-of-charge to patients
- e. Center visits for photographs
- f. Medcosonolator or medotherm
- g. Experimental procedures
- h. Services that are not medically necessary
- i. Laboratory, pathology or radiology services which are not performed in conjunction with a center visit
- j. Substance Abuse Center Services
- k. Vaccines, for members younger than nineteen years of age that are available through the VFC program.

PART II - CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001. Reimbursement Methodology

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1001.1 Federally Qualified Health Center Services

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 H at a PPS per encounter visit. Each FQHC’s per visit rate is based on its reasonable cost of providing Medicaid-covered services including other ambulatory services cost during FY 1999 and FY 2000. This baseline rate, effective January 1, 2001, is utilized as the basis for determining rates in succeeding years. Annually, each FQHC’s per visit rate is calculated by adjusting the prior year’s rate by the Medical Economic Index (MEI).

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

Rev 01/09

1001.2 Changes in Scope of Services

A change in scope of services for an FQHC is defined as a change in the type, intensity, duration and/or amount of services. It is the center’s responsibility to recognize any changes in their scope of services and, to notify the Department of these changes and to provide the department with documentation and projections of the cost and volume impact of the change. (Refer to Appendix J)

Rev 01/09

1001.3 FQHC contracting with Care Management Organizations (CMO)

When an FQHC provides services listed in Appendix H pursuant to a contract between the center and a managed care entity Care Management Organization (as defined in Social Security Act section 1932(a) (1) (B)), the State shall perform a reconciliation at least annually, or more often 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 CMO on an aggregate annual base. Any such supplemental payments shall be made pursuant to a payment schedule of four months or more agreed to by the State and the clinic.

1001.4 **Cost Reports**

Rev 07/04

Rev Rev 01/09

The Benefits Improvement and Protection Act (BIPA) of 2000 eliminated the requirement for the submission of annual cost reports. 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.

1001.5 **Members with Medicaid Only**

Rev 01/09

The appropriate claim form for reimbursement of FQHC Services provided to patients covered only by Medicaid is the CMS-1500. Centers should complete this form and forward it to the Department's fiscal agent after each date of treatment. Detailed instructions for completion of the CMS-1500 are contained in Appendix G of this manual.

1001.6 **Members with Medicaid/Medicare**

Rev 01/09

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. Additional information may be found in the Appendix G of this manual.

APPENDIX A

MEDICAL ASSISTANCE ELIGIBILITY CERTIFICATION

Medicaid & PeachCare for Kids Member Identification Card Sample

Rev 01/2007

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

Rev 07/05

Rev 01/07

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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

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

Plan: Georgia Better Health Care
After Hours: (123) 123-1234 X1234

Verify eligibility at www.gdhp.georgia.gov

300 OERSTED

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

Payor: For Non-Managed Care Members
Customer Service: 404-298-1228 (Local) or 1-800-766-4456 (Toll Free)

ACS, Inc.	SXC, Inc.	Mail Paper Claims to:
Member: Box 3000	Rx BIN-001553	SXC Health Solutions, Inc.
Provider: Box 5000	Rx PCN-GAM	P.O. Box 3214
Prior Authorization: Box 7000	SXC Rx Prior Auth	Lisle, IL 60532-8214
McRae, GA 31055	1-866-525-5827	Rx Provider Help Line
		1-866-525-5826

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

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

APPENDIX B

STATEMENT OF PARTICIPATION

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

Written request for copies should be forwarded to:

**GA HEALTH PARTNERSHIP (GHP)
Provider Enrollment Unit
P. O. Box 4000
McRae, GA 30155-4000**

OR

Phone your request to:

1 (800) 766-4456

APPENDIX C

EXPLANATION OF FQHC VISITS

Definition of an FQHC Visit PPS rate Encounter

Rev 01/09

An FQHC 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. In order for the FQHC 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.

Counting FQHC Visits

Rev 01/09

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 subsequent to the initial visit, or receives separate treatment for an abnormality or a preexisting problem in conjunction with a Health Check screening, another visit may be billed. In addition, separate FQHC 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.

Examples

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.

- Rev 01/09 Example 5: An 8-year-old boy is seen in the center for a HealthCheck Screening. During the screening the practitioner determines the boy has an abnormality or a preexisting problem requiring treatment. Per wording in the CPT manual, if the problem is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate E/M code can also be billed. Both the HealthCheck screening code and the E/M code will be paid the FQHC per visit rate.
- Rev 01/09 Example 6: 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.
- Rev 01/09 Example 7: A patient is admitted to the hospital and the physician provides hospital care to the member during the period of hospitalization. The FQHC 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 D

GEORGIA BETTER HEALTH CARE PROGRAM OVERVIEW

The Program

Georgia Better Health Care (GBHC) is the Primary Care Case Management (PCCM) program for the State of Georgia. The objectives of this program are to improve access to medical care - particularly primary care services, enhance continuity of care through creation of a “medical home”, and decrease cost through reduction of unnecessary medical services. Georgia Better Health Care operates as a statewide program under a managed care amendment to the state plan, replacing the 1915(b) waiver program, approved by the Centers for Medicare and Medicaid Services (CMS).

Primary Care Providers (PCPs)

Unique to Georgia Better Health Care is a process that matches Medicaid members to a Primary Care Provider (PCP). Through an on-going provider/patient relationship, the PCP provides and coordinates all health care services, including referrals for necessary specialty services, and maintains 24-hour availability to members. The primary care provider either provides directly or coordinates the delivery of covered health care services. These services may include general medical care, specialty care, dental and Health Check services for children, or hospitalizations.

Physician participation in GBHC is open to general practitioners, family practitioners, pediatricians, general internists and gynecologists. Nurse practitioners who specialize in family practice, pediatrics or gynecology are also eligible to enroll as PCPs. Physician Assistants may enroll to become a GBHC provider if they have a collaborative agreement with a licensed physician with hospital admitting privileges and the location of the practice must be in a “Primary Care Health Professional Shortage Area” and/or a “Medically Underserved Area/Population” as specified by the Health Resources and Services Administration. Physician specialists, public health department clinics and hospital outpatient clinics may enroll if they agree to the requirements of the PCP role described in Part II Policies and Procedures for Georgia Better Health Care Services, 602.3. Providers receive a monthly case management fee for each assigned member. Medicaid-covered services delivered by the PCP are reimbursed on a fee-for-service basis according to the regular Medicaid fee schedule.

During enrollment, members are given the opportunity to select a PCP. For those who do not make a selection, assignment is based on maintaining existing as well as historical provider/member relationships, to the extent possible. Lacking historical usage, the member is assigned based on age, sex and geographic proximity to the PCP.

GBHC Member Eligibility

Enrollment with a PCP in GBHC is mandatory for all Medicaid members with the exception of those listed in Part II, Policies and Procedures for Georgia Better Health Care, 703. GBHC members are recognized by the primary care information on their identification card that lists the provider name, address, and telephone number of the members PCP. Under plan name, Georgia Better Health Care will be listed. Member eligibility, including current PCP, should be verified

for each date of service through the GHP Web Portal, the IVR system or the Customer Interaction Center.

GBHC Referrals

A referral is a request by a PCP for a member to be evaluated and/or treated by a different physician, usually a specialist. Referrals are required when a GBHC PCP refers a member to:

- A specialist for evaluation and/or medical care
- A provider who is “covering” for the PCP during periods of absence from the PCP setting (such as week-end coverage when the PCP is not in town)
- A Health Check provider for Health Check screening

Each referral entered will result in a unique number that must be placed on the claim form. Referrals are valid for 90 days from the effective date. The effective date is either the date the referral is entered, or it may be backdated up to thirty days to accommodate for coverage situations. A quick reference guide to GBHC referrals can be found in Part II, Policies and Procedures for Georgia Better Health Care Services, Appendix R.

Medicaid prior approval and preadmission certification requirements remain applicable to services delivered to Georgia Better Health Care members, unless specifically waived.

Services Exempt from Georgia Better Health Care Referral

Referrals are not required for ancillary services, diagnostic testing, DME, home health, emergency services, Individual Education Plan (IEP) Services or hospitalizations. Additional exemptions from GBHC Referral are:

1. Services delivered by providers enrolled in the following Medicaid programs:
 - Anesthesiology Services (DMA Form 85 only)
 - Community Care Services
 - Dental Services (Excluding Oral Surgery)
 - Dialysis Services
 - Early Intervention Case Management
 - Family Planning Services
 - Health Department Services: Diagnostic, Screening & Preventive Services (DSPS)
 - Hospice Services

- Independent Care
- Independent Laboratory Service
- Non-emergency transportation & Ambulance Services
- Nursing Home, ICF/MR, Swing Bed Services
- Optometry Services (Including eye glasses)
- Pathology (Interpretation and report)
- Pharmacy services
- Podiatry services
- Pregnancy related services
- Psychology and other Mental Health services
- Targeted case management
- Therapeutic residential intervention services
- Waivered home care

2. Services exempted from GBHC referral are based on procedure code:

Hospital Emergency Department Services	
CPT Codes:	99281
	99282
	99283
	99284
	99285
Obstetrics & Family Planning	
CPT Codes:	ICD-9 Codes:
59000-59899	630-676
58300-58301	V22-V37
58600-58615	760-779
11975-11977	
X9312 (Norplant Kit)	
Psychiatric Services	
CPT Codes:	90801-90871, M0064
90842 & 90844 are <u>non-covered</u> Medicaid services	
M0064	
Foot Care Services (provided by medical doctor)	
CPT Codes:	27600-29750
Ophthalmology	
CPT Codes:	ICD-9 Codes:
92002-92499	360-379

The ordering provider will be responsible for obtaining any necessary Prior Authorizations or Preadmission Certifications. The ordering provider, if not the PCP, must have a valid referral from the PCP.

APPENDIX E

COPAYMENT

Effective with dates of service July 1, 1994, and after, a \$2.00 member copayment is required on all Federally Qualified Health Center Services (FQHC) Community Health Center Services (CHC). The \$2.00 copayment will be deducted from the center's "All-Inclusive" rate when payment is made.

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:

- Emergency services (Refer to Appendix F Hospital Manual as Educational Guideline; procedure codes range from 99281-99285)
- Family Planning services

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

The 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, Enter "FP" in item 24H on the CMS-1500 claim form.

GHP will automatically deduct the copayment amount from the provider's payment for claims processed with dates of service July 1, 1994, and after. Do not deduct the copayment from your submitted charges. The application of the copayment 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.

APPENDIX F

VACCINE FOR CHILDREN PROGRAM

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.ghp.georgia.gov, or call (404) 657-5013 or 1 (800) 848-3868.

APPENDIX G

BILLING INSTRUCTIONS AND CLAIM FORMS

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 is:

- 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.

- Medicaid/Medicare Crossover CMS-1500

Rev 04/05

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 twenty-four (24) 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.

- Billing Manual

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 providers for specific billing instructions.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)</small>										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 M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																			
CITY					STATE					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: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY/GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
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: MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY.					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____ 17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____										22. MEDICAID 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 EMG		C. _____		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER		E. DIAGNOSIS POINTNER		F. \$ CHARGES		G. DAYS OR UNITS		H. REPORT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #											
1																													
2																													
3																													
4																													
5																													
6																													
25. FEDERAL TAX I.D. NUMBER					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. BALANCE DUE \$				
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. _____									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PLACE OF SERVICE CODES

11 – Office

12 – Home

21 – Inpatient Hospital Services Unit

22 – Outpatient Hospital Services Unit

23 – Emergency Room -Hospital

24 – Ambulatory Surgical Center

25 – Birthing Center

31 – Skilled Nursing Facility

32 – Nursing Facility

33 – Custodial Care Facility

34 – Hospice

50 - Federally Qualified Health Center

51 – Inpatient Psychiatric Facility

52 – Psychiatric Facility Partial Hospitalization (Not a covered POS for Georgia Medicaid)

53 – Community Mental Health Center

54 – Intermediate Care Facility / Mentally Retarded

55 – Residential Substance Abuse Treatment

56 – Psychiatric Residential Treatment Center (Not a covered POS for Georgia Medicaid)

61 – Comprehensive Inpatient Rehabilitation Facility

62 – Comprehensive Outpatient Rehabilitation Facility

65 – End Stage Renal Disease Treatment Facility or Office

71 – State or Local Public Health Clinic

72 – Rural Health Clinic/Community Health Center

99 – Other

Rev 01/09

Completion of the Health Insurance Claim Form (CMS-1500) (Items not required by Georgia DMA are not included in these instructions)

This section provides specific instructions for completing the Health Insurance Claim Form (CMS-1500). A sample invoice is included for your reference.

- Item 1 Health Insurance Coverage
Check Medicaid box for the patient's coverage.
- Item 1a Insured's I.D. Number
Enter the Member Medicaid Number exactly as it appears on the Eligibility card.
- Item 2 Patient's Name
Enter the patient's name exactly as it appears on the Eligibility card, (last name first).
- Item 3 Patient's Date of Birth and Sex

Enter the patient's 8-digit birth date (MM/DD/CCYY) and sex.
- Item 9 Other Insured's Name
If the member has other third party coverage for these services, complete with the name of the policyholder. If no other third party coverage is involved, leave blank. Medicare is not considered third party.

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. (Refer to Chapter 300 of the Policies and Procedures Manual applicable to all providers.)

When a liable third party carrier is identified within the computer system, the services billed to Medicaid will be denied. The information necessary to bill the third party carrier will be provided as part of the Remittance Advice on the Third Party Carrier Page.
- Item 9a Other Insured's Policy or Group Number
If the member has other third party coverage for these services, enter the policy or group number.
- Item 9d Insurance Plan Name or Program Name
Enter the insurance plan name or the program name and carrier code. (*Carrier codes are located in the Third Party Insurance Carrier Listing.)
- Item 10 Was Condition Related To
Check all the appropriate boxes.

- Item 10a Employment? (Current or Previous)
Check the appropriate box.
- Item 10b Auto Accident?
Check the appropriate box.
- Item 10c Other Accident?
Check the appropriate box.
- Item 14 Date of Current Illness, Injury or Pregnancy
Enter the exact or approximate date of either the first symptom of illness; injury or accident; or last menstrual period (in the case of pregnancy).
- Item 17 Name of Referring Physician
Enter the name of the physician or other source that referred the patient. Leave blank if there is no referral.
- Item 17a ID Number of Referring Physician
Enter the referring physician UPIN (Unique Physician Identification Number) or Medicaid provider number or State license number. (If the member is a GBHC member, enter the GBHC referral number.)
- Item 18 Hospitalization Dates Related to Current Services
Enter the dates of admission and discharge from an inpatient facility in month, date, year, (MM/ DD/YY) format.
- Line 19: Reserved for Local Use

If Health Check screening is being billed, information should be included here to indicate if a referral is needed: Use indicator codes Y (yes) or N (no) as appropriate and add appropriate condition code (NU, ST, S2 and/or AV). See most recent Part II Policies and Procedures for Health Check Services Manual for more information on this Health Check (EPSDT) federally required information.
- Item 20 Outside Laboratory
Check Yes or No. Charges are not needed.
- Item 21 Diagnosis or Nature of Illness or Injury

Enter the ICD-9-CM diagnosis code related to the service billed on the line. The special categories of codes which begin with “E” and “M” are not acceptable by the Department. The remaining special categories of codes which begin with “V” are acceptable only when the code describes the primary diagnosis and indicates suspected or proven conditions which warrant medically necessary services.

When coding any diagnosis on the claim, the code must appear on the claim form using the identical format (excluding the decimal point) as shown in the ICD-9-CM book (example: 2943).

Item 22 Medicaid Resubmission TCN #
Enter the TCN (Transaction Control Number) of the previous original/denied claim you are resubmitting.

Item 23 Prior Authorization Number
Enter the twelve digit Precertification Number as required for inpatient hospital admissions and selected outpatient hospital or ambulatory surgical center services as issued by the Georgia Medical Care Foundation, if applicable.

Item 24a Dates of Service (DOS)/National Drug Code

Rev 01/09 Enter in the top shaded portion the 11-digit NDC number, preceded by the 2-digit qualifier N4. The NDC number should correspond with the CPT/HCPCS code(s) entered in Field 24d.

Enter in the bottom un-shaded portion the date on which the procedure/service occurred. Enter that date once in the box. Federally Qualified Health Centers should not bill for multiple encounters (visits) on the same claim form. The date must be entered in MM/DD/YY format (e.g., enter 03/01/02 for March 1, 2002).

Rev 01/09 Item 24b Place of Service (P.O.S.)
Enter in the bottom un-shaded portion the valid P.O.S CODE is 50.

Item 24d Procedures/ Services/ Supplies

Enter in bottom un-shaded portion the appropriate five (5) digit code from the most current edition of CPT — 4 (Current Procedural Terminology —4th Edition) without modifiers. All codes for injectable drugs must be from the DMA Physician’s Injectable Drug List.

DO NOT SUBSTITUTE OTHER CODES.

A valid encounter code must be billed for each FQHC claim submitted. A list of valid encounter codes can be found in Appendix H.

Although reimbursement is provided according to the “all inclusive rate” per encounter, all services provided must be coded on the claim.

Each service for which reimbursement is being requested must be listed on a separate line with a corresponding charge.

Item 24e Diagnosis Pointer
Enter in the bottom un-shaded portion the number “1”, “2”, “3”, “4”, as related to the corresponding ICD-9 CM diagnosis code entered in Item 21.

Item 24f Charges
Enter in the bottom un-shaded portion the product of your “usual and customary” charge for the procedure multiplied times the units of service.

Item 24g Days or Units
Enter in the bottom un-shaded portion the number of times the procedure was performed. Units billed should be evenly divisible by the number of days in Item 24a.

NOTE:

If you are billing more than one (1) unit for the same procedure code on the same date of service, please use one (1) line on the CMS-1500 and in field G list your total units. If you use more than one line, the system will consider the subsequent lines a duplicate and will deny them.

Item 24h EPSDT/Family Planning
If the services were provided as a result of a referral by the Health Check (EPSDT) Program, enter “ET”. The Health Check program is only for individuals under twenty-one years of age.

Or

If this service was for family planning purposes, enter “FP”. Please consult your Policies and Procedures manual for further information on which procedures are related to family planning.

This field is required for all Health Check/Family Planning procedures codes billed on the claim. If neither applies, leave blank.

Item 26 Patient’s Account No.
Enter the patient’s record number used internally by the clinic. If not used, leave blank.

Item 28 Total Charge
Enter the total of the charges listed for each line.

Item 29 Amount Paid
Enter the amount received from third party. If not applicable, leave blank.

Note: Do not enter Medicaid co-payments collected at the time of service into this field. Do not enter Medicare payment information in this field.

Item 30 Balance Due
Enter the submitted charge less any third party payment received.

Item 31 Signature of Physician or Supplier Including Degrees or Credentials
The provider must sign or signature stamp each claim for services rendered and enter the date.

Unsigned invoice forms cannot be accepted for processing.

Item 32 Name and Address of Facility Where Services Rendered
enter the full name, location (city) of the facility where billed services were performed.

Enter the FQHC NPI number in field 32A.

Enter the Medicaid facility Provider number assigned to the FQHC in field 32B.

Item 33 Physician's Supplier's Billing Name. Address. Zip Code and Phone #
Enter the provider's name and address. Providers must notify the GHP Provider Enrollment Unit in writing of address changes.

PIN Number:

Enter the FQHC NPI number in field 33A.

Enter the identifying Medicaid Payee Provider number assigned to the FQHC in field 33B.

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.

Mail Claims To:

**GHP
P.O. Box 5000
McRae, GA 31055**

APPENDIX H
PROCEDURE CODES REIMBURSABLE AT FQHC PPS RATE

Evaluation and Management Services:**Office or Other Outpatient Services**

New Patient	99201 - 99205
Established Patient	99211 - 99215

Hospital Observation Services

Hospital Observation Discharge Services	99217
Initial Hospital Observation Services	99218 - 99220

Hospital Observation or Inpatient Care Services

(Including Admission and Discharge Services) 99234 - 99236

Hospital Inpatient Services

Initial Hospital Care	99221 - 99223
Subsequent Hospital Care	99231 - 99233
Hospital Discharge Services	99238

Consultations

Office Consultations	99241 - 99245
Initial Inpatient Consultations	99251 - 99255

Emergency Department Services

New or Established patient	99281 - 99285
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Critical Care Services

Adult (over 24 months of age)	99291 - 99292
Pediatric	99471 - 99472
Neonatal	99468 - 99469

Nursing Facility Services

Initial Nursing Facility Care	99304 - 99306
Subsequent Nursing Facility Care	99307 - 99310
Other Nursing Facility services	99318

Home Services

New Patient	99341 - 99345
Established Patient	99347 - 99350

Preventive Medicine Services – (Health Check Visits)

Please refer to Health Check Manual Appendix C for proper billing with EP modifier, when appropriate

New Patient	99381 - 99385
Established Patient	99391 - 99395

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
90801, 90802

Psychiatric Therapeutic Procedures
90804 – 90814, 90846, 90853

Office or Other Outpatient Services

New Patient	99201 - 99205
Established Patient	99211 - 99215

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 99201– 99215 in item 24D on the CMS-1500 claim form.

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

Office or Other Outpatient Services

New Patient	99201 - 99205
Established Patient	99211 – 99215

Podiatry Services:

Office or Other Outpatient Services

New Patient	99201 - 99205
Established Patient	99211 – 99215

Pregnancy –Related Services:

99342, 99347, 99348

Perinatal Case Management:

T2022

APPENDIX I

GEORGIA HEALTH PARTNERSHIP (GHP)

Provider Correspondence

(Including claims submission)

GHP

P.O. Box 5000

McRae, GA 31055

Provider Enrollment

GHP

P.O. Box 88030

Atlanta, GA 30356

Prior Authorization &

Pre-Certification

GHP

P.O. Box 7000

McRae, GA 31055

Electronic Data Interchange (EDI)

1-800-987-6715

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

Provider Inquiry Numbers

Phone: 800-766-4456 (Toll free)

Fax: 1-866-483-1044 and 1045

Web Contact Address <http://www.ghp.georgia.gov>

APPENDIX J
(Added 01/2009)

CHANGE IN SCOPE OF SERVICES

1. Change in Scope of Service is defined in accordance with Section 1000 of this manual and generally represents the following:
 - a. The addition or deletion of a new category of service as defined in Section 901 and 904 of this Manual; or
 - b. (b) 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.
 - c. (c) “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.
2. A change in scope of service may include but is not limited to the following:
 - a. 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 January 1, 2002;
 - b. 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;
 - c. The addition of a physician to a site that only offered nurse practitioner services previously;
 - d. An increase in the intensity of services provided.
3. The following situations are not considered a change in scope of services:
 - a. Wage increases;
 - b. Negotiated union contracts;
 - c. Renovations or other capital expenditures;
 - d. The addition of a disease management program;
 - e. An increase in the number of staff working in the clinic such as the addition of:
 - i. A lower level staff member such a family nurse practitioner when a site employs a family physician;
 - ii. A hygienist when a dentist is employed at the site;
 - iii. A physical therapy assistant when the site employs a physical therapist; and
 - iv. Social service staff;
 - f. 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;
 - g. 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;
 - h. An increase in patient volume; and
 - i. An increase in office hours.

4. An FQHC's request for a rate increase 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.
5. 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.
6. A rate adjustment due to a change in scope shall be granted only once for a particular circumstance for a particular FQHC.
7. A request for rate review due to a change in scope of service must be filed in accordance with the following procedures:
 - a. The request for review of a change in scope of service must be in writing.
 - b. The request for a rate review must indicate that it is due to a change in scope of service.
 - c. 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:
 - i. A community needs assessment shows that population demographic changes warrant the change in scope of service; or
 - ii. A business plan or other similar documentation indicates that the new service is warranted; and
 - iii. Efforts were made to address the problem outside of the rate review process.
 - d. 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.
8. 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.
9. If a request for a rate adjustment due to a change in scope of service is granted, the following provisions will apply:
 - a. 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.
 - b. 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.
 - c. 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.
 - d. The department's decision at the conclusion of the rate review process shall be considered final.
 - e. An FQHC must notify the department in writing within ninety days of any permanent decrease in a scope of service.

APPENDIX K

(Added 01/2009)

Health Check Codes Separately Billable at FFS Rate

Inter-periodic Vision Only and Hearing Only Procedure Codes Listed in Health Check Manual Appendix D are separately reimbursable without an encounter visit.

Immunization and Tuberculin Skin Test Procedure Codes Listed in Health Check Manual Appendix E are separately Reimbursable with a Health Check encounter visit.

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

APPENDIX L

Non-Emergency Transportation

People enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid recipients to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?

If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m.. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, **you must contact the NET Broker serving the county you live in** to ask for non-emergency transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NET broker?

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, **call the Member CIC toll free at 866-211-0950.**

Region	Broker / Phone number	Counties served
North	Southeastans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Clarke, Cobb, Dade, Dawson, Douglas, Elbert, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Greene, Gwinnett, Habersham, Hall, Haralson, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Newton, Oglethorpe, Oconee, Paulding, Pickens, Polk, Rabun, Rockdale, Stephens, Towns, Union, Walker, Walton, White, Whitfield
Atlanta	Southeastans Local	Fulton, DeKalb

Central	Southeastrans Toll free 1-866-991-6701 Local 404-305-3535	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Crawford, Dodge, Fayette, Hancock, Heard, Henry, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Pulaski, Putnam, Spalding, Telfair, Treutlen, Troup, Twiggs, Upson, Washington, Wheeler, Wilcox, Wilkinson
East	LogistiCare Toll free 1-888-224-7988	Appling, Atkinson, Bacon, Brantley, Bryan, Burke, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Columbia, Effingham, Emanuel, Evans, Glascock, Glynn, Jeff Davis, Jefferson, Jenkins, Liberty, Lincoln, Long, McDuffie, McIntosh, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Ware, Warren, Wayne, Wilkes
Southwest	Southwest Georgia Regional Development Center Toll free	Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner,