

PART II

**POLICIES
AND
PROCEDURES
FOR
RURAL HEALTH CLINIC
SERVICES**



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAL ASSISTANCE

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**PART II – POLICIES AND PROCEDURES
FOR
RURAL HEALTH CLINIC SERVICES**

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

PART II - CHAPTER 600

SPECIAL CONDITIONS OF PARTICIPATION

- 60.1** 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 Rural Health Clinic Services must meet the following special conditions:

601.1 Rural Health Clinic (RHC) Provider Status

An RHC Provider must be a medical facility that meets the criteria defined for provider eligibility in Chapter 700. All RHC services provided by qualified individuals employed by or under contract with an RHC are billed using the facility's provider number (e.g. RHC's NPI, RHC's Medicaid ID number for each location). The clinic must also be fully certified by the Standards and Licensure Unit of the Office of Regulatory Services, Georgia Department of Human Resources, in accordance with Part I, Section 106, of the Policies and Procedures Medicaid /Peachcare for Kids manual. Satellite locations must be licensed and certified separately, and a Medicaid provider number obtained for each location involved in the provision of care. At the time of enrollment, the RHC must submit to the Department the names and provider numbers of all physicians and other practitioners who are Clinic-based. Any changes in provider status must be reported to the Provider Enrollment Unit immediately.

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601.2 RHC Reimbursable Services

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

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

601.3 Provider Staff Requirements

The RHC agrees that primary care services are to be provided by licensed physicians, or by licensed physician assistants, nurse practitioners or nurse midwives operating under the direct supervision of an RHC physician and within the scope of the physician extender's licensure or certification and in accordance with the current approved written protocol applicable to each profession. The clinic shall furnish such

protocol to the Department, its authorized representatives or contractual agents, upon request.

Direct supervision does not mean that the physician must be in the same room when services are rendered. However, the physician must be immediately available at least by telephone to provide direction or assistance when necessary.

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Services of licensed clinical psychologists and licensed clinical social workers are not required, but can be considered an RHC 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 RHC service in areas where there is a shortage of home health agencies. (See Chapter 903.8 of this manual for further discussion).

The RHC agrees to provide the Provider Enrollment Unit a list of all the practitioners providing medical services at the clinic with their individual assigned Medicaid provider number if they are enrolled in the Medicaid Program. Further, the RHC must submit all enrollment of any practitioner in any Medicaid category of service other than the RHC Program to the Provider Enrollment Unit.

The RHC 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 RHC's staff.

601.4 **Billing for RHC Services**

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

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“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 RHC shall also furnish the Department, its authorized representatives or contractual agents, with all information that may be requested regarding “usual and customary” fees.

The RHC also agrees to ensure that no staff or contract provider will seek separate reimbursement from the Department for specific services

billable under the RHC program. Further, the RHC agrees that laboratory, pathology, radiological, and other services ordered by the RHC staff but provided by an organization independent of the RHC must be billed by the provider of the service and not the RHC. (See Chapter 1000 of this manual and the Billing Manual.)

601.5 RHC Reimbursement Rates

Rev. 01/09

Regardless of the level of service rendered, the RHC agrees to accept an all-inclusive Prospective Payment System (PPS) rate per visit with a procedure code listed in Appendix G. The PPS rate was established based on the methodology explained in Chapter 1000 of this manual.

Provider-Based (Hospital-Based) RHC

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The RHC located at Critical Access Hospitals (CAH), who selected alternative payment methodology, are exempted from the requirement. (See Section 1001.4 for details)

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601.6 Other Ambulatory Services Provided by an RHC

RHC's who provide additional services that are outside the definition of an RHC 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.

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

601.7 RHC Cost Reports

Rev. 01/09

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

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SPECIAL ELIGIBILITY CONDITIONS

701. **Provider Eligibility**

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 the Census is automatically eligible for Rural Health Clinic (RHC) Provider status.

702. **Member Eligibility**

There are no special eligibility conditions which members must meet in order to receive RHC services other than those stipulated in Part I, Section 107 of the Policies and Procedures for **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 in the Rural Health Clinic Services Program. However, clinics should contact the Georgia Health Partnership (GHP) Inquiry line prior to providing services which may not fall within the scope of primary care or for which reimbursement is unsure. GHP inquiries may be called to 1-800-766-4456.

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. The Commissioner may invoke this action 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.

Rev 01/09 **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 specific 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. The Commissioner may invoke this action 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. **RHC Services**

RHC services are those primary care services provided to patients by providers who are eligible for RHC 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's assistants, nurse-midwives and nurse practitioners. In addition, RHC services include those provided by clinical psychologists, and clinical social workers. In areas where there is a shortage of home health agencies, RHC services may also include those services provided to a homebound Medicaid patient by a visiting nurse on a part-time or intermittent basis. The RHC 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 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 903.9 of this manual.

901.1 **RHC Core Services**

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

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. An RHC visit is defined in Appendix C.

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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 RHC 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 RHC 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 RHC 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 RHCs 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**

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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 RHC health care practitioner, meaning the health care practitioner must be immediately available when necessary even by telephone.

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

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901.3 **Location Where RHC Services Can Be Provided**

RHC Core Services can be provided at the Clinic, a hospital an (either in-patient or outpatient setting), at the patient's place of residence (including nursing homes), or other medical facility. (See Section 906

for details) All care provided at these locations by staff employed by an RHC are considered RHC Core services and are all reimbursed on an all-inclusive Prospective Payment System reimbursement rate per visit based on the PPS rate assigned to the specific clinic. (See Chapter 1000 for more details). An RHC visit is defined in Appendix C.

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901.4 **Other Ambulatory Services**

In addition to Core services, an RHC provider 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 G are reimbursable at all inclusive PPS rate per visit. The reasonable costs associated with these services are reported on the RHC report and are considered as part of the RHC PPS baseline rate calculation. (See Chapter 1000 for more information).

902. **Coding of Claims**

The claim forms required by the Department for billing Rural Health Clinic (Facility-Based and Free-Standing) services are the National Uniform Billing form (UB-04) and the CMS-1500 form respectively. See Appendix F of this manual for the required information to file both claim forms for RHC services.

Provider coding of both diagnosis and procedures is required for all claims. The coding schemes acceptable by the Department are the ICD-9-CM (International Classification of Diseases - 9th Edition - Clinical Modification) for diagnosis and the CPT (Current Procedural Terminology - 4th Edition) for procedures. Copies of the CPT and ICD-9-CM code books are available for purchase from the following organizations:

CPT-4 and ICD-9-CM

American Medical Association
Order Department
P. O. Box 7046
Dover, DE 19903-7046

Or call: 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

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” (E800-E999) and “M” (M800-M9970/1) are not accepted by the Department. 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 your 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 (examples: 402; 4020; 40200).

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902.2 Revenue Codes

Provider-Based (Hospital-based) rural health clinics must identify services provided using revenue code 521 as described in the Georgia Uniform Billing Manual when billing for rural health clinic services. Revenue code 522 is to be used for home visit services by a practitioner. Revenue code 527 is to be used by Visiting Nurse services to a member’s home when in a home health shortage area. Revenue code 636 for injectable drugs. Further, the clinics must use the appropriate revenue code to specify and identify any other services provided such as: pharmacy services, medical equipment. Billing instructions for Provider-Based rural clinics are presented in Appendix F of this manual.

902.3 CPT

The RHC must select the procedure code(s) that best describes the procedure(s) performed. The following instructions apply to all clinic claims:

1. Codes deleted from previous editions of the CPT are not reimbursable and should not be submitted.
2. Codes for “Unlisted Procedures” which end in “99” are not accepted by the Department and should not be submitted.
3. CPT modifiers for clarifying circumstances are not accepted by the Department for services rendered in an RHC. 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 Clinic is “72”.

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4. Annual updates to the CPT are effective as soon as possible after the month of publication. This applies to deletions, additions, and/or revisions. Clinics will be notified on their Remittance Advices as to the effective date of these changes. It is the clinic's responsibility to maintain an up-to-date CPT publication.

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5. When billing CPT or HCPC codes the RHC should bill the appropriate Place of Service Code on the billing Form.

903. **Special Instructions**

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All "core" services described in Section 901 which rendered by a rural health clinic under this program must be performed in conjunction with a visit as described in Appendix C. Several services require special coding or other instructions described below

903.1 **Family Planning Services**

Clinics, that provide family planning services, must enter "FP" in item 24H on the CMS-1500 claim form. Hospital Based Rural Health clinics must enter A4 in the condition code field on the UB- 92. Examples of outpatient family planning procedures are examination, IUD insertion and removal, diaphragm fitting, tubal ligation, birth control pills, artificial insemination, and 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 Physician's Injectable Drug List that 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 January 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**

Laboratory procedures are defined and listed in the CPT and fall within the procedure code range of 80002 through 89399. Laboratory services

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furnished by RHC staff are not separately reimbursable but must be listed on the claim form in conjunction with an RHC visit. Clinics referring members to laboratory facilities independent of the clinic may not bill the Department for such services. Laboratory services completed independent of the clinic must be billed by the laboratory facility that completes them.

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Clinics collecting specimens and forwarding them to an independent or public health laboratory may not bill for the collection and handling, nor may clinics bill for the test procedure.

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

There are six of the above wide ranges of laboratory services that are mandatory for RHC 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 (only by visual comparison method) and
6. primary culturing for transmittal to a certified laboratory.

Note: To perform gram stains, microscopic examination of urine sediments or tests for pinworm, the clinic is required to have the appropriate CLIA certification.

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

903.4 **Obstetrical Services**

Rural Health Clinics may be reimbursed for antepartum and postpartum services if and when these services are available at the clinic. The appropriate CPT codes must be used on the claim form if antepartum and postpartum care services are provided by the RHC for which they will be

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reimbursed at the PPS rate for the RHC per visit. (Refer to Appendix G of this manual for the valid CPT codes)

The delivery however, is not considered an RHC 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 RHC TIN. The RHC 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 RHC.

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 reduces 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 **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. However, Health Check visits are reimbursable at the PPS rate to those ~~rural~~ clinics and the clinic's staff professionals who are enrolled as Health Check screening providers. RHC's may enroll in the Health Check Program by contacting the Department's Provider Enrollment Unit. RHC 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 RHC must keep the listing current until the RHC is enrolled, in order to avoid the loss of reimbursement at the PPS rate for services provided by the practitioners not identified as RHC 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 law requires that newborns have screening and testing for congenital adrenal hyperplasia, galactosemia, maple syrup urine disease, homocystinuria, phenylketonuria, tyrosinemia, hypothyroidism and sickle cell hemoglobin testing.

The infant's blood for these tests shall be collected not earlier than forty-eight (48) hours after birth and no later than when the infant is one (1) week old. Cord blood may be used for hypothyroidism screening and sickle cell testing. If an infant is discharged from the hospital before forty-eight (48) hours after birth, the newborn must be retested prior to one (1) week of age.

903.6 **Newborn Eligibility**

All RHC 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 **Radiology Services**

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Radiology procedures are defined and listed in the CPT-4 and fall within the range of 70010-79900. Radiology services furnished by the clinic's staff are not separately reimbursable but must be listed on the claim form whenever performed and must always be in conjunction with an RHC visit.

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

903.8 **Vaccines for Children Program (VFC)**

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Rev. 01/04

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

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

903.9 Visiting Nurse Services

The RHC 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. The services are rendered by an RN or LPN under a written plan of care approved and reviewed every sixty (60) days by the physician supervising the RHC.

903.10 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 American 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-4 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 a RHC 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 |
| 92588 Evoked Otoacoustic Emissions, Comprehensive, 3 units/year |

904 Other Ambulatory Clinics Services

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

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1. Early and Periodic Screening, Diagnosis and Treatment (RHCs should enroll in the Health Check Program COS 600)

2. Dental Services

3. -Vision Care Services

4. Pharmaceutical Services

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5. Podiatry Services

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6. Pregnancy-Related services

7. 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 RHC Services program do not apply to these “other” ambulatory services. Billing must be submitted according to the policies and procedures for each program. The certain service visits will be reimbursed at all-inclusive PPS rate per visit. (See 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 shall reimburse only one source of care, either the referred secondary or tertiary practitioner or the primary care provider enrolled as an RHC provider. Coordination of above care between the secondary or tertiary care provider and the RHC provider is mandatory to avoid duplicate billing and denial of reimbursement.

906. **Alternate Places of Service**

Rural health clinic services are reimbursable when furnished to a patient at the clinic, hospital, other medical facility, or at the member’s home. The following restrictions apply to alternate place(s) of service.

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1. Hospitals

Clinics may be reimbursed for services rendered in hospitals when such services are included in the procedure codes listed in Appendix G. Services may be provided on either an outpatient or inpatient basis and may be rendered by a RHC physician or physician extender. Preadmission certification is required according to procedures outlined in Section 803 of this manual.

2. Nursing Homes

Clinics may be reimbursed for services rendered in nursing homes when such services are included in the procedure codes listed in Appendix G and rendered by a RHC physician. 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 clinic 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.

3. Other Clinics

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

4. Residential

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

Visits to homebound members by Visiting Nurse are reimbursable when rendered in accordance with Section 903.9 of this manual.

907. **Non-Covered Services**

The following services or procedures are non-covered RHC services. This list is indicative of non-covered services and is not meant to be exhaustive:

1. Services that are prohibited by Certification or Licensure.
2. All procedure codes listed in the CPT-4 as “unlisted procedures” which end in “99”.
3. Services and/or procedures performed without regard to the policies contained in this Policy Manual;
4. Services normally provided free of charge to patients.
5. Clinic visits for photographs.
6. Medcosonolator or medotherm.
7. Experimental procedures.
8. Services that are not medically necessary.
9. Laboratory or radiology services which are not performed in conjunction with a clinic visit.
10. Substance Abuse Clinic Services.
11. Vaccines for members less than nineteen years of age that are available through the VFC program.

PART II - CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001. Reimbursement Methodology

1001.1 **Freestanding and Hospital-Based Rural Health Clinic Services**

Rev 01/09

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 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).

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 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.

For newly qualified RHCs 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.

Clinics 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.

Rev 01/09

1001.2 **Changes in Scope of Services**

A change in scope of services for a RHC is defined as a change in the type, intensity, duration and/or amount 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. (See Appendix J)

Rev 01/09

1001.3 RHC contracting with Care Management Organizations (CMO)

When an RHC provides services listed in Appendix G 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 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 the 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.

Rev 01/09

1001.4 Alternative Payment Methodology

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.

1001.5 Cost Reports

Rev 01/09

January 1, 2001 The Benefits Improvement and Protection Act (BIPA) of 2000 eliminated the requirement for the submission of 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.

1001.6 Members with Medicaid Only

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. Detailed instructions for completion of the CMS-1500 and the UB-04 are contained in Appendix F of this manual.

1001.7 **Members with Medicaid/Medicare**

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

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

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.gdp.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:

**Georgia Health Partnership
Provider Enrollment Unit
P. O. Box 88030
Atlanta, GA 30356**

OR

Phone your request to:

1 (800) 766-4456

APPENDIX C

EXPLANATION OF RHC VISITS

Definition of a RHC Visit (PPS rate encounter)

Rev 01/09 A “RHC Visit” is defined as a face-to-face encounter between a clinic 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 RHC per visit rate to be paid as a PPS encounter, one of the CPT procedure codes listed in Appendix H must be recorded on a claim.

Counting Clinic 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 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.

Examples

Rev 01/09 Example 1: A patient visits the clinic 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 clinic 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 clinic by the physician. A non-clinic 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 clinic by a physician assistant. The patient returns to the clinic 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.

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Example 5: An 8-year-old boy is seen in the clinic for a Health Check 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 Health Check screening code and the E/M code will be paid the RHC per visit rate.

Rev 01/09 Example 6: A 17-year-old patient is seen in the clinic by a physician for the treatment of a broken arm. The patient is also seen in the clinic 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 G. 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 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 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 based on procedure code:

Hospital Emergency Department Services

| | | |
|-------------------|-------|-------|
| CPT Codes: | 99281 | 99284 |
| | 99282 | 99285 |
| | 99283 | |

Obstetrics & Family Planning

| | |
|-------------------|---------------------|
| CPT Codes: | ICD-9 Codes: |
| 59000-59899 | 630-676 |
| 58300-58301 | V22-V37 |
| 58600-58615 | 760-779 |
| 11975-11977 | S0180 Implanon |

Psychiatric Services

| | |
|-------------------|--------------------|
| CPT Codes: | 90801-90871, M0064 |
|-------------------|--------------------|

Non-covered Medicaid services
90842, 90844, 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

Rev 7/04

Effective with dates of service July 1, 1994, and after, a \$2.00 member co-payment is required on all Rural Health Clinic Services (RHC). The \$2.00 co-payment will be deducted from the center's "All-Inclusive" rate when payment is made.

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

- Pregnant women
- Members under 21 years of age
- Nursing facility residents
- Hospice care members
- Women diagnosed with breast or cervical cancer and receiving Medicaid under the Women's Health Medicaid Program, aid categories 245 and 800, only.

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

- Emergency services (See 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 co-payment.

The department may not be able to identify all members who are exempt from the co-payment. 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 and "A4" in the condition code field (FL 24) on the UB- 92 claim form.

GHP will automatically deduct the co-payment amount from the provider's payment for claims processed with dates of service July 1, 1994, and after. Do not deduct the co-payment from your submitted charges. The application of the co-payment will be identified on the remittance advice. A new explanation of benefit (EOB) code will indicate payment has been reduced due to the application of co-payment.

APPENDIX F

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 Rural 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.

- UB-04 (National Uniform Billing Form)

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

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, RHC providers should refer to the “Medicaid Secondary Claims User Guide” located online 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 F should be referred to by RHC providers for specific billing instructions.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|--|---|--|--|--|--|
| PICA <input type="checkbox"/> | | | | | | | | | | PICA <input type="checkbox"/> | | | | | | | | | |
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> SLU/LING <input type="checkbox"/> OTHER <input type="checkbox"/> | | | | | | | | | | 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 <input type="checkbox"/> F <input type="checkbox"/> | | | | | | | | | |
| 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"/> | | | | | | | | | |
| CITY | | | | | STATE | | | | | 7. INSURED'S ADDRESS (No., Street) | | | | | 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> | | | | |
| ZIP CODE | | | | | TELEPHONE (Include Area Code) () | | | | | CITY | | | | | STATE | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 10. IS PATIENT'S CONDITION RELATED TO: | | | | | | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | | | | | | a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | | | | | | b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ | | | | | | | | | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | |
| 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. | | | | | | | | | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | | | | | | | |
| SIGNED _____ DATE _____ | | | | | | | | | | a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | | | | | |
| 14. DATE OF CURRENT: MM DD YY | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | | | | | | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | | | | | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. FROM MM DD YY TO MM DD YY | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | | | | | | | | | 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____ | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | | | | | | | | | | 22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ | | | | | | | | | |
| B. PLACE OF SERVICE _____ | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER _____ | | | | | | | | | |
| C. EMG _____ | | | | | | | | | | F. \$ CHARGES _____ | | | | | | | | | |
| D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) _____ | | | | | | | | | | G. DAYS OR UNITS _____ | | | | | | | | | |
| E. DIAGNOSIS POINTER _____ | | | | | | | | | | H. ERSDT 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 <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | | 26. PATIENT'S ACCOUNT NO. _____ | | | | | | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | | | | | | | | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| SIGNED _____ DATE _____ | | | | | | | | | | 28. TOTAL CHARGE \$ _____ | | | | | | | | | |
| 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | 29. AMOUNT PAID \$ _____ | | | | | | | | | |
| a. NPI _____ | | | | | | | | | | 30. BALANCE DUE \$ _____ | | | | | | | | | |
| b. _____ | | | | | | | | | | 33. BILLING PROVIDER INFO & PH # () | | | | | | | | | |
| a. NPI _____ | | | | | | | | | | b. _____ | | | | | | | | | |

NUCC Instruction Manual available at: www.nucc.org

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

Figure 1. CMS-1500 Form

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
- 41 – Ambulance – Land
- 42 – Ambulance Air or Water
- 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

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) [12-90]. 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 member's current 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. (See 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 who 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.
- 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 Division. 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 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,

Or

Enter the Prior Authorization Number provided by the DMA, if applicable. If not, leave blank.

Rev 01/09

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

Rev 01/09 Enter in the bottom unshaded portion the date on which the procedure/service occurred. Enter that date once in the box. Rural 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).

Item 24b Place of Service (P.O.S.)
Enter in the bottom unshaded portion the valid P.O.S CODE, e.g. the clinic is 72.

Item 24d Procedures/ Services ~~or~~ Supplies
Enter in the bottom unshaded portion the appropriate five (5) digit code from the most current edition of CPT (Current Procedural Terminology –4th Edition) without modifiers. All codes for injectible drugs must be from the DMA Physician’s Injectible Drug List.

DO NOT SUBSTITUTE OTHER CODES.

A valid encounter code must be billed for each Community Health Clinic claim submitted. A list of valid encounter codes can be found in Appendix G.

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 unshaded portion the number “1”, “2”, “3”, etc as relates to the corresponding ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) diagnosis code related to the diagnosis code entered in Item 21.

Item 24f Charges
Enter in the bottom unshaded 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 unshaded 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 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.

Rev 01/09 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.

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 NPI number in field 33A.

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

NOTE:

Reimbursement for Rural Health Clinic 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. Rural Health Clinic Services are reimbursed according to the clinics assigned "all inclusive" rate. Please refer to Appendix F of this manual for clinic encounter explanation.

Mail Claims To:

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

APPROVED OMB NO. 0938-0279

| | | | | | | | | | | | | | | | | | | | | | |
|----------------------------|----------------|----------------------------|--|----------------------------|--------------------|-------------------------|----------------|-------------------------|--------|---------------------------------|---------|-----------------------|--|----------------|--------------------|------------------|--|------------------------|----|----|--|
| 1 | 2 | | 3 PATIENT CONTROL NO. | | | | 4 TYPE OF BILL | | | | | | | | | | | | | | |
| | 5 FED. TAX NO. | | 6 STATEMENT COVERS PERIOD FROM THROUGH | | 7 COV. D. | 8 N-C.D. | 9 C-I.D. | 10 L-R.D. | 11 | | | | | | | | | | | | |
| 12 PATIENT NAME | | | | | 13 PATIENT ADDRESS | | | | | | | | | | | | | | | | |
| 14 BIRTHDATE | | 15 SEX | 16 MS | 17 DATE ADMISSION | | 18 HR | | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | | | 24 CONDITION CODES | | | | 31 | | |
| 32 OCCURRENCE CODE DATE | | 33 OCCURRENCE CODE DATE | | 34 OCCURRENCE CODE DATE | | 35 OCCURRENCE CODE DATE | | 36 OCCURRENCE CODE DATE | | 37 OCCURRENCE SPAN FROM THROUGH | | 38 | | | | A | | | | | |
| a | | b | | c | | d | | e | | f | | g | | | | B | | | | | |
| b | | c | | d | | e | | f | | g | | h | | | | C | | | | | |
| 39 VALUE CODES CODE AMOUNT | | 40 VALUE CODES CODE AMOUNT | | 41 VALUE CODES CODE AMOUNT | | 42 REV. CD. | | 43 DESCRIPTION | | 44 HCPCS / RATES | | 45 SERV. DATE | | 46 SERV. UNITS | | 47 TOTAL CHARGES | | 48 NON-COVERED CHARGES | | 49 | |
| a | | b | | c | | d | | e | | f | | g | | h | | i | | j | | k | |
| b | | c | | d | | e | | f | | g | | h | | i | | j | | k | | l | |
| c | | d | | e | | f | | g | | h | | i | | j | | k | | l | | m | |
| d | | e | | f | | g | | h | | i | | j | | k | | l | | m | | n | |
| e | | f | | g | | h | | i | | j | | k | | l | | m | | n | | o | |
| f | | g | | h | | i | | j | | k | | l | | m | | n | | o | | p | |
| g | | h | | i | | j | | k | | l | | m | | n | | o | | p | | q | |
| h | | i | | j | | k | | l | | m | | n | | o | | p | | q | | r | |
| i | | j | | k | | l | | m | | n | | o | | p | | q | | r | | s | |
| j | | k | | l | | m | | n | | o | | p | | q | | r | | s | | t | |
| k | | l | | m | | n | | o | | p | | q | | r | | s | | t | | u | |
| l | | m | | n | | o | | p | | q | | r | | s | | t | | u | | v | |
| m | | n | | o | | p | | q | | r | | s | | t | | u | | v | | w | |
| n | | o | | p | | q | | r | | s | | t | | u | | v | | w | | x | |
| o | | p | | q | | r | | s | | t | | u | | v | | w | | x | | y | |
| p | | q | | r | | s | | t | | u | | v | | w | | x | | y | | z | |
| q | | r | | s | | t | | u | | v | | w | | x | | y | | z | | aa | |
| r | | s | | t | | u | | v | | w | | x | | y | | z | | aa | | ab | |
| s | | t | | u | | v | | w | | x | | y | | z | | aa | | ab | | ac | |
| t | | u | | v | | w | | x | | y | | z | | aa | | ab | | ac | | ad | |
| u | | v | | w | | x | | y | | z | | aa | | ab | | ac | | ad | | ae | |
| v | | w | | x | | y | | z | | aa | | ab | | ac | | ad | | ae | | af | |
| w | | x | | y | | z | | aa | | ab | | ac | | ad | | ae | | af | | ag | |
| x | | y | | z | | aa | | ab | | ac | | ad | | ae | | af | | ag | | ah | |
| y | | z | | aa | | ab | | ac | | ad | | ae | | af | | ag | | ah | | ai | |
| z | | aa | | ab | | ac | | ad | | ae | | af | | ag | | ah | | ai | | aj | |
| aa | | ab | | ac | | ad | | ae | | af | | ag | | ah | | ai | | aj | | ak | |
| ab | | ac | | ad | | ae | | af | | ag | | ah | | ai | | aj | | ak | | al | |
| ac | | ad | | ae | | af | | ag | | ah | | ai | | aj | | ak | | al | | am | |
| ad | | ae | | af | | ag | | ah | | ai | | aj | | ak | | al | | am | | an | |
| ae | | af | | ag | | ah | | ai | | aj | | ak | | al | | am | | an | | ao | |
| af | | ag | | ah | | ai | | aj | | ak | | al | | am | | an | | ao | | ap | |
| ag | | ah | | ai | | aj | | ak | | al | | am | | an | | ao | | ap | | aq | |
| ah | | ai | | aj | | ak | | al | | am | | an | | ao | | ap | | aq | | ar | |
| ai | | aj | | ak | | al | | am | | an | | ao | | ap | | aq | | ar | | as | |
| aj | | ak | | al | | am | | an | | ao | | ap | | aq | | ar | | as | | at | |
| ak | | al | | am | | an | | ao | | ap | | aq | | ar | | as | | at | | au | |
| al | | am | | an | | ao | | ap | | aq | | ar | | as | | at | | au | | av | |
| am | | an | | ao | | ap | | aq | | ar | | as | | at | | au | | av | | aw | |
| an | | ao | | ap | | aq | | ar | | as | | at | | au | | av | | aw | | ax | |
| ao | | ap | | aq | | ar | | as | | at | | au | | av | | aw | | ax | | ay | |
| ap | | aq | | ar | | as | | at | | au | | av | | aw | | ax | | ay | | az | |
| aq | | ar | | as | | at | | au | | av | | aw | | ax | | ay | | az | | ba | |
| ar | | as | | at | | au | | av | | aw | | ax | | ay | | az | | ba | | bb | |
| as | | at | | au | | av | | aw | | ax | | ay | | az | | ba | | bb | | bc | |
| at | | au | | av | | aw | | ax | | ay | | az | | ba | | bb | | bc | | bd | |
| au | | av | | aw | | ax | | ay | | az | | ba | | bb | | bc | | bd | | be | |
| av | | aw | | ax | | ay | | az | | ba | | bb | | bc | | bd | | be | | bf | |
| aw | | ax | | ay | | az | | ba | | bb | | bc | | bd | | be | | bf | | bg | |
| ax | | ay | | az | | ba | | bb | | bc | | bd | | be | | bf | | bg | | bh | |
| ay | | az | | ba | | bb | | bc | | bd | | be | | bf | | bg | | bh | | bi | |
| az | | ba | | bb | | bc | | bd | | be | | bf | | bg | | bh | | bi | | bj | |
| ba | | bb | | bc | | bd | | be | | bf | | bg | | bh | | bi | | bj | | bk | |
| bb | | bc | | bd | | be | | bf | | bg | | bh | | bi | | bj | | bk | | bl | |
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| be | | bf | | bg | | bh | | bi | | bj | | bk | | bl | | bm | | bn | | bo | |
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| bg | | bh | | bi | | bj | | bk | | bl | | bm | | bn | | bo | | bp | | bq | |
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| bi | | bj | | bk | | bl | | bm | | bn | | bo | | bp | | bq | | br | | bs | |
| bj | | bk | | bl | | bm | | bn | | bo | | bp | | bq | | br | | bs | | bt | |
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| bm | | bn | | bo | | bp | | bq | | br | | bs | | bt | | bu | | bv | | bw | |
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| bq | | br | | bs | | bt | | bu | | bv | | bw | | bx | | by | | bz | | ca | |
| br | | bs | | bt | | bu | | bv | | bw | | bx | | by | | bz | | ca | | cb | |
| bs | | bt | | bu | | bv | | bw | | bx | | by | | bz | | ca | | cb | | cc | |
| bt | | bu | | bv | | bw | | bx | | by | | bz | | ca | | cb | | cc | | cd | |
| bu | | bv | | bw | | bx | | by | | bz | | ca | | cb | | cc | | cd | | ce | |
| bv | | bw | | bx | | by | | bz | | ca | | cb | | cc | | cd | | ce | | cf | |
| bw | | bx | | by | | bz | | ca | | cb | | cc | | cd | | ce | | cf | | cg | |
| bx | | by | | bz | | ca | | cb | | cc | | cd | | ce | | cf | | cg | | ch | |
| by | | bz | | ca | | cb | | cc | | cd | | ce | | cf | | cg | | ch | | ci | |
| bz | | ca | | cb | | cc | | cd | | ce | | cf | | cg | | ch | | ci | | cj | |
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| cb | | cc | | cd | | ce | | cf | | cg | | ch | | ci | | cj | | ck | | cl | |
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| cq | | cr | | cs | | ct | | cu | | cv | | cw | | cx | | cy | | cz | | da | |
| cr | | cs | | ct | | cu | | cv | | cw | | cx | | cy | | cz | | da | | db | |
| cs | | ct | | cu | | cv | | cw | | cx | | cy | | cz | | da | | db | | dc | |
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| cu</ | | | | | | | | | | | | | | | | | | | | | |

Completion of the National Uniform Billing Claim Form (UB-04 92)

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.

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.

- FL 24 Condition codes
thru 30 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 Value Codes
thru 41
a, b, c,& d Enter the appropriate value codes and units related to this bill that might affect payer processing. A value code 81 and one (1) unit for each outpatient visit that requires a copayment must be entered for outpatient services, Type of Bill “711”. If the outpatient visit billed does not require a copayment, a zero (0) must be entered.

- FL 42 Revenue Code
Enter 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
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.
- 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.

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 on line A of FL50, Medicaid information must be listed on line A through FL 66.

- FL 50 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 Provider Number
A, B, C Enter the number assigned to the provider by the payer indicated.

- FL 54 Prior Payments
A, B, C 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 Certification/SSN/HIC/ID No.
A, B, C Enter the Medicaid Member Client Number exactly as it appears on the Medicaid card.
- FL 61 Insured Group Name
A, B, C 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 Insurance Group Numbers
A, B, C 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 Treatment Authorization Code (Precertification)
A, B, C 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 Employment Status Code
A, B, C 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 Employer Name
A, B, C Enter employer name that might or does provide health care coverage for the individual in FL 58.
- FL 66 Employer Location
A, B, C Enter the specific location of employer of the insured individual identified in FL 58.
- FL 67 Principle Diagnosis Code
Enter the ICD-9-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 thru 75 Other Diagnosis Codes
Enter the ICD-9-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-9-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-9-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 thru E Other Procedure Codes and Dates
Enter the appropriate ICD-9-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 A, B Other Physician ID
Enter on line 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 (If the member is a GBHC member, enter the GBHC referral number on line B.)
- 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.

APPENDIX G

Rev 01/09

PROCEDURE CODES REIMBURSABLE AT RHC 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 |
|----------------------------|---------------|

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 services within the clinic must use modifier “ AJ “ with the valid appropriate encounter code that falls within range of 99201---99215 in item 24d on the CMS 1500 claim form and in field locator 44 on the UB-04.

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

Podiatry Services:

New Patient 99201 - 99205
Established Patient 99211 – 99215

Pregnancy –Related Services:

99342, 99347, 99348

Perinatal Case Management:

T2022

APPENDIX H

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 I

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) 843-3868.

APPENDIX J

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) The department has granted a request filed by an RHC that a service has changed in scope as described in Section 1001.2 of this Manual.
- (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 RHC that a service has changed in scope as described 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 RHC site that did not previously offer obstetrical services;
- (c) The addition of a physician to a site that only offered nurse practitioner services previously; or
- (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 RHC'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 RHC.

(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 RHC 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 RHC 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 RHC'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 rates 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 RHC.

(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 RHC must notify the department in writing within ninety days of any permanent decrease in a scope of service.

Health Check Codes Separately Billable at FFS Rate

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

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