Georgia Department of Public Health

BILLING RESOURCE MANUAL

JUNE 2014

PREFACE

The **Public Health Billing Resource Manual** provides policy & procedural guidance on how to bill 3rd party payers for public health programs and services. Developed as a billing resource tool; its purpose is to assist state, district and county public health staff in understanding the insurance coding and billing process.

Part I-The Policies and Procedures section focuses on the terms and conditions of billing and reimbursement from 3rd party payers. It provides guidance on eligibility & verification, coordination of benefits and billing procedures to avoid delays in reimbursement.

Part II-The Billing & Coding: Methodologies & Rates section emphasizes the importance of the clinical components of CPT coding to ensure 3rd party payers are charged at the appropriate level of service delivery and reimbursement.

The **Appendices** section includes Related Links, Billing Contact Information, Acronyms, Definitions, and other resources used in mastering the reimbursement process.

Amendments are made quarterly in accordance with policy changes in federal and state laws.

Disclaimer: Contract Provisions between DPH and 3rd Party Private Payers contain confidential and proprietary information that prohibits dissemination, distribution or disclosure of reimbursement rates to any parties other than county Boards of Health and DPH employees. These reimbursement rates are dispersed to appropriate DPH staff through the Department email system.

Currently, Georgia DPH is contracted with the following 3rd Party Payers for Immunization Services:

Medicaid Fee-For-Service (FFS)
Peach Care for Kids (PCK)
PeachState; Wellcare; Amerigroup (CMOs)
Medicare: Cahaba
BCBS of GA: State Health Benefit Plan (SHBP); PPO-Federal Employees Plan (FEP); Open Access HMO; Open Access Point of Service; Board of Regents/University System Employees
AETNA/CONVENTRY: HMO; PPO; Choice POS II; Managed Choice; Open Access Managed Choice; Elect Choice; Aetna Select; Open Access Aetna Select; Medicare Advantage HMO; Coventry National (PPO); Medicare Advantra

Note: Medicaid, PCK, CMOs, and Medicare are accepted for other services, i.e., Health Check, Family Planning, Adult Health, etc. in most of our county health departments.

TABLE OF CONTENTS

PART I

BILLING POLICIES & PROCEDURES

Section 1

Provider Enrollment

1.1 Introduction

Providers must be enrolled as a qualified provider with a 3rd party payer before they can submit claims for reimbursement. This section provides guidance on the Enrollment Process. Please refer to *Part I Policy & Procedures for Medicaid/Peachcare for Kids* under the Provider Manual Section @ www.mmis.georgia.gov for complete information on Provider Enrollment.

1.2 Medicaid Enrollment Process

Beginning September 1, 2014, DCH will require that all institutional providers submit their enrollment applications online through GAMMIS (www.mmis.georgia.gov). DCH is implementing this process to increase efficiency and effectiveness, and expedite the enrollment process, which will reduce the time it takes to enroll providers into Georgia Medicaid.

Effective September 1, 2014, DCH and HP will no longer accept paper enrollment applications from institutional providers. Paper applications received after this date will be returned to the applicant with instructions on how to submit it online.

On January 1, 2015, DCH will implement this same process for all individual practitioners. Paper applications received after this date will be returned to the applicant with instructions on how to submit it online.

Important factors for Providers to keep in mind during the enrollment process:

- ✓ Go to https://www.mmis.georgia.gov to submit application and ALL supporting documents including NPI confirmation letter and Tax ID information
- ✓ Complete all sections of the application
- ✓ Respond promptly to any requests for additional information or documents
- ✓ Each location where services are provided must be enrolled
- ✓ An Approval Notice with effective date of enrollment will be sent to Provider. If denied, notification explaining denial and the right to appeal is sent to Provider
- ✓ Federal regulations require that some Providers may have to pay an application fee prior to executing a provider agreement
- ✓ Providers must report any changes in information within 10 days to the Enrollment Unit or submit the change request online

To be considered as an in-network provider, health departments identified as a "facility" must enter into a contractual agreement with 3rd party payers to provide a limited range of services to covered members.

The Georgia Department of Public Health is contractually recognized by private plans as an "In-network Ancillary Provider." An Ancillary Provider is the collective of state and county entities that have been selected by a Plan for participation as a "Network Provider", that has signed an Ancillary Provider Agreement and that will provide only those services identified in the Agreement.

Health department services are provided by licensed physicians, nurse practitioners, registered and licensed nurses, social workers and dieticians who operate under the direct supervision of a Health Director/Physician, and within the scope of the physician's extender's licensure or certification and in accordance with the current approved written protocol applicable to each of the aforementioned professions.

The Provider Agreement also includes specific guidance on the Responsibilities, Reimbursement Rates and Claim Submission Processes that both parties must adhere to.

State office staff, under the auspices of the Commissioner, submits health department provider locations for all sites, provider numbers, tax ID, and NPI number to all private payers to load into their billing system and satisfy the provider enrollment terms of the Agreement.

Information on Provider Enrollment for Medicare Part B can be found @
https://www.cahabagba.com/part-b/

Section 2

Insurance Eligibility & Verification

2.1 Introduction

The business of Public Health begins with clients seeking services at local county health departments. This Section provides guidance on client intake and the steps required to obtain insurance information for billable services rendered in public health.

2.2 Eligibility & Verification

Frontline staff should brief clients on the intake process prior to receiving services. An effective intake process begins with a registration form that gathers vital information on the client's demographics, insurance coverage, and services requested. *New Patients* should complete a form at their first visit and *Established Patients* should complete one if they have any changes in their information since their last visit. Verifying and updating this information is critical at every visit.

Important Steps that should be taken with every client at every visit:

- Copy the client's primary and any secondary insurance cards
- Verify eligibility, policy status, effective date, type of plan and **Exclusions**
- Inform client of their responsibility for co-pays, coinsurances and deductibles
- Inform client of **Waiver** for non-covered services and payment options

It is the Providers responsibility to verify coverage **before** services are rendered. Failure to do so may result in non-payment of non-covered services and difficulties recouping payment from the client after services have been provided. "Active" coverage does not guarantee reimbursement for services listed on the Fee Schedule. Please refer to the client's individual Insurance Plan/Exclusions to identify "Non-Covered" services.

In order to charge clients for non-covered services, a **Waiver for Non-Covered Services** with the following information must be provided to the client:

- ✓ Identify the service that is not covered
- ✓ Identify covered service that may be available in lieu of the non-covered service
- ✓ The cost of the service and payment arrangements
- ✓ The client must sign the Waiver indicating acceptance of the non-covered service and agreement to pay for the non-covered service

Medicaid/CMO eligibility can be verified at https://www.mmis.georgia.gov/portal;
CMO portals: *PeachState* http://www.pshpgeorgia.com/for-providers/;
WellCare https://georgia.wellcare.com/provider;
Amerigroup providers.amerigroup.com/pages/home.aspx

Provider Discretion: It is a Provider's discretion to accept a Medicaid member as a client.

By accepting a Medicaid member as a client, the Provider

1) Agrees to accept, as payment in full, the amount paid by Medicaid for all covered services with the exception of co-pays and payments from 3rd party payers.
2) Is prohibited from choosing specific procedures for which the Provider will accept Medicaid, whereby the Medicaid client would be required to pay for one type of covered service and Medicaid to pay for another service if applicable.

Failure to comply with these procedures will subject the Provider to sanctions, up to and including termination from the Medicaid Program.

When a client is ready to check-out, the paystation collects any copayments, deductibles, and service fees. Payment in full is expected at time of service. If a client is unable to pay, the clinical manager may make payment arrangements. The clinic manager should reinforce the Board of Health's billing policy and resolve the issue with the client through an agreed payment plan.

2.3 WIC Eligibility

Clients that come to the health department requesting WIC Services must provide proof of income for eligibility into the Program. Additional information and Income Guidelines can be found via the web @ http://dph.georgia.gov/WIC

Section 3

Coordination of Benefits

3.1 Introduction

By federal law, Medicaid is the "payer of last resort" in most circumstances. Coordination of Benefits (COB) is the process of determining the primary payer. This section will help define the "payer of last resort" status when submitting claims for payment. To find out more information on COB please refer to *The Medicaid Secondary Claims User Guide* @ www.mmis.georgia.gov under Provider Manuals.

3.2 Primary & Secondary Payers

A third party resource is an individual, entity, or program that is or may be liable to pay for all or part of the expenses for medical care provided to a Medicaid client. COB regulations require that all health plans coordinate benefits to eliminate duplication of payment and ensure clients receive the maximum benefits they are entitled to. Medicaid will consider payment of a claim only after all other 3rd party resources have been exhausted.

EXCEPTIONS: In accordance with federal regulations, a Provider does not have to exhaust other health plan benefits with respect to: a) Non-institutionalized pregnancy related claims; b) Claims for preventive and pediatric services including Health Check.

Filing a Medicaid COB Claim: When a client has other coverage that is potentially liable for payment of a claim, a COB claim is required prior to billing Medicaid. A COB claim submitted to Medicaid will be processed in one of two ways:

1. **Cost-avoid**: A Provider must bill the primary payer before billing Medicaid. Medicaid will pay the claim once the primary payer processing information is included on the claim.
2. **Pay-and-chase:** Medicaid will pay for the services and then attempt to recover from the liable 3rd party. If Medicaid pays for these services, the Provider cannot bill the 3rd party payer.

When the liability of a 3rd party cannot be established or is not available to pay for the client's services within an applicable timeframe, Medicaid will reimburse the Provider for covered services in accordance with standard reimbursement procedures.

Crossover Claims: A Medicare crossover claim is any claim that is approved by Medicare and then sent to Medicaid for consideration of payment not to exceed the sum of the Medicare deductible, co pay, or coinsurance.
The claim must be approved by Medicare in order to be considered a crossover claim. "Approved" does not mean paid; sometimes the charges approved by Medicare are applied

to the deductible. In these situations, the claim is approved, but no payment is made by Medicare.

It is important to remember that claims that are denied by Medicare are not crossover claims. If a member is a Qualified Medicare Beneficiary (QMB) and Medicare denies the claim, do not bill Medicaid.

The receipt of a crossover claim by Medicaid does not mean that Medicaid will make a payment on the claim. If Medicaid approves the claim, a payment of the sum of the coinsurance and deductible may be made. If the Medicare payment on a claim is equal to or greater than the Medicaid maximum allowable amount, Medicaid will not pay anything on the claim, but the claim will still be a paid Medicaid claim.

NOTE: For QMB members, Medicaid will be reimbursed payments for the Medicare coinsurance, deductible, and HMO Sub Copay amounts, less applicable 3rd party liabilities and patient Medicaid co-pays.

WHAT IF…the Medicaid Member is also eligible for Medicare?		
SERVICE BY MEDICAID PROGRAM	**MEDICARE**	**MEDICAID**
Health Check/Immunization	Does not Cover	Primary Payer
Family Planning	Does not Cover	Primary Payer
Perinatal Case Management/Pregnancy Related Services	Does not Cover	Primary Payer
Dental Services (Health Check, Adult)	Does not Cover	Primary Payer
Adult Services/Immunizations	Primary Payer-Flu, Pneumonia, Hep B; MNT; Preventive Services	Secondary Payer
Nurse Practitioner/Physician Services	Primary Payer	Secondary Payer

WHAT IF…the Medicaid Member is also eligible for other private insurance coverage?		
SERVICE BY MEDICAID PROGRAM	**PRIVATE INSURANCE**	**MEDICAID**
Health Check/Immunizations	N/A	Primary Payer
Perinatal Case Management/Pregnancy Related Services	N/A	Primary Payer
Family Planning	COB REQUIRED	
Adult Services/Immunizations	COB REQUIRED	
Nurse Practitioner/Physician Services	COB REQUIRED	
Dental Services (Health Check, Adult)	COB REQUIRED	

The following tips will assist Providers in reducing payment delays attributed to COB-related problems:

1. **Ask All Patients about Secondary Insurance Coverage.** Collect and confirm primary and secondary insurance information at each visit.
2. **Know What Plans and Payers Need to Pay Claims.** Nearly all plans require a copy of the Explanation of Benefits (EOB) from the primary payer prior to paying a claim as the secondary payer. Most plans and payers publish their requirements and the information should be available in provider manuals, online, and by contacting physician/provider representatives.
3. **Primary & Secondary Payers:** The following rules are used determine the primary and secondary payer: a) The payer covering the patient as a subscriber will be the primary payer. b) If the patient is a dependent child, the payer whose subscriber has the earlier birthday in the calendar year will be the primary payer. This is known as the Birthday Rule.

Section 4

Claim Submission / Resubmission

4.1 Introduction

The Submission & Resubmission of Claims focuses on the importance of converting clinical services provided to a client into billable claims and submitting them via an Electronic Data Interchange to 3rd party payers for reimbursement. To receive proper payment for services, public health billing staff must collect accurate information required to submit a CMS 1500 insurance form correctly.

4.2 Claim Requirements

Providers must take all reasonable measures to determine a 3rd Party Payer's liability for covered services prior to filing a Medicaid claim. If a 3rd party insurance plan denies or pays insufficiently the applicable reimbursement rate, a Provider may submit a claim to be paid the applicable reimbursement rate minus any reimbursement received from other resources. These claims must be billed to Medicaid within 3 months of the date of the denial/payment but not more than 12 months from the date of service. Claims that do not generate a response from the carrier may be filed with Medicaid using the COB Notification Form DMA-410, indicating no response was received.

Failure to file a claim within six months after a service is rendered and/or failure to obtain a required prior approval or precertification will result in a denial of that claim. Obtaining prior approval or precertification does not guarantee payment of a claim.

If a Provider believes a negative adjustment is appropriate, the Provider may adjust and resubmit a claim. This can be done @ www.mmis.georgia.gov

A 3rd Party Payer may deny part or all of a claim for the following reasons: 1) The services are not covered; 2) The client was not eligible on the date of service; 3) The provider failed to obtain prior approval or precertification for the required services; or, 4) The services provided have been determined to be medically unnecessary.

Federal law prohibits State payments for Medicaid services to anyone other than a provider, except in specified circumstances. Expressly prohibited are payments to collection agencies working on a percentage or other basis unrelated to the cost of processing the billing.

4.3 Filing Time Limits

Amerigroup.	**Submission:** 6 months to submit clean claims **Appeals/Payment Disputes:** 30 calendar days of the adjudication date of the EOP.
PeachState	**Submission:** 6 months to submit clean claims. **Resubmission:** The claim must clearly be marked as "RESUBMISSION" and include the original claim number within 45 days following initial filing; Failure to mark the claim as a resubmission and include the claim number or EOP may result in the claim being denied as a duplicate, or exceeding the filing limit deadline. **Appeals/Payment Disputes:** 30 calendar days of the adjudication date of the EOP.
Wellcare	**Submission of claims:** 6 months from the date of service. **Appeals/Payment Disputes:** 90 calendar days of the adjudication date of the EOB.
Medicaid	**Submission:** 6 months after the date of service. **Appeals/Payment Disputes:** Within 3 months of the month in which the denial occurred.
Medicare	**Submission:** Claims must be received within1 calendar year from the date of service. **Appeals/Reconsiderations:** Must be submitted within 6 months of the date on the notice of redetermination letter.
BCBS	**Submission:** 3 months from date of service. **Resubmission:** 2 months after original submission. **Appeals/Payment Disputes:** Documentation including cover letter outlining issue. 10 pages or less can be faxed to 877-868-7950; More than 10 pages can be mailed to BCBSGa, Attn: Provider Appeals, P.O. Box 9907, Columbus, GA 31908.
AETNA/COVENTRY	**Submission:** 6 months from date of service. **Resubmission:** 45 days after original submission. **Appeals/Payment Disputes:** 6 months from date of last payment adjustment.

4.4 Appeals Process

Every health insurance company has a grievance and appeal procedure defined in its policy. You can appeal a 3rd party payer's decision to deny a claim or pay less than the amount billed. Please refer to the appropriate payer's website for instructions on to appeal a claim.

The 3rd party payer may still deny a claim based on medical necessity despite pre-approval and a correctly coded claim. Appeal requests that do not contain sufficient information will not be processed.

PART II

BILLING & CODING: METHODOLOGIES & RATES

Section 5

Immunization Services

5.1 Methodologies

The following guidance will allow for successful billing and maximum reimbursement of Immunization Services.

- Information on the GA Immunization Program's Eligibility Criteria for vaccines can be found @ dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Oct2013-Elig-table_0.pdf
- Uninsured/Underinsured clients, ≤18 years, may be eligible for VFC vaccines through the HC Program. The HC Program will reimburse the cost of the vaccine (private stock) and the admin code for patients 19-20 years (The EP Modifier must be used). Uninsured/Underinsured clients, ≥21 years, may be eligible for State Supplied vaccines through the DSPS Program.
- The P4HB Waiver will reimburse for Tdap & Hep B (county purchased) for 18-20 yrs.
- Please refer to Health Check Manual @ www.mmis.georgia.gov under Provider Manuals for the DCH VFC Vaccine Administration Fee policy and the Peachcare Rate differential.
- If no other E/M service is provided on the same day, a 99211 at the maximum allowable amount of $17.46, can be billed with State supplied vaccines that are not reimbursable by Medicaid. (Medicaid will deny the vaccine but should pay the office visit)
- The Medicare Direct Plan is the primary payer for immunizations provided to **SHBP** retirees. The Claim address is on the back of the member's ID card.
- Local health departments are recognized as Ancillary Providers for BCBS. BCBS will reimburse for immunization services provided to members from other states and federal employees that have BCBS PPO and HMO coverage.
- Providers may not charge or seek reimbursement from a **BCBS or AETNA/COVENTRY Plan** member for covered services. This does not prohibit the collection of copayments, coinsurance, and deductibles. For non-covered services, providers will inform the client of the Waiver for non-covered services.
- Clinics must use place of service Code 03 for Flu vaccine administered to Medicaid/CMO children at school-based flu clinics.

5.2 EPSDT: *Birth up to 19 years*

Service Description	CPT Code	Modifier	ICD-9 DX	Rate	2014 RVU	Age Restriction
Vaccine Administration						
Immunization Admin, 1st or only component	90460	EP	V03.9	$10.00	0.70	
Immunization Admin, single	90471	EP	V03.9	$10.00	0.70	
Immunization Admin, each add. component	90472	EP	V03.9	$10.00	0.35	
Immunization Admin, intranasal or oral	90473	EP	V03.9	$10.00	0.70	
Immunization Admin, each add./multiple	90474	EP	V03.9	$10.00	0.35	
Vaccines – VFC Supplied						
Tuberculin Skin Test	86580	EP	V74.1	$2.99	0.22	
Hep A, 2 dose	90633	EP	V05.3	$0.00	0.94	
Hep A, 3 dose	90634	EP	V05.3	$0.00	0.99	
Hep A-Hep B (Twinrix)	90636	EP	V05.3	$0.00	2.59	≥18yrs
HIB, Hemophilus b conjugate, 3 dose (Pedvax)	90647	EP	V03.81	$0.00	0.80	
HIB, Hemophilus b conjugate (ACTHIB), 4 dose	90648	EP	V03.81	$0.00	0.75	
HPV, Human Papilloma Virus (Gardasil)	90649	EP	V04.89	$0.00	3.57	9-18yrs
Influenza, preservative free (Fluzone)	90655	EP	V04.81	$0.00	0.48	6-35mths
Influenza, preservative free (Fluzone)	90656	EP	V04.81	$0.00	0.35	3-18yrs
Influenza, (Fluzone)	90657	EP	V04.81	$0.00	0.17	6-35mths
Influenza	90658	EP	V04.81	$0.00	0.43	3-18yrs
Pneumococcal conjugate 13 Valent (Prevnar 13)	90670	EP	V03.82	$0.00	4.05	≤5yrs
Influenza, quadrivalent ,live, intranasal use (Flumist)	90672	EP	V04.81	$0.00	0.69	2-18yrs
Rotavirus Vaccine, 3 dose, live (RotaTeq)	90680	EP	V04.89	$0.00	2.12	
Rotavirus Vaccine, 2 dose, live (Rotarix)	90681	EP	V04.89	$0.00	2.12	6mths-6yrs
Influenza, quadrivalent (Fluarix)	90686	EP	V04.81	$0.00	0.54	3-18yrs
DTaP-IPV, Booster	90696	EP	V06.3	$0.00	0.00	4-6yrs
DTaP-Hib-IPV (Pentacel)	90698	EP	V06.8	$0.00	2.12	6wks-5yrs
DTaP, Diphtheria, tetanus, pertusis	90700	EP	V06.1	$0.00	0.71	≤7yrs
MMR, Measles, Mumps, Rubella	90707	EP	V06.4	$0.00	1.41	1-18yrs
MMRV, Measles, Mumps, Rubella, Varicella	90710	EP	V06.8	$0.00	3.76	12mths-12yrs
IPV, Inactivated Polio (IPOL)	90713	EP	V04.0	$0.00	0.80	
Td, Tetanus, diphtheria toxoid, preservative free	90714	EP	V06.5	$0.00	0.54	7-18yrs
Tdap, Tetanus, diphtheria toxoid & pertusis	90715	EP	V06.1	$0.00	0.89	7-18yrs
Varicella	90716	EP	V05.4	$0.00	2.07	1-18yrs
DTaP-Hep B-IPV (Pediarix)	90723	EP	V06.8	$0.00	2.07	
Pneumococcal 23-Valent (Pneumovax 23)	90732	EP	V03.82	$0.00	2.02	2-18yrs
Meningococcal conjugate	90734	EP	V03.89	$0.00	2.68	2-18yrs
Hep B (Engerix-B)	90744	EP	V05.3	$0.00	0.68	
Hep B-Hib (COMVAX)	90748	EP	V06.8	$0.00	1.57	

5.2 EPSDT: *19 to 20 years*

Service Description	CPT Code	Modifier	ICD-9 DX	Rate	2014 RVU
Vaccine Administration					
Immunization Admin, 1st or only component	90471	EP	V03.9	$10.00	0.70
Immunization Admin, each add. component	90472	EP	V03.9	$10.00	0.35
Immunization Admin, intranasal or oral	90473	EP	V03.9	$10.00	0.70
Immunization Admin, each add./multiple	90474	EP	V03.9	$10.00	0.35
Vaccines – County Supplied					
Hep A, 2 dose	90632	EP	V05.3	$51.55	1.44
Hep A-Hep B (Twinrix)	90636	EP	V05.3	$98.52	2.59
HPV, Human Papilloma Virus (Gardasil)	90649	EP	V04.89	$150.50	3.57
Influenza, preservative free (Fluzone)	90656	EP	V04.89	$12.40	0.35
Influenza	90658	EP	V04.81	$14.96	0.43
Influenza, quadrivalent ,live, intranasal use (Flumist)	90672	EP	V04.81	$24.60	0.69
Influenza, quadrivalent (Fluarix)	90686	EP	V04.81	$19.41	0.54
MMR, Measles, Mumps, Rubella	90707	EP	V06.4	$57.34	1.41
Td, Tetanus, diphtheria toxoid, preservative free	90714	EP	V06.5	$19.93	0.54
Tdap, Tetanus, diphtheria toxoid & pertusis	90715	EP	V06.1	$31.84	0.89
Varicella	90716	EP	V05.4	$100.41	2.07
Pneumococcal 23-Valent (Pneumovax 23)	90732	EP	V03.82	$72.35	2.02
Meningococcal conjugate	90734	EP	V03.89	$120.48	2.68
Hep B, 3 dose schedule	90746	EP	V05.3	$59.71	1.67
Hep B, 4 dose, dialysis or immunosuppressed	90748	EP	V05.3	$119.42	1.57

5.3 DSPS: *21 years & older*

Service Description	CPT Code	ICD-9 DX	Rate	2014 RVU	Age Restriction
Vaccine Administration					
Immunization Admin, 1 per visit	99211	V03.9	$17.46	0.56	
Vaccines - County Supplied					
TB Skin Test	86580	V74.1	$2.99	0.22	
Hep A-Hep B (Twinrix)	90636	V05.3	$98.52	2.59	
HPV, Human Papilloma Virus (Gardasil)	90649	V04.89	$150.50	3.57	21yrs
Influenza, Intradermal	90654	V04.81	$18.92	0.53	21-64yrs
Influenza, preservative free	90656	V04.81	$12.40	0.35	
Influenza	90658	V04.81	$14.96	0.43	
Influenza, quadrivalent ,live, intranasal use (Flumist)	90672	V04.81	$24.60	0.69	
Influenza, quadrivalent (Fluarix)	90686	V04.81	$19.41	0.54	
Influenza, quadrivalent (Flulaval)	90688	V04.81	$15.33	0.00	
DT, Diphtheria, tetanus toxoid	90702	V06.1	$39.16	0.58	≤7yrs
MMR, Measles, Mumps, Rubella	90707	V06.4	$59.56	1.41	
IPV, Inactivated Polio	90713	V04.0	$29.17	0.80	≥19yrs
Td, Tetanus, diphtheria toxoid, preservative free	90714	V06.5	$19.93	0.54	
Tdap, Tetanus, diphtheria toxoid & pertusis	90715	V06.1	$31.84	0.89	7-55yrs
Varicella	90716	V05.4	$100.41	2.07	
Pneumococcal	90732	V03.82	$72.35	2.02	
Meningococcal polysaccharide (Menomune)	90733	V05.9	$106.49	2.97	
Meningococcal conjugate (Menactra, Menveo)	90734	V03.89	$120.48	2.68	21-55yrs
Zoster (shingles) live (Zostavax)	90736	V05.8	$176.96	4.51	≥60yrs
Hep B, dialysis or Immunosuppressed	90740	V06.8	$119.42	3.33	
Hep B, dialysis or Immunosuppressed (Engerix-B)	90747	V05.8	$119.42	3.33	

Medicaid Members 21 years and older may be eligible for State Supplied Vaccines

Clients with Medicaid that does not cover vaccinations are considered underinsured and may be eligible for 317 funded vaccines. They must meet the **Age Requirements below** and **Eligibility Criteria** to qualify for state supplied vaccines. *Note: State supplied Tdap is available for Medicaid members 56 years and older or until they are covered by Medicare Part D Plan.*

Service Description	CPT Code	ICD-9 DX	Rate	2014 RVU	Age Requirement
Vaccines – State Supplied					
Hep A	90632	V05.3	$0.00	1.44	≥21yrs
HPV	90649	V04.89	$0.00	3.57	22-26yrs
Pneumococcal conjugate 13 (Prevnar 13)	**90670**	**Pending approval from Immunization Program. Eff. Date TBD**			
Tdap	90715	V06.1	$0.00	0.89	≥56yrs
Zoster (shingles) live (Zostavax)	**90736**	**Pending approval from Immunization Program. Eff. Date TBD**			
Hep B	90746	V05.3	$0.00	1.67	≥21yrs

5.4 Medicare Part B

Service Description	CPT Code	ICD-9 DX	001 / 099 Rate	2014 RVU	Age Restriction
Vaccine Administration					
Admin. Influenza	G0008	V04.81	$24.41 / $22.30	0.70	
Admin. Pneumococcal	G0009	V03.82	$24.41 / $22.30	0.70	
Admin. Hep. B	G0010	V05.3	$24.41 / $22.30	0.70	
Vaccines					
Influenza, preservative free, Intradermal use	90654	V04.81	$18.92	0.53	18-64yrs
Influenza, preservative free	90655	V04.81	$17.24	0.48	6-35mths
Influenza, preservative free	90656	V04.81	$12.40	0.35	≥3yrs
Influenza	90657	V04.81	$6.02	0.17	6-35mths
Influenza, cell cultures (Flucelavax)	90661	V04.81	$20.67	0.58	≥18yrs
Influenza, preservative free, high dose	90662	V04.81	$30.92	0.89	≥65yrs
Influenza, live, intranasal, quadravalent	90672	V04.81	$24.60	0.69	2-49yrs
Influenza, preservative free (Flublok)	90673	V04.81	$36.48	1.02	18-49yrs
Influenza, quadrivalent (Fluzone)	90685	V04.81	$23.23	0.65	6-35mths
Influenza, quadrivalent (Fluzone, Fluarix)	90686	V04.81	$19.41	0.54	≥3yrs
Influenza, quadrivalent (Flulaval)	90688	V04.81	$16.81	0.00	≥3yrs
Influenza, >3yrs, (Afluria)	Q2035	V04.81	$11.54	0.32	≥3yrs
Influenza, >3yrs, (FluLaval)	Q2036	V04.81	$9.58	0.24	≥3yrs
Influenza, >3yrs, (Fluvirin)	Q2037	V04.81	$14.96	0.42	≥3yrs
Influenza, >3yrs (Fluzone)	Q2038	V04.81	$12.04	0.34	≥3yrs
Pneumococcal	90732	V03.82	$49.73	2.02	
Hep B	90746	V05.3	$59.71	1.67	
Pending Rates and Effective Date of Service					
Influenza, quadrivalent (Fluzone)	90687	V04.81	Pending	0.00	6-35mths

5.5 BCBS

Service Description	CPT Code	ICD-9 DX	Rate	2014 RVU
Vaccine Administration				
Immunization Admin, single	90471	V03.9		0.70
Immunization Admin., each add./multiple	90472	V03.9		0.35
Immunization Admin., intranasal or oral	90473	V03.9		0.70
Immunization Admin., each add./multiple	90474	V03.9		0.35
Vaccines				
TB Skin Test	**86580**	**Pending approval from BCBS. Eff. Date TBD**		
Hepatitis A, adult	90632	V05.3		1.44
Hepatitis A, pediatric, 2 dose	90633	V05.3		0.94
Hepatitis A, pediatric/adolescent, 3 dose	90634	V05.3		0.99
Hep A, Hep B (Twinrix)	90636	V05.3		2.59
HIB, Hemophilus influenza, 4 dose	90645	V03.81		0.75
HIB, Hemophilus influenza, 3 dose	90647	V03.81		0.80
HIB, Haemophilus b conjugate (ACTHIB), 4 dose	90648	V03.81		0.75
HPV, Human Papilloma Virus **Male & Female**	90649	V04.89		3.57
Influenza, preservative free, Intradermal	90654	V04.81		0.53
Influenza, preservative free	90655	V04.81		0.48
Influenza, preservative free, split virus, >3 yrs	90656	V04.81		0.35
Influenza, split virus, 6-35 mnths	90657	V04.81		0.17
Influenza, >3yrs	90658	V04.81		0.43
Influenza, split virus, preservative free, inc. antigen	90662	V04.81		0.89
Pneumococcal conjugate	90669	V03.82		2.67
Pneumococcal conjugate 13 Valent (Prevnar 13)	90670	V03.82		4.05
Influenza, quadrivalent live, intranasal use (Flumist)	90672	V04.81		0.69
Rabies	90675	V04.5		6.59
Rotavirus, 3 dose, live	90680	V04.89		2.12
Rotavirus, 2 dose, live	90681	V04.89		2.12
Influenza, quadrivalent, 6-35 mths (Fluzone)	90685	V04.81		0.65
Influenza, quadrivalent, ≥ 3 yrs (Fluzone, Fluarix)	90686	V04.81		0.54
DTAP-IPV, Booster (4-6yrs)	90696	V06.3		0.00
Dtap-Hib-IPV (Pentacel), 6wks-6yrs	90698	V06.8		2.12
DTaP, Diphtheria, tetanus, acellular pertusis	90700	V06.1		0.71
DT, Diphtheria & tetanus toxoid (Decavac)	90702	V06.1		0.58
Tetanus toxoid	90703	V03.7		1.10
MMR, Measles, Mumps, Rubella	90707	V06.4		1.41
MMRV, Measles, Mumps, Rubella, Varicella	90710	V06.8		3.76
IPV, Inactivated Polio	90713	V04.0		0.80
TD, Tetanus & diphtheria toxiods, preservative free, >7yrs	90714	V06.5		0.54
TDAP, Tetanus, diphtheria toxoid & acellular pertusis	90715	V06.1		0.89

5.5 BCBS (Continued)

Service Description	CPT Code	ICD-9 DX	Rate	2014 RVU
Varicella	90716	V05.4		2.07
DTAP, Hep B, and IPV	90723	V06.8		2.07
Pneumococcal conjugate for adult use	90732	V03.82		2.02
Meningococcal polysaccharide	90733	V05.9		2.97
Meningococcal conjugate	90734	V03.89		2.68
Zoster, live, > 60 (Shingles)	90736	V05.8		4.51
Hepatitis B, Dialysis or IM	90740	V06.8		3.33
Hepatitis B pediatric/adolescent dose	90744	V05.3		0.68
Hepatitis B adult dosage	90746	V05.3		1.67
Hep B-Hib (COMVAX)	90748	V06.8		1.67

BCBS: SHBP Medicare Enrollees

Service Description	CPT Code	ICD-9 DX	Rate	2014 RVU
Vaccine Administration				
Admin Influenza	G0008	V04.81		0.70
Admin Pneumococcal	G0009	V03.82		0.70
Admin Hep B	G0010	V05.3		0.70
Vaccines				
Influenza, split virus, preservative free, 6-35mths	90655	V04.81		0.48
Influenza, split virus, preservative free, >3yrs	90656	V04.81		0.35
Influenza, split virus, 6-35mths	90657	V04.81		0.17
Influenza, split virus, preservative free, inc. antigen	90662	V04.81		0.89
Influenza, quadrivalent live, intranasal use (Flumist)	90672	V04.81		0.69
Influenza, quadrivalent, 6-35 mths (Fluzone)	90685	V04.81		0.65
Influenza, quadrivalent, ≥ 3 yrs (Fluzone, Fluarix)	90686	V04.81		0.54
Influenza, >3yrs, (Afluria)	Q2035	V04.81		0.32
Influenza, >3yrs, (FluLaval)	Q2036	V04.81		0.24
Influenza, >3yrs, (Fluvirin)	Q2037	V04.81		0.42
Influenza, >3yrs (Fluzone)	Q2038	V04.81		0.34
Influenza, >3yrs (not otherwise specified)	Q2039	V04.81		0.00
Pneumococcal conjugate	90732	V03.82		2.02
Hep B	90746	V05.3		1.67

5.8 AETNA/COVENTRY

Service Description	CPT Code	ICD-9 DX	Rate	2014 RVU
Vaccine Administration				
Immunization Admin, single	90471	V03.9		0.70
Immunization Admin, each addl/multiple	90472	V03.9		0.35
Immunization Admin, intranasal or oral	90473	V03.9		0.70
Immunization Admin, each addl/multiple	90474	V03.9		0.35
Vaccines				
TB Skin Test	86580	V74.1		0.22
Rabies immune globulin	90375	V04.5		6.11
Hepatitis A, adult	90632	V05.3		1.44
Hepatitis A, pediatric, 2 dose	90633	V05.3		0.94
Hepatitis A, pediatric/adolescent, 3 dose	90634	V05.3		0.99
Hep A, Hep B (Twinrix)	90636	V05.3		2.59
HIB, Hemophilus influenza, 4 dose	90645	V03.81		0.81
HIB, Hemophilus influenza, 3 dose	90647	V03.81		0.80
HIB, Haemophilus b conjugate (ACTHIB), 4 dose	90648	V03.81		0.75
HPV, Human Papilloma Virus **Male & Female**	90649	V04.89		3.57
Influenza, preservative free, Intradermal	90654	V04.81		0.53
Influenza, preservative free	90655	V04.81		0.48
Influenza, preservative free, split virus, ≥ 3 yrs	90656	V04.81		0.35
Influenza, split virus, 6-35 mnths	90657	V04.81		0.17
Influenza, >3yrs	90658	V04.81		0.43
Influenza, split virus, preservative free, inc. antigen	90662	V04.81		0.89
Pneumococcal conjugate	90669	V03.82		2.67
Pneumococcal conjugate 13 Valent (Prevnar 13)	90670	V03.82		4.05
Influenza, quadrivalent live, intranasal use (Flumist)	90672	V04.81		0.69
Rabies	90675	V04.5		6.59
Rotavirus, 3 dose, live	90680	V04.89		2.12
Rotarix, live, oral, 6mths-6yrs	90681	V04.89		2.12
Influenza, quadrivalent, 6-35 mths (Fluzone)	90685	V04.81		0.65
Influenza, quadrivalent, ≥ 3 yrs (Fluzone, Fluarix)	90686	V04.81		0.54
DTAP-IPV Booster (4-6yrs)	90696	V06.3		0.00
Dtap-Hib-IPV (Pentacel), 6wks-6yrs	90698	V06.8		2.12
DTaP, Diphtheria, tetanus, acellular pertusis	90700	V06.1		0.71
Tetanus toxoid	90703	V03.7		1.10
MMR, Measles, Mumps, Rubella	90707	V06.4		1.41
MMRV, Measles, Mumps, Rubella, Varicella	90710	V06.8		3.76
IPV, Inactivated Polio	90713	V04.0		0.80
TD, Tetanus & diphtheria toxiods, preservative free, >7yrs	90714	V06.5		0.54
TDAP, Tetanus, diphtheria toxoid & acellular pertusis	90715	V06.1		0.89

5.6 AETNA/COVENTRY (Continued)

Service Description	CPT Code	ICD-9 DX	Rate	2014 RVU
Varicella	90716	V05.4		2.07
DTAP, Hep B, and IPV	90723	V06.8		2.07
Pneumococcal conjugate for adult use	90732	V03.82		2.02
Meningococcal polysaccharide	90733	V05.9		2.97
Meningococcal conjugate	90734	V03.89		2.68
Zoster, live, > 60 (Shingles)	90736	V05.8		4.51
Hepatitis B, Dialysis or IM	90740	V06.8		3.33
Hepatitis B pediatric/adolescent dose	90744	V05.3		0.68
Hepatitis B adult dosage	90746	V05.3		1.67
Hep B, dialysis or IM, 4 dose	90747	V05.8		3.33
Hep B-Hib (COMVAX)	90748	V06.8		1.57

AETNA/COVENTRY: Medicare Advantage/Medicare Advantra

Service Description	CPT Code	ICD-9 DX	Rate	2014 RVU
Vaccine Administration				
Admin. Influenza	G0008	V04.81		0.70
Admin. Pneumococcal	G0009	V03.82		0.70
Admin. Hep. B	G0010	V05.3		0.70
Vaccines				
Influenza, preservative free, Intradermal use	90654	V04.81		0.53
Influenza, preservative free, 6-35mths	90655	V04.81		0.48
Influenza, preservative free, >3yrs	90656	V04.81		0.35
Influenza, 6-35mths	90657	V04.81		0.17
Influenza, preservative free, high dose	90662	V04.81		0.89
Influenza, quadrivalent live, intranasal use (Flumist)	90672	V04.81		0.69
Influenza, quadrivalent, 6-35 mths (Fluzone)	90685	V04.81		0.65
Influenza, quadrivalent, ≥ 3 yrs (Fluzone, Fluarix)	90686	V04.81		0.54
Influenza, >3yrs, (Afluria)	Q2035	V04.81		0.32
Influenza, >3yrs, (FluLaval)	Q2036	V04.81		0.24
Influenza, >3yrs, (Fluvirin)	Q2037	V04.81		0.42
Influenza, >3yrs (Fluzone)	Q2038	V04.81		0.34
Influenza, >3yrs (not otherwise specified)	Q2039	V04.81		0.00
Pneumococcal	90732	V03.82		2.02
Hep B	90746	V05.3		1.67

Section 6

Child Health Services

6.1 Methodologies

The Health Check (HC) program covers the screening portion of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. It is a well-child or preventative health care program for all Medicaid-eligible children birth to 21 years of age and PeachCare-eligible children birth to 19 years of age. Women 18 to 21 years of age enrolled in the Planning for Healthy Babies Program (P4HB) are not eligible to receive HC services.

Add **Modifier 25** along with the EP modifier to the HC visit code when VFC vaccines are administered during the visit. Use diagnosis code **V20.2** with each administration code ONLY when administered during a HC visit. Use the appropriate vaccine diagnosis code with the administration code when administered outside of a Health Check visit.

Developmental Screening: A Developmental Screening should be performed at HC visits: 9, 18, and 30 months. Providers must bill code 96110 in addition to the health check code, EP modifier, and diagnosis code V20.2 or V70.3 in order to receive reimbursement for the screening. A screening can be performed during a Catch-Up visit and billed with the EP and HA modifiers.

Lead Assessment: The 12 and 24-month HC visits will not be reimbursed without the lead level screening component and documentation of CPT codes 36415 or 36416.

If abnormalities or preexisting problems occur during a HC visit that requires additional work to perform key components of an E/M service, code 99211 or 99212 along with the HC visit code. Add modifier EP and 25 to the E/M code to indicate a separately identifiable service. **CPT Code 99211 is not reimbursable when it is provided on the same DOS with the vaccine administration codes regardless of the use of Modifier 25.**

Please visit www.mmis.georgia.gov for the Health Check Manual under the Provider Manuals tab for PeachCare rate differentials and additional billing requirements for HC services; and, under Provider Notices tab for a Health Check Medicaid Fair presentation for tips on the new VFC administration fee policy.

Early Intervention Case Management: Billing consists of, a minimum, one face-to-face contact with the eligible member and family and three indirect contacts per one calendar month.

DSPS is a Medicaid category of service solely for public health providers. County Boards of Health are enrolled as the qualified Medicaid provider of diagnostic, screening and

preventative services provided under the DSPS program. DSPS will pay providers for only one office visit per client, per date of service.

Health departments agree to provide diagnostic, screening and treatment services in an office, clinic, school-based clinic, home, or other similar physical facility within the boundaries of the State of Georgia.

Children 1st and Children's Medical Services Case Management Services provided to Medicaid and PeachCare eligible children in health departments, are billable when provided by licensed nurses, social workers and nutritionists within the scope of their licensure and state law. Case management services are billed under DSPS.

CMOs (Amerigroup & PeachState) will pay to complete a Children 1st and First Care "Initial Assessment" on their members, but all other follow-up services require prior approval. Title V-special needs children are exempt from CMO enrollment.

Nutritional Counseling (Individual or Group): Dietitians licensed by the Georgia Board of Examiners may bill for Nutritional Counseling. Nutritional assessments and counseling visits are billed to Medicaid as office visit codes.

If a client receives a clinical (nurse) service and a nutritional counseling (dietician) service on the same day, the office visit code should reflect the appropriate level of service provided; the higher "enhanced" office visit.

6.2 Health Check Visits

Service Description	CPT Code	Modifier	Rate	2014 RVU
Periodic Healthcheck Visits				
New Screening: Normal/Abnormal; 0 days - 11 months	99381	EP	$67.38	3.10
New Screening: Normal/Abnormal; 12 months - 4 years	99382	EP	$67.38	3.23
New Screening: Normal/Abnormal; 5 years - 7 years	99383	EP	$67.38	3.37
New Screening: Normal/Abnormal; 8 years - 11 years	99383	EP	$55.38	3.37
New Screening: Normal/Abnormal; 12 years - 17 years	99384	EP	$55.38	3.81
New Screening: Normal/Abnormal; 18 years - 20 years	99385	EP	$55.38	3.70
Established Screening: Normal/Abnormal; 3 days - 11 months	99391	EP	$67.38	2.79
Established Screening: Normal/Abnormal; 12 months - 4 years	99392	EP	$67.38	2.98
Established Screening: Normal/Abnormal; 5 years - 7 years	99393	EP	$67.38	2.97
Established Screening: Normal/Abnormal; 8 years - 11 years	99393	EP	$55.38	2.97
Established Screening: Normal/Abnormal; 12 years - 17 years	99394	EP	$55.38	3.25
Established Screening: Normal/Abnormal; 18 years - 20 years	99395	EP	$55.38	3.32
Catch-Up Healthcheck Visits				
New Screening: Normal/Abnormal; 0 days - 11 months	99381	EP, HA	$67.38	3.10
New Screening: Normal/Abnormal; 12 months - 3 years	99382	EP, HA	$67.38	3.23
Established Screening: Normal/Abnormal; 0 days - 11 months	99391	EP, HA	$67.38	2.79
Established Screening: Normal/Abnormal; 12 months - 3 years	99392	EP, HA	$67.38	2.98
Interperiodic Healthcheck Exam				
Established Interperiodic Healthcheck Exam	99211	EP	$17.46	0.56
New / Established Interperiodic Healthcheck Exam	99201/99212	EP	$29.67	1.21/1.22
New / Established Interperiodic Healthcheck Exam	99202/99213	EP	$40.70	2.08/2.04
New / Established Interperiodic Healthcheck Exam	99203/99214	EP	$62.71	3.02/3.01
Interperiodic Vision & Hearing				
Interperiodic Vision: Normal/Abnormal	99173	EP	$5.62	0.08
Interperiodic Hearing, pure tone, air only	92551	EP	$5.62	0.33
Interperiodic Hearing, pure tone audiometry, air only	92552	EP	$5.62	0.86
Interperiodic Hearing, pure tone audiometry, air and bone	92553	EP	$5.62	1.03
Interperiodic Hearing, speech audiometry threshold	92555	EP	$5.62	0.64
Interperiodic Hearing, speech audiometry threshold w/ speech recognition	92556	EP	$5.62	1.02
Interperiodic Hearing, Abnormal/Referral	V5008	EP	$5.62	1.13
Special Services				
Developmental Testing	96110	EP	$11.77	0.23
Tuberculin Skin Test	86580	EP	$3.00	0.22
Screening for developmental handicaps in early childhood (ASQ)	99211		$17.46	0.56
Modifier required for healthcheck screenings provided to a foster child		EP, TJ		

6.3 Children's Intervention Services

Service Description	CPT Code	Modifier	Rate	2014 RVU
Nursing Services				
Medication Administration	T1502	HA, TD	$5.78	0.00
Treatment, includes assessment	T1002	HA	$5.78	0.00
Nutrition Services				
Nutrition Evaluation	97802	HA	$14.89	1.00
Nutrition Services	97803	HA, TS	$14.89	0.86
Audiology Services				
Aural Rehabilitation	92507	UC, HA	$62.53	2.25
Pure tone audiometry (threshold), air only	92552	HA	$15.63	0.86
Speech audiometry threshold	92555	HA	$13.38	0.64
Basic comprehensive audiometry; pure tone, air, bone, speech,	92557	HA	$42.04	1.06
Tympanometry (impedance testing)	92567	UC, HA	$18.46	0.41
Acoustic reflex testing	92568	HA	$13.38	0.44
Conditioning play audiometry	92582	HA	$25.19	1.91
Evoked response (EEG) audiometry	92585	HA	$109.76	3.67
Automated Auditory Brainstem Response	92586	HA	$65.99	2.35
Evoked Otacoustic Emissions-limited	92587	HA	$52.51	0.62
Evoked Otacoustic emissions, comprehensive, diagnostic eval	92588	HA	$70.52	0.94
Occupational Therapy Services				
Evaluation	97003	HA	$52.99	2.38
Aquatic Therapy	97113	GO,HA	$22.32	1.21
Manual Therapy Techniques	97140	GO, HA	$22.97	0.84
Therapeutic Activities, Direct member contact	97530	GO, HA	$19.76	0.98
Sensory Integrative Tech to enhance sensory processing	97533	GO, HA	$24.46	0.82
Self Care/Home Management Training	97535	HA	$21.67	0.98
Community/Work Reintegration Training	97537	HA	$21.37	0.85
Physical Performance Test	97750	GO, HA	$22.31	0.94
Physical Therapy Services				
Evaluation-Limit 1 per cal year	97001	HA	$52.99	2.12
Re-evaluation-Limit 1 every 180 days	97002	HA	$25.06	1.19
Therapeutic Procedure, one or more areas	97110	HA	$20.07	0.90
Neuromuscular Reeducation of Movement	97112	HA	$21.03	0.94
Gait Training	97116	HA	$18.85	0.80
Therapeutic Activities, Direct member contact	97530	GP, HA	$19.76	0.98
Ultrasound	97035	HA	$10.69	0.36

6.3 Children's Intervention Services (Continued)

Service Description	CPT Code	Modifier	Rate	2014 RVU
Speech-Language Pathology Services				
Speech Language Therapy; individual treatment	92507	GN, HA	$62.53	2.25
Tympanometry	92567	GN, HA	$18.46	0.41
Treatment of Swallowing Dysfunction and/or Oral Function	92526	HA	$44.66	2.45
Developmental Testing Extended	96111	HA	$62.10	3.63

6.4 Early Intervention Case Management

Service Coordination	T2022		$145.00	0.00
Follow-up Service	T2022	TS	$135.00	0.00

6.5 DSPS

Service Description	CPT Code	Rate	2014 RVU
Children 1st; 1st Care & CMS Case Mgmt; Nutritional Counseling; Ages & Stages; Walk-In Svcs			
New Problem Focused / Established Minimal	99201 / 99211	$35.13 / $17.46	1.21/0.56
New Expanded Prob. Focused / Established Problem Focused	99202 / 99212	$54.57 / $29.67	2.08/1.22
New Detailed Low Complexity / Established Expanded Problem Focused	99203 / 99213	$76.53 / $40.70	3.02/2.04
New Comprehensive Moderate / Established Detailed Moderate	99204 / 99214	$110.51 / $62.71	4.64/3.01
New Comprehensive Complex / Established Comprehensive Complex	99205 / 99215	$137.12 / $93.46	5.78/4.03
Home Visits			
New / Established - Problem Focused	99341 / 99347	$50.30 / $39.65	1.55/1.56
New / Established - Expanded Problem Focused	99342 / 99348	$72.33 / $60.65	2.24/2.36
New / Established - Detailed Complexity	99343 / 99349	$106.14 / $91.64	3.66/3.57
New / Established - Comprehensive	99344 / 99350	$135.87 / $132.35	5.11/4.98
New Comprehensive Complex	99345	$147.25	6.16

Service Description	CPT Code	Modifier	Rate	2014 RVU
Special Services				
Initial lead investigation	T1028		$229.60	0.00
Post hazard abatement	T1028	U-1	$197.34	0.00

6.6 Nurse Practitioner & Physician Services

Service Description	CPT Code	Rate	2014 RVU
New Problem Focused / Established Minimal	99201/99211	$35.13 / $17.46	1.21/0.56
New Expanded Prob. Focused / Established Problem Focused	99202/99212	$54.57 / $29.67	2.08/1.22
New Detailed Low Complexity / Established Expanded Problem Focused	99203/99213	$76.53 / $40.70	3.02/2.04
New Comprehensive Moderate / Established Detailed Moderate	99204/99214	$110.51 / $62.71	4.64/3.01
New Comprehensive Complex / Established Comprehensive Complex	99205/99215	$137.12 / $93.46	5.78/4.03

Section 7

Women's Health Services

7.1 Methodologies

The **Planning for Healthy Babies (P4HB)** Waiver expands the provision of Family Planning services for women that do not qualify for other Medicaid benefits or have lost Medicaid coverage for any reason, and meet specific eligibility criteria.

Eligible clients are enrolled in one of three components of P4HB Waiver Program:

1. Family Planning - family planning related services
2. Inter-pregnancy Care - family planning and services for women who have delivered a VLBW baby
3. Resource Mother Outreach-inclusive of a specially trained case manager to women on traditional Medicaid plans who have delivered a VLBW baby

Services for P4HB do not begin until the member is enrolled in a CMO. When a P4HB client becomes pregnant they are no longer eligible for the program. When PE Medicaid is approved, there are 2 categories active during that time span. All pregnancy related services must be billed to the PE Medicaid and not the P4HB program.

For additional information visit www.planning4healthybabies.org

Presumptive Eligibility (PE): PE is an expedited process of enrolling eligible pregnant women and women diagnosed with breast or cervical cancer in the Medicaid program. Pregnant women are granted temporary FFS Medicaid until they are assigned to a CMO. All billable services for PE clients are billed to FFS Medicaid until the client is assigned to a CMO. Women diagnosed with breast or cervical cancer are temporarily granted the full range of traditional Medicaid services until they are assigned to a CMO.

Public health departments are designated as qualified providers under federal legislation to perform presumptive eligibility Medicaid determinations.

DSPS Billing- On date FFS Medicaid eligibility is determined, bill the DSPS program for all clinical services provided to client. (an appropriate level of office visit, labs, pregnancy test, Women's Health Medicaid Case Management)

Perinatal Case Management (PCM): A Comprehensive visit (T2022) can be provided and billed on the same date of service that PE eligibility is determined.

Tobacco Cessation Counseling for Pregnant Women: Policies and Procedures on Counseling visits are located in the Physician Services Manual, Section 903.18.

- ✓ Pregnant women that apply for PE and are in Medicaid FFS status are eligible to receive PCM services and Tobacco Cessation Counseling during the same visit.
- ✓ Codes 99406 or 99407 may be billed along with a distinct E&M service if warranted during the same visit. Counseling may not be used as a basis for the E/M code selection.
- ✓ Modifier 25 must be added to the E&M service
- ✓ Wellcare will not pay the health departments for prenatal services.
- ✓ The Cessation counseling must be face-to-face in a clinic setting. Only one 12-week (3 months) treatment period allowed per pregnancy; may begin at any trimester. Only one monthly session billed and documented in medical record per treatment period (3 months).
- ✓ For "non-funded WIC" nutritionists who are also qualified as DSPS providers, the counseling visits can be billed (if beyond the two mandatory WIC nutrition counseling visits) in addition to the DSPS Nutritional Counseling service codes.

340B Pharmaceutical Pricing: When a covered entity (health department) purchases pharmaceutical products at the 340B price and bills Medicaid/CMOs for the product, the amount billed cannot exceed the entity's actual acquisition cost, plus a dispensing or administration fee as established by the State Medicaid Agency.

DISCLAIMER: Not all payers cover dispensing or administrative fees.

7.2 Family Planning

Service Description	CPT Code	Modifier	Rate	2014 RVU
Removal, Norplant, subsequent insertion of Nexplanon	11976	FP	$106.11	4.10
Insertion, Nexplanon	11981	FP	$100.90	3.87
Insertion, IUD	58300	FP	$62.48	1.98
Urine pregnancy test by visual method (PubHlth)	81025	FP	$7.96	0.24
New Initial Visit, Comprehensive	99204	FP	$110.51	4.64
Established Supply Visit	99211	FP	$17.46	0.56
Established Brief Visit, Problem focused	99212	FP	$29.67	1.22
Established Visit, Comprehensive, Low Complexity	99213	FP	$40.70	2.04
Established Visit,, Comprehensive, Moderate Complexity	99214	FP	$62.71	3.01
Established Annual Visit, Comprehensive	99215	FP	$93.46	4.03
Contraceptive Supply, condom, Male, Each unit	A4267	FP	**340b Price**	0.01
Inject. Medroxprogesterone Acetate for Contracep Use, 1Mg	J1050	FP	**340b Price**	0.01
Paragard/Intrauterine copper contraceptive	J7300	FP	**340b Price**	11.16
Mirena IUD	J7302	FP	**340b Price**	11.62
Nexplanon Implant System	J7307	FP	**340b Price**	0.00

7.3 Perinatal Case Management

Comprehensive	T2022		$72.60	0.00
Brief F/U	T2022	TS	$12.10	0.00
Extended F/U	T2022	TS, TG	$36.31	0.00
Postpartum	T2022	U1	$48.40	0.00

7.4 Childbirth Education

Class One, Two, Three, Four, Five, Six (60 minutes each)	99412		$9.45	0.60
Newborn Feeding (60 min)	99412	HD	$9.45	0.60
Newborn Care (60 min)	99412	HD	$9.45	0.60

7.5 Pregnancy Related Services

Visit #1 New	99342		$60.75	2.24
Visit # 2 Established	99347		$60.75	1.56
Visit # 3 Established	99348		$47.25	2.36
Visit # 4 Established	99348	HD	$47.25	2.36

7.6 DSPS

Service Description	CPT Code	Rate	2014 RVU
Maternity & Delivery Care			
Antepartum Care Only; 4-6 visits	59425	$284.91	13.80
Antepartum Care Only; 7 or more visits	59426	$488.24	24.69
Postpartum Care Only (Separate procedure)	59430	$96.12	5.60

7.6 DSPS (Continued)

Service Description	CPT Code	Rate	2014 RVU
Radiology: Diagnostic Ultrasound			
Echography, pregnant uterus	76805	$116.39	4.43
Echography, preg uterus, multiple gestation, after 1st trimester	76810	$231.23	2.89
Echography, preg. uterus, limited	76815	$78.03	2.70
Echography, preg, follow-up or repeat	76816	$64.06	3.55
Home Visits			
New / Established - Problem Focused	99341 / 99347	$50.30 / $39.65	1.55/1.56
New / Established - Expanded Prob. Focused	99342 / 99348	$72.33 / $60.65	2.24/2.36
New / Established - Detailed Complexity	99343 / 99349	$106.14 / $91.64	3.66/3.57
New / Established - Comprehensive	99344 / 99350	$135.87 / $132.35	5.11/4.98
New Comprehensive Complex	99345	$147.25	6.16
Tobacco Cessation Services for Pregnant Women			
Smoking & Tobacco use Cessation counseling visit; intermediate (3-10 min)	99406	$10.51	0.41
Intensive, greater than 10 minutes	99407	$20.71	0.79
Preventive Medicine Counseling/Risk Factor Reduction			
Approximately 15 min. ***Individual Services***	99401	$0.00	1.06
Approximately 30 min. ***Individual Services***	99402	$0.00	1.80
Approximately 45 min. ***Individual Services***	99403	$0.00	2.51
Approximately 60 min. ***Individual Services***	99404	$0.00	3.21
Approximately 30 min. ***Group Services***	99411	$0.00	0.49
Approximately 45 min. ***Group Services***	99412	$0.00	0.63
Presumptive Eligibility & Women's Health Medicaid Case Mgmt			
New Problem Focused / Established Minimal	99201/99211	$35.13 / $17.46	1.21/0.56
New Expanded Prob. Focused / Established Problem Focused	99202/99212	$54.57 / $29.67	2.08/1.22
New Detailed Low Complexity / Established Expanded Problem Focused	99203/99213	$76.53 / $40.70	3.02/2.04
New Comprehensive Moderate / Established Detailed Moderate	99204/99214	$110.51 / $62.71	4.64/3.01
New Comprehensive Complex / Established Comprehensive Complex	99205/99215	$137.12 / $93.46	5.78/4.03

7.7 Nurse Practitioner & Physician Services

Removal, Implanon	11976	$106.11	4.32
Diaphragm or cervical cap fitting with instructions	57170	$56.07	1.81
Colposcopy	57452	$69.12	3.26
Colposcopy with biopsy	57454	$89.33	4.59
Removal of IUD	58301	$72.99	2.87
New Problem Focused / Established Minimal	99201/99211	$35.13 / $17.46	1.21/0.56
New Expanded Prob. Focused / Established Problem Focused	99202/99212	$54.57 / $29.67	2.08/1.22
New Detailed Low Complexity / Established Expanded Problem Focused	99203/99213	$76.53 / $40.70	3.02/2.04
New Comprehensive Moderate / Established Detailed Moderate	99204/99214	$110.51 / $62.71	4.64/3.01
New Comprehensive Complex / Established Comprehensive Complex	99205/99215	$137.12 / $93.46	5.78/4.03

Section 8

Adult Health Services

8.1 Methodologies

Diagnostic, Screening & Preventive Services (DSPS): Is a Medicaid category of services solely for public health providers. County Boards of Health are enrolled as the qualified Medicaid provider.

Health departments agree to provide diagnostic, screening and treatment services in an office, clinic, school-based clinic, home, or other similar physical facility within the boundaries of the State of Georgia.

Nutritional Counseling (Individual & Group): Dietitians licensed by the Georgia Board of Examiners may bill for Nutritional Counseling. Medicaid reimburses for new patient nutritional assessment, established patient nutritional, counseling and nutritional group counseling visits.

DSPS will pay for one office visit per client, per date of service. If client receives a clinical service (nurse) and a nutritional counseling (dietician) service on the same day, billing should reflect the appropriate level of services provided; higher "enhanced"" office visit.

To bill Medicaid/CMOs for dispensing TB medicine; providers must perform face-to face, system review services warranting a minimal level office visit.

TCM for Adults with AIDS: New Client Comprehensive Assessment may only be billed once for each client served. One extended follow-up may be billed monthly, not to exceed three (3) per calendar year. Brief follow-ups are conducted as necessary, but no less than once per month. At least one of the following ICD-9 codes must be included on the claim when billing for Targeted Case Management Adults with AIDS: 1) 042 2) 079.53 or 3) 795.71.

When a Medicaid client with dual coverage receives TCM or Ryan White Services (Title II), Medicaid is the Primary Payer.

Please refer to the following website to obtain current Medicare Preventive Service rates based on your locality. https://apps.cahabagba.com/fees/getPhysician.do

8.2 DSPS

Service Description	CPT Code	Rate	2014 RVU
STD; TB; SHAPP; Ryan White; Nutritional Counseling; Walk In Services			
New Problem Focused / Established Minimal	99201/99211	$35.13 / $17.46	1.21/0.56
New Expanded Prob. Focused / Established Problem Focused	99202/99212	$54.57 / $29.67	2.08/1.22
New Detailed Low Complexity / Established Expanded Problem Focused	99203/99213	$76.53 / $40.70	3.02/2.04
New Comprehensive Moderate / Established Detailed Moderate	99204/99214	$110.51 / $62.71	4.64/3.01
New Comprehensive Complex / Established Comprehensive Complex	99205/99215	$137.12 / $93.46	5.78/4.03
Radiologic examination, chest; single view frontal	71010	$24.44	0.70
Radiologic exam, chest, 2 views, frontal & lateral	71020	$31.11	0.91
Pathology & Laboratory			
Handling, conveyance of specimen to lab	99000	$0.00	0.19
Routine venipuncture or finger/heel/ear stick for collection of specimen(s)	36415	$0.00	0.09
Urinalysis, by dip stick/tablet reagent, non-automated with microscopy	81000	$3.99	0.13
Non-automated without microscopy	81002	$3.21	0.10
Urine pregnancy test by visual method	81025	$7.96	0.26
Blood, occult; feces	82270	$4.04	0.13
Cholesterol, serum or whole blood, total	82465	$5.47	0.18
Glucose; quantitative	82947	$4.93	0.16
Glucose, blood by glucose monitoring device (FDA, home use)	82962	$2.94	0.09
Blood Count, Hemoglobin	85018	$2.98	0.10
Tuberculosis test, blood (QFT)	86480	$77.93	2.50
Wet mount	87210	$5.36	0.17
Tissue exam for fungi (e.g. KOH slide)	87220	$5.36	0.17
Home Visits			
New / Established - Problem Focused	99341 / 99347	$50.30 / $39.65	1.55/1.56
New / Established - Expanded Prob. Focused	99342 / 99348	$72.33 / $60.65	2.24/2.36
New / Established - Detailed Complexity	99343 / 99349	$106.14 / $91.64	3.66/3.57
New / Established - Comprehensive	99344 / 99350	$135.87 / $132.35	5.11/4.98
New Comprehensive Complex	99345	$147.25	6.16

8.2 DSPS (Continued)

Service Description	CPT Code	Modifier	Rate	2014 RVU
Preventive Medicine Counseling/Risk Factor Reduction				
Approximately 15 min. ***Individual Services***	99401		$0.00	1.06
Approximately 30 min. ***Individual Services***	99402		$0.00	1.80
Approximately 45 min. ***Individual Services***	99403		$0.00	2.51
Approximately 60 min. ***Individual Services***	99404		$0.00	3.21
Approximately 30 min. ***Group Services***	99411		$0.00	0.49
Approximately 45 min. ***Group Services***	99412		$0.00	0.63

8.3 Targeted Case Management for Adults w/ AIDS

New Client Comprehensive Assessment	T2023		$126.00	3.21
Extended Follow-up	T2023	TS, U1	$84.00	1.80
Brief Follow-up	T2023	TS	$42.00	1.06

8.4 MEDICARE PREVENTIVE SERVICES

Service Description	CPT Code	Rate	2014 RVU
Nurse Practitioner			
New Problem Focused / Established Minimal	99201/99211	**Please refer to the Adult Health Methodologies Section for the link to find current rates based on your service locality**	1.21/0.56
New Expanded Prob. Focused / Established Problem Focused	99202/99212		2.08/1.22
New Detailed Low Complexity / Established Expanded Problem Focused	99203/99213		3.02/2.04
New Comprehensive Moderate / Established Detailed Moderate	99204/99214		4.64/3.01
New Comprehensive Complex / Established Comprehensive Complex	99205/99215		5.78/4.03
Diabetes Self-Management Training			
Diabetes, self-mgmt training svcs, Individual (30 min)	G0108		1.53
Diabetes, self-mgmt training svcs, Group, 2 or more (30 min)	G0109		0.41
Diabetes Screening			
Blood Glucose Test	82947		0.16
Post glucose dose; includes glucose	82950		0.19
Glucose Tolerance Test (GTT)	82951		0.52
Screening Pap Test & Pelvic Exam			
Cervical or vaginal cancer screening; pelvic & clinical breast exam	G0101		1.12
Screening pap smear; obtaining, preparing and conveyance of smear to lab	Q0091		1.35
Screening Mammograms			
Computer-aided detection (Use 77057 in conjunction w/ 77052)	77052		0.30
Screening mammography, bilateral, 2 views	77057		2.40
Screening mammogram, bilateral, all views	G0202		4.08
Colorectal Cancer Screening			
Cancer screening; fecal occult blood test, consecutive collection w/ 1 determination	82270		0.13
Cancer screening; fecal occult blood test, 1-3 simultaneous	G0328		0.64

8.4 MEDICARE PREVENTIVE SERVICES (Continued)

Service Description	CPT Code	Rate	2014 RVU
Smoking Cessation		Please refer to the Adult Health Methodologies Section for the link to find current rates based on your service locality	
Cessation counseling visit; intermediate, greater than 3 min up to 10 min	99406		0.41
Cessation counseling visit; intensive, greater than 10 min	99407		0.79
HIV Screening			
Infectious antibody detection, EIA technique, HIV-1 and/or HIV-2 screening	G0432		0.55
Infectious antibody detection, ELISA technique, HIV-1 and/or HIV-2 screening	G0433		0.55
Registered Dietician			
Medical Nutrition Therapy		Please refer to the Adult Health Methodologies Section for the link to find current rates based on your service locality	
Initial Assessment, Individual (15 min)	97802		1.04
Re-assessment, Individual (15 min)	97803		0.90
Group assessment, 2 or more individuals, each (30 min)	97804		0.46
Re-assessment, 2nd referral in 1st yr, Individual (15 min)	G0270		0.90
Re-assessment, 2nd referral in 1st yr, Group, 2 or more individuals, each (30 min)	G0271		0.46
Diabetes Self-Management Training			
Diabetes, outpatient self-mgmt training svcs, individual, (30 min)	G0108		1.53
Diabetes, outpatient self-mgmt training svcs, Group, 2 or more individuals, (30 min)	G0109		0.41

Section 9

Dental Services

9.1 Methodologies

Under the Georgia Medicaid program, there are three (3) separate components of dental coverage:

- The Health Check Program is for Members under twenty-one years old (eligibility ends at the end of the month in which they turn twenty-one),

- The Adult Dental Program is for Members over twenty-one; Dental services under this program are available as a result of need by the Member. Adult dental services only covers emergency and related services, except those services listed on Appendix B-1 of the Dental Services Provider Manual for validated pregnant members.

- Dental Services for Pregnant Women are expanded dental services for pregnant women that begin on the date of service following verification of pregnancy and extend to the date of delivery; The member is liable for non-covered services and services rendered after the date of delivery or during the member's non-pregnant state.

9.2 HEALTHCHECK (HC); ADULT (A); PREGNANT (P)

Service Description	CPT Code	HC	A	P	Rate	2014 RVU
Periodic Oral Evaluation - established patient	D0120	●		●	$22.77	0.50
Limited oral Evaluation - problem focused	D0140	●	●		$38.29	0.84
Comprehensive Oral Evaluation - new or established patient	D0150	●		●	$39.33	0.88
Intraoral - complete series (including bitewings)	D0210	●			$75.25	1.47
Intraoral - periapical first film	D0220	●	●		$13.45	0.29
Intraoral - periapical, each additional film	D0230	●	●		$10.35	0.26
Intraoral - Occlusal Film	D0240	●			$19.66	0.47
Bitewing, single film	D0270	●			$14.49	0.29
Bitewing, two films	D0272	●			$21.73	0.47
Bitewing, four films	D0274	●			$33.12	0.66
Panoramic Option	D0330	●	●		$56.92	1.37
Prophylaxis	D1110	●		●	$32.08	1.06
Prophylaxis - child	D1120	●			$32.08	0.72
topical fluoride varnish	D1206	●			$17.59	0.65
topical application of fluoride	D1208	●		●	$17.59	0.00
Sealant - per tooth	D1351	●			$27.94	0.57
Space maintainer - fixed unilateral	D1510	●			$180.09	3.69
space maintainer-fixed-bilateral	D1515	●			$238.05	5.17
Space maintainer - removable bilateral	D1525	●			$210.76	6.27
Re-cementation of Space Maintainer	D1550	●			$45.54	0.80
Amalgam - one surface	D2140	●			$53.82	1.26
Amalgam - one surface	D2140	●		●	$60.03	1.26
Amalgam - two surfaces	D2150	●			$69.34	1.62
Amalgam - two surfaces	D2150	●		●	$77.62	1.62
Amalgam - three surfaces	D2160	●			$82.80	1.96
Amalgam - three surfaces	D2160	●		●	$94.18	1.96
Amalgam –four or more surfaces, primary or permanent	D2161	●		●	$98.08	2.40
Resin-based composite - one surface, anterior	D2330	●		●	$71.41	1.55
Resin-based composite - two surfaces, anterior	D2331	●		●	$91.08	1.98
Resin-based composite - three surfaces, anterior	D2332	●		●	$110.74	2.42
Resin-based composite - one surface, posterior	D2391	●			$80.73	1.81
Resin-based composite - one surface, posterior	D2391	●		●	$88.80	1.81
Resin-based composite - two surfaces, posterior	D2392	●		●	$95.22	2.37
Resin-based composite - two surfaces, posterior	D2392	●		●	$110.74	2.37
Resin-based composite - four or more surfaces, posterior	D2394	●		●	$126.37	3.61
Resin-based composite - four or more surfaces, posterior	D2394	●		●	$151.42	3.61
Re-cement Crowns	D2920	●			$41.40	1.08
Prefabricated stainless steel crown - primary tooth	D2930	●			$143.86	2.93
Prefabricated stainless steel crown - permanent tooth	D2931	●			$162.49	3.31
Prefabricated resin crown - composite Crown	D2932	●			$176.98	3.53
Prefabricated esthetic coated stainless steel crown, primary tooth	D2934	●			$143.86	4.04
Sedative Fillings	D2940	●			$54.85	1.12
Pin Retention per tooth in addition to restoration	D2951	●			$28.98	0.63

9.2 HEALTHCHECK (HC); ADULT (A); PREGNANT (P)

Service Description	CPT Code	HC	A	P	Rate	2014 RVU
Comprehensive Periodontal	D0180			•	$39.33	0.96
Resin based composite, 4+ anterior	D2335			•	$131.44	2.86
Resin based composite - three surfaces, posterior	D2393			•	$137.65	2.95
Prefabricated post and core in addition to crown	D2954	•		•	$54.22	3.53
Therapeutic pulpotomy (excluding final Restoration)	D3220	•			$90.04	1.81
Pulpal Debridement, Primary and Permanent Teeth	D3221	•			$91.08	1.99
Anterior (excluding final restoration)	D3310	•			$77.64	7.52
Anterior (excluding final restoration)	D3310	•			$379.84	7.52
Bicuspid (excluding final restoration)	D3320	•			$463.68	9.21
Apicoectomy/periradicular surgery - anterior	D3410	•			$229.81	8.48
Apicoectomy/periradicular surgery (each additional root)	D3426	•			$38.06	3.61
Gingivectomy or Gingivoplasty - four or more contiguous teeth	D4210	•			$157.38	6.63
Gingival flap procedure, including root planning	D4240	•		•	$129.37	8.39
Gingival flap, including root planning 1-3 teeth	D4241			•	$97.03	4.87
Osseous Surgery (including flap entry and closure)	D4260	•			$341.00	14.01
Pedicle soft tissue graft procedure	D4270	•			$272.14	9.95
Periodontal Scaling & root planning 4+ teeth	D4341			•	$140.76	2.80
Periodontal scaling 1-3 teeth	D4342			•	$105.57	1.62
Periodontal maintenance	D4910			•	$42.20	1.72
Complete denture maxillary	D5110	•			$673.78	16.16
Complete denture mandibular	D5120	•			$673.78	16.16
Immediate denture maxillary	D5130	•			$554.12	17.62
immediate denture mandibular	D5140	•			$554.12	17.62
Maxillary Partial - Resin Base	D5211	•			$276.64	13.64
Maxillary Partial - Resin Base	D5211	•			$569.25	13.64
Mandibular Partial - Resin Base	D5212	•			$661.36	15.85
Mandibular Partial - Resin Base	D5212	•			$276.64	15.85
Adjust Complete Denture - maxillary	D5410	•			$23.77	0.87
Adjust Complete Denture - mandibular	D5411	•			$23.77	0.87
Adjust partial Denture - maxillary	D5421	•			$11.76	0.87
Adjust Partial Denture - mandibular	D5422	•			$11.76	0.87
Repair broken complete denture base	D5510	•			$73.48	1.77
Replace broken teeth - per tooth	D5640	•			$92.17	1.62
Add tooth to existing partial denture	D5650	•			$92.17	2.21
Adding clasp to existing partial denture	D5660	•			$110.74	2.65
Reline complete maxillary denture (laboratory)	D5750	•			$156.56	4.94
Reline complete mandibular denture (laboratory)	D5751	•			$156.56	4.94
Tissue Conditioning - maxillary	D5850	•			$47.54	1.56
Tissue Conditioning - mandibular	D5851	•			$47.54	1.56

9.2 HEALTHCHECK (HC); ADULT (A); PREGNANT (P)

Service Description	CPT Code	HC	A	P	Rate	2014 RVU
Extraction, coronal remnants - deciduous tooth	D7111	●	●		$48.12	1.21
Extraction, erupted tooth or exposed root	D7140	●	●		$64.17	1.60
Extraction, erupted tooth or exposed root	D7140	●	●		$61.06	1.60
Surgical removal of erupted tooth	D7210	●	●		$128.34	2.85
Removal of impacting tooth - soft tissue..	D7220	●	●		$160.42	3.57
Removal of impacted tooth - partially bony.	D7230	●	●		$214.24	4.74
Removal of impacted tooth -	D7240	●	●		$251.50	5.57
Surgical removal of residual tooth roots (cutting procedure).	D7250	●	●		$135.58	3.01
Oroantral fistuala closure	D7260	●			$307.45	17.69
Tooth re-implantation and/or stabilization	D7270	●	●		$276.34	5.54
Surgical access of an unerupted tooth	D7280	●			$256.68	5.16
Biopsy of oral tissue - soft	D7286	●	●	●	$219.42	4.42
Biopsy of oral tissue - soft	D7286	●	●	●	$29.55	4.42
Alveoplasty in conjunction with extractions - 4+ teeth	D7310	●			$150.07	2.95
Alveoplasty in conjunction with extractions - 1-3 teeth	D7311	●			$54.22	2.58
Alveoplasty not in conjunction with extractions - 1-3 teeth	D7320	●			$669.64	4.79
Alveoplasty not in conjunction with extractions	D7321	●			$63.86	4.05
Excision of malignant tumor Lesion diameter up to 1.25cm	D7440	●			$843.52	14.01
Removal of benign cyst or tumor lesion diameter up to 1.25cm	D7450	●			$477.13	8.85
Removal of benign cyst or tumor diameter greater than 1.25cm	D7451	●			$750.37	12.09
Removal of benign cyst or tumor up to 1.25cm	D7460	●			$477.13	8.85
Removal of benign cyst or tumor/lesion diameter greater than over 1.25cm	D7461	●			$769.00	12.09
Removal of lateral exostosis (maxilla or mandible)	D7471	●			$230.55	10.95
Incision and drainage of abscess - intraoral soft tissue	D7510	●	●		$142.83	3.16
Incision and drainage of abscess - extraoral soft tissue	D7520	●	●		$682.06	15.10
Removal of reaction-producing foreign bodies of musculoskeletal system	D7540	●	●		$62.99	6.02
Partial ostectomy/sequestrectomy for removal of non-vital bone.	D7550	●			$231.31	3.76
Maxilla -open reduction (teeth immobilized, if present)	D7610	●	●		$994.11	48.29
Maxilla - closed reduction (teeth immobilized, if present)	D7620	●	●		$645.45	36.21
Mandible - open reduction (teeth immobilized, if present)	D7630	●	●		$994.11	62.78
Mandible - closed reduction (teeth immobilized, if present)	D7640	●	●		$645.45	39.84
Closed Reduction of dislocation	D7820	●	●		$115.71	8.70
Suture of recent small wounds up to 5cm	D7910	●	●		$218.38	4.84
Complicated suture greater than 5cm	D7912	●	●		$982.21	21.74
Frenulectomy (frenectomy or frenotomy) - separate procedure	D7960	●			$315.67	4.05
Excision of Hyperplasic Tissue (per arch)	D7970	●			$324.99	5.90
Excision of Pericoronal gingiva	D7971	●			$85.90	2.21
Appliance Removal incl removal of archbar	D7997	●			$19.03	3.39
Comprehensive Orthodontic Treatment of Adolescent Dentition	D8080	●			$844.62	3.39
Pre-Orthodontic treatment visit	D8660	●			$83.53	1.47

9.2 HEALTHCHECK (HC); ADULT (A); PREGNANT (P)

Service Description	CPT Code	HC	A	P	Rate	2014 RVU
Periodic Orthodontic treatment visit (as part of contract)	D8670				$105.57	3.39
Palliative (emergency) treatment of dental pain, minor procedure	D9110	●		●	$51.75	1.14
Local Anesthesia (not in conjunction with other services & procedures)	D9215			●	$10.00	0.35
Deep Sedation/General Anesthesia - first 30 minutes	D9220	●	●		$198.72	4.28
Deep Sedation/General Anesthesia - each additional 15 minutes	D9221	●	●		$49.68	1.93
Analgesia, anxiolysis, inhalation of nitrous oxide	D9230	●	●		$26.91	0.71
Intravenous conscious sedation - first 30 minutes	D9241	●	●		$195.61	3.32
Intravenous conscious sedation/analgesia, each additional 15 minutes	D9242	●	●		$97.80	1.62
Non-Intravenous Conscious Sedation	D9248	●	●		$50.00	1.03
Consultation diagnostic service provided by dentist or physician	D9310	●			$104.53	2.35
Hospital Call	D9420	●			$94.70	4.36
Office Visit After Regularly Scheduled Hours	D9440	●	●		$66.03	1.48
Therapeutic parenteral drug, single administration	D9610	●			$53.82	0.00
Other drugs & medication, by report	D9630	●			$38.29	0.00
Behavior Management, by report (Only post approval is required)	D9920	●			$56.92	0.00

Section 10

Miscellaneous Services

10.1 Methodologies

Most of our public health departments provide Immunization, Child Health, Women's Health, and Adult Health Services that are covered by our contracted payers. These same services along with other services that are not covered at all may also be provided to patients who have other insurance or are uninsured or underinsured at a set fee. Each County Board of Health sets their own fees for these services and payment may be required at time of service. Listed are a few of the additional services that may be provided at some health departments.

SELF-PAY SERVICES	
Blood Pressure, Height, and Weight Checks	Fees for these services are set by the local County Boards of Health.
Copy of Medical Records	
CPR Certification Services	
DNA Collection Services	
Drug Testing Collection Services	
Fax Medical Records	
General Lab Services	
Health Check Services	
I-693 Form Completion	
International Travel Services	
Lice and Scabies Checks	
Pregnancy Tests	
Prepare Immunization & Hearing, Vision, Dental Certificates w/o service	
Refugee Screening Services	
Sports Physicals w/ Certificate	
SSI Services	

Section 11

Appendices

11.1 Component Requirements for Office/Home Visits

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by a recognized health care provider and reported by a specific CPT code(s).

A new patient is one who has not received any professional services from the physician, health care provider or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.

The Level of Service is based on the following Components: For **all of the key components**, i.e., history, examination, and medical decision-making, must meet or exceed the stated requirements to qualify for a particular level of office visit.

For **two of the three components**, i.e., history, examination, and medical decision-making, must meet or exceed the state requirements to qualify for a particular level of office visit.

When counseling and/or coordination of care dominates more than 50% of the face-to-face encounter, then **time** shall be considered the controlling factor to qualify for a particular level of office visit.

Component Requirements for Office Visits

Office or Other Outpatient Services						
Patient: New						
Required Components: 3/3						
Code		99201	99202	99203	99204	99205
Required Key Components	**History and Exam (#1 and #2)**					
	Problem Focused	x				
	Expanded Problem Focused		x			
	Detailed			x		
	Comprehensive				x	x
	Medical Decision Making (#3)					
	Straightforward	x	x			
	Low			x		
	Moderate				x	
	High					x
Contributory Factors	**Presenting Problem (Severity) (#1)**					
	Self-Limited or Minor	x				
	Low to Moderate		x			
	Moderate			x		
	Moderate to High				x	x
	Counseling and Coordination of Care (#2 and #3) See E/M Guidelines					
	Typical Face-to-Face Time (#4)					
	Minutes	10	20	30	45	60

Office or Other Outpatient Services						
Patient: Established						
Required Components: 2/3						
Code		99211	99212	99213	99214	99215
Required Key Components	**History and Exam (#1 and #2)**					
	Problem Focused	N/A	x			
	Expanded Problem Focused			x		
	Detailed				x	
	Comprehensive					x
	Medical Decision Making (#3)					
	Straightforward	N/A	x			
	Low			x		
	Moderate				x	
	High					x
Contributory Factors	**Presenting Problem (Severity) (#1)**					
	Minimal	x				
	Self-Limited or Minor		x			
	Low to Moderate			x		
	Moderate to High				x	x
	Counseling and Coordination of Care (#2 and #3) See E/M Guidelines					
	Typical Face-to-Face Time (#4)					
	Minutes	5	10	15	25	40

Component Requirements for Home Visits

Home Services					
Patient: New					
Required Components: 3/3					
Code	99341	99342	99343	99344	99345
Required Key Components					
History and Exam (#1 and #2)					
Problem Focused	x				
Expanded Problem Focused		x			
Detailed			x		
Comprehensive				x	x
Medical Decision Making (#3)					
Straightforward	x				
Low		x			
Moderate			x	x	
High					x
Contributory Factors					
Presenting Problem (Severity) (#1)					
Low	x				
Moderate		x			
Moderate to High			x		
High				x	
Unstable/Significant New Problem					x
Counseling and Coordination of Care (#2 and #3) See E/M Guidelines					
Typical Face-to-Face Time (#4)					
Minutes	20	30	45	60	75

Home Services				
Patient: Established				
Required Components: 2/3				
Code	99347	99348	99349	99350
Required Key Components				
Interval History and Exam (#1 and #2)				
Problem Focused	x			
Expanded Problem Focused		x		
Detailed			x	
Comprehensive				x
Medical Decision Making (#3)				
Straightforward	x			
Low		x		
Moderate			x	
Moderate to High				x
Contributory Factors				
Presenting Problem (Severity) (#1)				
Self-Limited or Minor	x			
Low to Moderate		x		
Moderate to High			x	
Moderate to High/Unstable/ Significant New Problem				x
Counseling and Coordination of Care (#2 and #3) See E/M Guidelines				
Typical Face-to-Face Time (#4)				
Minutes	15	25	40	60

11.2 RELATED LINKS

Immunization Schedules: http://www.cdc.gov/vaccines/schedules/index.html

Advance Beneficiary of Notice and Instructions: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf

Medicaid eligibility and submit claims: https://www.mmis.georgia.gov

Medicaid Provider Manuals & Fee Schedules: https://www.mmis.georgia.gov

Centers for Medicare & Medicaid Services: http://www.cms.gov/

Peach State Health Plan: http://www.pshpgeorgia.com

Amerigroup: https://providers.amerigroup.com/pages/ga-2012.aspx

Wellcare: http://georgia.wellcare.com

BCBS: http://www.bcbsga.com/home-providers.html

AETNA: http://www.aetna.com/

11.3 ACRONYMS

ADA AMERICAN DENTAL ASSOCIATION
CIS CHILDREN INTERVENTION SERVICES
CMO CARE MANAGEMENT ORGANIZATION
CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
COB COORDINATION OF BENEFITS
COS CATEGORY OF SERVICE
CPT CURRENT PROCEDURAL TERMINOLOGY
DOS DATES OF SERVICE
DSPS DIAGNOSTIC, SCREENING AND PREVENTIVE SERVICES
EDI ELECTRONIC DATA INTERCHANGE
EOB EXPLANATION OF BENEFITS
EOMB EXPLANATION OF MEDICARE BENEFITS
EPSDT EARLY& PERIODIC SCREENING DIAGNOSIS & TREATMENT
FFS FEE-FOR-SERVICE
HC HEALTH CHECK
HCPCS HEALTHCARE COMMON PROCEDURE CODING SYSTEM
HIPAA HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
ICD-9 INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH EDITION
NDC NATIONAL DRUG CODE
NPI NATIONAL PROVIDER IDENTIFIER
PCM PERINATAL CASE MANAGEMENT
POS PLACE OF SERVICE
PPO PREFERRED PROVIDER ORGANIZATION
QMB QUALIFIED MEDICARE BENEFICIARY
RA REMITTANCE ADVICE
TPA THIRD PARTY ADMINISTRATOR
TPL THIRD PARTY LIABILITY
UB UNIFORM BILLING

DEFINITIONS

Administrative Review: The formal reconsideration, as a result of the proper and timely submission of a provider or member's request, which has proposed an adverse action.

Adverse Action (provider): An instance in which the Division: a) denies or reduces the amount of reimbursement claimed; b) recovers funds previously paid; c) sets or changes reimbursement rates, or d) suspends, terminates, or refuses to enroll, re-enroll, or reinstate a provider.

Banner Message: Messages on a RA informing providers of upcoming changes in Medicaid policies. They are also posted at www.mmis.georgia.gov.

Claim: A bill for services, a line item of service, or all services for one recipient within a bill.

Clean Claim: One that can be processed without obtaining additional information.

Coordination of Benefits: The processes used to determine which payer has primary responsibility for payment of claims when more than one plan is in effect at the same time.

Co-payments: A set amount that is collected from the patient at time of service.

Covered Service: A service for which reimbursement is allowed through the Georgia Medical Assistance Programs.

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT): Immunizations, health screenings, vision, hearing, and dental services, and other diagnostic services that are provided to members under the age of 19.

Electronic Data Interchange (EDI): Electronic claims submission, eligibility, remittance advice, and clearinghouse services for several submission media and claim formats.

Medicaid Provider ID: The number assigned to a provider enrolled in the Medicaid program. The ID is required for the paper claims submission, web-based transactions, Medicaid forms, and for all other Medicaid activities.

National Provider Identifier (NPI): The 10-digit number used as a healthcare provider identifier. It is used as the identifier on standard electronic transactions such as claims and eligibility inquiries.

Prior approval: Approval of services by a provider prior to the time they are rendered.

Third Party: Any individual, entity, or program that may be liable to pay all or part of the expenses for medical care furnished to a member.

Remittance Advice (RA): Claims that are paid, denied, adjusted, or placed in process will be listed on the RA. Information on the RA is used to assist the provider in reconciling accounts and guarding against false or erroneous billings.

Denied Claims: The RA will indicate the adjustment reason code and remark code that indicates why a particular claim could not be paid. If the provider does not resubmit the claim, the charges for the services should be written off any accounts receivable records maintained by the provider.

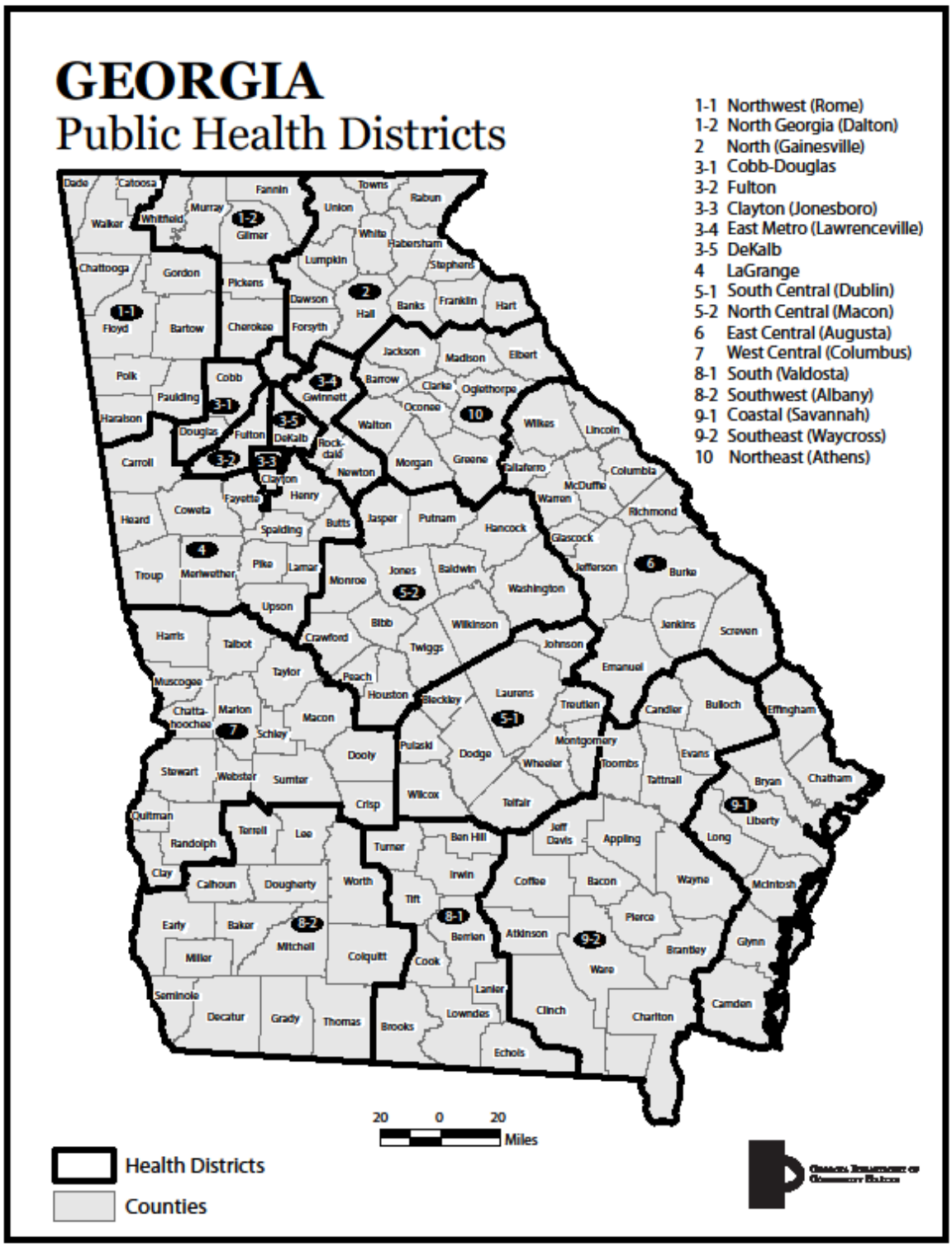
Adjustments: The RA will indicate positive adjustments to previous payments made to the provider and negative adjustments resulting from rate changes, retrospective review, or other actions by the provider or the Division.

Financial Transactions: The RA will indicate refund adjustments, recoupments subtracted from the amount payable, voluntary refunds by the provider, and lump sum payouts.

Adjustment Requests: If the amount reimbursed to an enrolled provider is not correct, a positive or negative adjustment may be necessary. The adjustment request must include sufficient documentation to identify each claim.

11.4 HEALTH PLANS BY REGION

Region	Counties	Health Plans
Atlanta	Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Henry, Jasper, Newton, Paulding, Pickens, Rockdale, Spalding, Walton	Amerigroup, Peach State, WellCare
Central	Baldwin, Bibb, Bleckley, Chattahoochee, Crawford, Crisp, Dodge, Dooly, Harris, Heard, Houston, Johnson, Jones, Lamar, Laurens, Macon, Marion, Meriwether, Monroe, Muscogee, Peach, Pike, Pulaski, Talbot, Taylor, Telfair, Treutlen, Troup, Twiggs, Upson, Wheeler, Wilcox, Wilkinson	Amerigroup, Peach State, WellCare
East	Burke, Columbia, Emanuel, Glascock, Greene, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Putnam, Richmond, Taliaferro, Warren, Washington, Wilkes	Amerigroup, Peach State, WellCare
North	Banks, Catoosa, Chattooga, Clarke, Dade, Dawson, Elbert, Fannin, Floyd, Franklin, Gilmer, Gordon, Habersham, Hall, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Oconee, Oglethorpe, Polk, Rabun, Stephens, Towns, Union, Walker, White, Whitfield	Amerigroup, Peach State, WellCare
Southeast	Appling, Bacon, Brantley, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Effingham, Evans, Glynn, Jeff Davis, Liberty, Long, McIntosh, Montgomery, Pierce, Screven, Tattnall, Toombs, Ware, Wayne	Amerigroup, Peach State, WellCare
Southwest	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Clay, Clinch, Coffee, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Irwin, Lanier, Lee, Lowndes, Miller, Mitchell, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Terrell, Thomas, Tift, Turner, Webster, Worth	Amerigroup, Peach State, WellCare


GEORGIA
Public Health Districts
1-1 Northwest (Rome)
1-2 North Georgia (Dalton)
2 North (Gainesville)
3-1 Cobb-Douglas
3-2 Fulton
3-3 Clayton (Jonesboro)
3-4 East Metro (Lawrenceville)
3-5 DeKalb
4 LaGrange
5-1 South Central (Dublin)
5-2 North Central (Macon)
6 East Central (Augusta)
7 West Central (Columbus)
8-1 South (Valdosta)
8-2 Southwest (Albany)
9-1 Coastal (Savannah)
9-2 Southeast (Waycross)
10 Northeast (Athens)
20 0 20
Miles
Health Districts
Counties

11.5 District & State Billing Contacts

DISTRICT 1-1 ROME			CONTACT INFO
Bartow	Floyd	Polk	Julie Payne 1309 Redmond Rd., Rome, GA 30165 **Phone:** 706-295-6746
Catoosa	Gordon	Walker	
Chattooga	Haralson		
Dade	Paulding		
DISTRICT 1-2 DALTON			Cynthia Mann 100 W. Walnut Ave, Dalton, GA 30702 **Phone:** 706-272-2125 ext. 315
Cherokee	Gilmer	Pickens	
Fannin	Murray	Whitfield	
DISTRICT 2 GAINESVILLE			Anita Holsenbeck 1280 Athens St., Gainesville, GA 30507 **Phone:** 770- 535-5780
Banks	Hall	Towns	
Dawson	Hart	Union	
Forsyth	Lumpkin	White	
Franklin	Rabun		
Habersham	Stephens		
DISTRICT 3-1 COBB/DOUGLAS			Lisa Stevens 1650 County Services Pkwy, Marietta, GA 30008 **Phone:** 770-739-3214
Cobb	Douglas		
DISTRICT 3-2 FULTON			LaShonna Jackson 99 Jesse Hill Jr. Dr., Atlanta, GA 30303 **Phone:** 404-613-1220
Fulton			
DISTRICT 3-3 CLAYTON			Barbara Woodson 1117 Battlecreek Rd., Jonesboro, GA 30236 **Phone:** 678-479-2228
Clayton			
DISTRICT 3-4 GWINNETT			Veronica Hudson 2570 Riverside Parkway, Lawrenceville, GA 30045 **Phone:** 678- 442-6884
Gwinnett	Rockdale		
Newton			
DISTRICT 3-5 DEKALB			Parecia Benson 455 Winn Way, Decatur, GA 30031 **Phone:** 404-294-3830
Dekalb			
DISTRICT 4 LAGRANGE			Beth Crocker 122-A Gordon Commercial Dr., LaGrange, GA 30240 **Phone:** 706-298-7715
Butts	Fayette	Lamar	Spaulding
Carroll	Heard	Meriwether	Troup
Coweta	Henry	Pike	Upson
DISTRICT 5-1 DUBLIN			Tina Chavis 2121-B Bellevue Rd., Dublin, GA 31021 **Phone:** 478-275-6545
Bleckley	Montgomery	Wheeler	
Dodge	Pulaski	Wilcox	
Johnson	Telfair		
Laurens	Treutlen		

DISTRICT 5-2 MACON Baldwin, Bibb, Crawford, Hancock, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Washington, Wilkerson	Bobbie Birt 201 Second St, Suite 1100, Macon, GA 31201 **Phone:** 478-751-6026
DISTRICT 6 AUGUSTA Burke, Columbia, Emanuel, Glascock, Jefferson, Jenkins, Lincoln, Richmond, McDuffie, Screven, Taliferro, Warren, Wilkes	Debra Underwood 1916 N. Leg Rd., Bldg D, Augusta, GA 30909 **Phone:** 706-667-4262
DISTRICT 7 COLUMBUS Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumpter, Talbot, Taylor, Webster	Sherrie Martin 2100 Comer Ave., Columbus, GA 31904 **Phone:** 706-321-6206
DISTRICT 8-1 VALDOSTA Ben Hill, Berrin, Brooks, Cook, Echols, Irvin, Lanier, Lowndes, Tift, Turner	Susan Green 312 N. Patterson St., Valdosta, GA 31605 **Phone:** 229-333-7587
DISTRICT 8-2 ALBANY Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	Trish Johnson, Kimberly Sherrer PO Box 547, 327 Sunset Ave, Newton, GA 39870 **Phone:** 229-734-4701
DISTRICT 9-1 COASTAL Bryan, Camden, Chatham, Effingham, Glenn, Liberty, Long, McIntosh	Connie Rozier 150 Scranton Connector, Brunswick, GA 31525 **Phone:** 912-437-4472
DISTRICT 9-2 WAYCROSS Appling, Atkinson, Bacon, Brantley, Bulloch, Candler, Charlton, Clinch, Coffee, Evans, Jeff Davis, Pierce, Tattnall, Toombs, Ware, Wayne	Starla Sutton 1101 Church St., Waycross, GA 31501 **Phone:** 912-427-2042
DISTRICT 10 ATHENS Barrow, Clarke, Elbert, Jackson, Madison, Morgan, Greene, Oconee, Oglethorpe, Walton	Kim McGinnis 220 Research Dr., Athens, GA 30605 **Phone:** 706-583-2856
STATE OFFICE 2 Peachtree Street, NW, Atlanta, GA 30303	Kimberly Russell, Billing Specialist (10th floor) **Phone:** 404-657-9634
	Paula Brown, Project Officer (15th floor) **Phone:** 404-232-1393