PART II

POLICIES AND PROCEDURES
for
HOME HEALTH SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

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TABLE OF CONTENTS

Home Health Services 4
Chapter 600: Conditions of Participation 4
601. General Criteria 4
602. Home Health and Waiver Services 9
603. Elderly and Disabled Waivers – Community Care Services (CCSP) and SOURCE Programs 10
604. Independent Care Waiver Program and Traumatic Brain Injury Program 10
605. NOW/COMP Waiver 11
606. GAPP 11
607. PeachCare for Kids 11
608. Record Keeping Requirements 11
Chapter 700: Special Eligibility Conditions 14
701. Special Member Eligibility Criteria 14
702. Place of Residence 19
Chapter 800: Prior Approval 20
801. General 20
802. Medicare/Medicaid Eligible 20
803. Maximum Visits 20
804. Community Care Services Program (CCSP) Referrals 23
805. Independent Care Waiver Program (ICWP) Traumatic Brain Injury (TBI) Referrals 24
Chapter 900: Scope of Services 26
901. Admission Requirements 26
902. Skilled Nursing Services 26
903. Home Health Aide Services 34
904. Therapy Services 35
905. The Clinical Record 38
906. On-Site Reviews and Audits 39
907. Non-Covered Services 40
908. Supplies 41
Chapter 1000: Basis For Reimbursement 45
1001. Reimbursement Methodology 45
1002. Nonallowable Costs 47
1003. Appeal of Reimbursement Rates 50
1004. Provider Return on Equity 50

1005. Classification of Agencies 50
Appendix A 52
Medicaid Member Identification Card Sample 52
Appendix B 53
Definitions 53
Appendix C 54
Home Health Cost Data Form (Free Standing) 54
Appendix D 55
Home Health Cost Data Form (Hospital-Based) 55
Appendix E 56
Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation 56
Appendix F 57
Co-Payment 57
Appendix G 60
Notice of Your Right to a Hearing 60
Appendix H 61
New CMS 1500 Claim Form (version 02/12) 61
Appendix H-1 62
Health Insurance Claim Form 1500 Instructions 62
Appendix I 66
Home Health Services National Code Table 66
Appendix J 70
COS 200 – Home Health Services Program – Addition of Branch Location 70
Appendix K 71
Health Care Providers 71
Appendix L 72
Durable Medical Equipment Face-To-Face Encounters 72
Appendix M 74
Provider Preventable Conditions, Never Events, and Hospital Acquired Conditions 74
Appendix N 75
General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) providers 75
Appendix O 76
Screening, Brief Intervention, and Referral of Treatment (SBIRT) Services 76
Appendix P 78
Radiological Services 78

Policy Revision Record

from 2025 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
04/01/2025	N/A	No changes were made this quarter.	N/A	N/A
01/01/2025	All	Re-formatting of entire policy.	M	N/A
01/01/2025	Appendix L	Removed Appendix page for Ga Families.	D	N/A
01/01/2025	Appendix E	Removed Appendix pages for Non-Emergency Transportation Program.	D	N/A
01/01/2025	Appendix T	Removed Appendix Pages for Ga Families 360.	D	N/A
01/01/2025	Appendix E	Added Appendix Page for Ga Families, Non-Emergency Transportation Program and Ga Families 360.	A	N/A
01/01/2025	Appendix H	Removed Blank page	D	N/A
01/01/2025	Appendix R	Removed Blank Page	D	N/A

[1] The revisions outlined in this Table are from January 2025 to current. For revisions prior to 2025, please see prior versions of the policy.

601. General Criteria

In addition to the general conditions of participation identified in Part I, Section 106 of this manual, providers in the Home Health Services Program must meet the following conditions:

601.1. Licensure and Certification

601.1.1. The home health agency must be currently licensed by the Survey and Certification of the Department of Healthcare Facility Regulations (HFR) Healthcare Licensing Unit.

601.1.2. The home health agency must be currently certified to render services under Medicare (Title XVIII).

601.1.2.1. Copies of the following documents must be submitted with the enrollment application:

601.1.2.1.1. The Medicare certification notice, indicating the counties for which the agency has certification, with the Medicare provider number; and

601.1.2.1.2. A copy of the License issued by the HFR Healthcare Licensing Office indicating services approved and the counties in which the agency is licensed to operate.

601.1.2.1.3. A copy of the completed HFR Healthcare Licensing ownership disclosure form or a copy of the Division's ownership disclosure form.

601.1.3. Home health agencies established after June 30, 1979, must be approved by and possess a Certificate of Need from the State Health Planning Agency. A copy of such certification must be submitted with the enrollment application. Home health agencies established prior to July 1, 1979, must present certification of start-update.

601.1.3.1. The home health agency must maintain current clinical records on all patients as described in Section 904.

601.1.3.2. The home health agency must maintain justification for home health services in the Plan of Care with a copy of the signed physician orders.

601.1.3.3. The home health agency must agree to periodic, on-site patient care reviews and financial audits by authorized

representatives of the Division.

601.1.3.4. The home health agency must not bill the Division more than the rate charged private pay patients for similar services. The agency must maintain and make available records of both Medicaid and private pay patients for a minimum of three years in order to document compliance with this provision.

601.1.3.5. The home health agency must bill only for completed services rendered in the patient's home. If the agency attempts to visit a patient and the patient is not at home, the agency must not bill the Division for an attempted visit. Efforts made by home health agencies to bill the Division for service visits to patients not at home will not be reimbursed, or reimbursement made will be recouped.

601.1.3.6. The home health agency is responsible for assuring that there is no duplication of services (see note box). Additionally, the home health agency agrees not to provide services to members when those services are provided through other Medicaid programs. Other Medicaid programs include but are not limited to Children's Intervention Services, Children's Intervention School Services, Model Waiver Services, Mental Retardation Waiver Program, Physician Services, Perinatal Case Management, Mental Health Services, Independent Care Waiver Program and Therapy Services.

601.1.3.6.1. A provider may submit an application to Gainwell Technologies Services. Gainwell Technologies Services post office box is closed effective May 1, 2015. See Part I Policy and Procedures for Medicaid and PeachCare for Kids Manual, Section 112, for the paperless initiative requirements and the current Gainwell Technologies mailboxes.

NOTE: When a referral is received for home health services, it is the responsibility of the home health agency to verify a member's participation in the Community Care Services program before providing services by contacting the local Area Agency on Aging.

601.1.3.7. The home health agency must notify Provider Enrollment as the fiscal agent and the Division in writing of changes in enrollment status such as: name change, new address and telephone number, additional

subunits or branches, dissolution of a corporation, voluntary termination from the program, loss of certification or licensure, or filing of bankruptcy petitions. Each notice of change must include the date on which the change is to be effective.

601.1.3.8. Home health agencies that provide services under subcontract must submit copies of such contractual agreements to the Division. Such agreements must specify which home health services are being subcontracted and must specify that the Medicaid enrolled home health agency retains administrative and supervisory responsibility for staff and services subcontracted.

601.1.3.9. The need for home health services to be provided by a home health agency (HHA) that is not a governmental entity may not be certified or recertified, and a plan of care may not be established and reviewed, by any physician who has a significant ownership interest in or a significant financial or contractual relationship with the agency. "Significant financial or contractual relationship" means receiving any compensation as an officer or director of the HHA or a relationship that involves direct or indirect business transactions that, in any fiscal year, amount to more than $25,000 or five percent of the agency's total operating expenses, whichever is less. "Business transactions" means salaried employment contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment and space. A physician will be considered to have "significant ownership interest" if he or she has a direct or indirect ownership interest of five percent or more in the capital, the stock, or the profits of the home health agency; has an ownership interest of five percent or more in any mortgage, deed of trust, note, or other obligation that is secured by the agency, if that interest equals five percent or more of an HHA organized as a corporation, or is a partner in an HHA organized as a partnership.

601.1.3.10. The home health agency must disclose ownership information, pursuant to Section 106.25 of the Part I Policies and Procedures manual for Medicaid and PeachCare for Kids, to the Division upon initial enrollment and annually thereafter. The agency may provide a copy of the Office of Regulatory Services disclosure form or a copy of the completed Division's Ownership Disclosure Form.

601.1.3.11. Gainwell Technologies Services post office box is

closed. See Part I Policy and Procedures for Medicaid and PeachCare for Kids Manual, Section 112, for the paperless initiative requirements and the current Gainwell Technologies mailboxes.

601.1.3.12. Parent agencies, subunits, and branch offices must meet the guidelines outlined in the Rules and Regulations for Home Health Agencies Chapter 290-5-38-.06 from the Department of Human Resources, as described below:

601.1.3.12.1. A "Parent Home Health Agency" means the agency that develops and maintains administrative controls of subunits and branch offices.

601.1.3.12.2. A "subunit" means a semiautonomous organization that serves patients in a geographic area different from that of the parent agency. The subunit, by virtue of the distance between it and the parent agency is judged incapable of sharing administration, supervision and services daily with the parent agency and must, therefore, independently meet the licensing requirements for a Home Health Agency and shall be separately licensed. A subunit shall be separately enrolled as a provider in the Georgia Medical Assistance program and shall be assigned a unique provider number.

601.1.3.12.3. A "Branch Office" means a location or site identified in the application or endorsement thereto from which a home health agency provides services within a portion of the total geographic area served by the parent agency. (The total geographic area served by the parent agency is defined by the counties in which the parent agency is licensed to provide approved services as indicated by its license.) The branch office is part of the home health agency and is located sufficiently close to share administration, supervision and services on a daily basis in a manner that renders it unnecessary for the branch independently to meet these rules and regulations.

601.2. Submission Requirements

For cost reporting periods ending on or after March 31, 2000, home health agencies (HHA) must submit cost reports currently required under the Medicare regulations in a standardized electronic cost reporting (ECR) format. (See 42 CFR Part 413.24 (f) (4).

The medium for transfer of cost reports submitted electronically to the department is either a 3 1/2" diskette, a compact diskette (CD/DVD), or a flash drive. These forms of transmission must be in IBM compatible format and the character set must be in ASCII. You must seek advanced approval from the Department to use other media such as magnetic tape, telephone transfer (i.e., modem), electronic mail (e-mail), or a secured website.

601.2.1. An acceptable cost report from providers filing electronic cost reports (ECRs) means that all the following items have been included in the submission:

601.2.1.1. A diskette, compact diskette (CD) or a flash drive of the ECR utilizing a CMS-approved vendor with the current specification date submitted.

601.2.1.2. An ECR that passes all level 1 edits.

601.2.1.3. A submitted print image file of the cost report except when using CMS free software.

601.2.1.4. The certification page (Worksheet S) of the ECR file with the actual signature of an officer (administrator or chief financial officer).

601.2.1.5. An exact match of the encryption code, date and time for the ECR displayed on the certification page to that of the ECR file encryption code, date and time. The date and time printed on the signed certification page must match the date and time in the type 1 record of ECR file.

601.2.1.6. An exact match of the encryption code, date and time for the print image displayed on the certification page to that of the print image file encryption code, date and time except when using CMS free software. The date and time printed on the signed certification page must match the date and time within the print image file.

601.2.1.7. For teaching hospitals, a complete Intern and Resident Information System (IRIS) diskette that will pass all IRIS system edits.

601.2.1.8. The settlement summary on the electronic certification page agrees with the settlement summary or applicable worksheet on the Medicare cost report produced from the electronic file.

601.2.1.9. Failure to comply with the requirements specified either

in Items 1-9 or 1-3 above will result in the automatic rejection of the cost report submission.

If the electronic submission requirement places a financial hardship on the provider OR if the provider qualifies as a low or no Medicare utilization provider, the provider may request either that the facility be granted an extension to comply or waiver of the electronic submission requirement. Such request must be submitted to the division in writing, with all necessary supporting documentation attached, no later than 30 days after the end of the facility's cost reporting period.

601.2.1.9.1. Exception from full cost reporting for lack of program utilization:

If a provider does not furnish any covered services to Medicare beneficiaries during a cost reporting period, the facility is not required to submit a full cost report. It must, however, submit an abbreviated cost report, as prescribed by CMS.

These documents must be submitted in accordance with the guidelines set forth in Section 1001.1.

601.2.2. The home health agency must have established policies on informing patients of the Patient Bill of Rights and Advanced Directives. The home health agency must provide information on the Patient's Bill of Rights and Advanced Directives to all patients receiving services in the Home Health Services Program. An agency's patient records must contain documentation that such information was provided.

601.2.3. The home health agency must not deny services to any eligible Medicaid member because of the member's inability to pay the copayment amount imposed. (See Appendix F-1)

602. Home Health and Waiver Services

A member may receive Home Health services while enrolled in a Waiver as allowed by the Waiver service policy. Typically, waiver policy prohibits waiver services that would be considered duplicative of Home Health Services. It is incumbent upon the Home Health agency to coordinate with the member's waiver case manager to avoid duplication of services.

NOTE: To research a member's enrollment in waiver programs, contact Gainwell Technologies Inquiry Unit at 1-800-766-4456.

602.1. Medicaid Waiver Programs include:

Category of Service (COS)

CCSP	590
GAPP	971
ICWP	660
SOURCE	930
NOW/COMP Waiver	681, 680

Waiver providers of Home Health Services must follow appropriate regulations regarding the Medical Plan of Treatment. Refer to the Department of Community Health's Policies and Procedures for Home Health Services. Please see below for specific policies related to each waiver program.

603. Elderly and Disabled Waivers – Community Care Services (CCSP) and SOURCE Programs

The first 50 visits for CCSP and SOURCE members are reimbursed under the Home Health Program. These 50 visits must be exhausted prior to a CCSP or SOURCE Waiver Home Delivered Services prior authorization request.

Instructions for referral of patients between home health and Community Care Services are contained in Section 804. Instructions for referral of patients between home health and SOURCE are contained in Section 805. CCSP or SOURCE members who require more than 50 visits as approved in their plan of care may receive additional visits reimbursed under CCSP or SOURCE.

Home Delivered Services (the home health like services available after the 50th visit) provided to CCSP and SOURCE members must be provided by CCSP approved home health agencies currently enrolled in CCSP. CCSP members must meet the eligibility criteria outlined in Chapter 700 of this manual to receive home health visits. A home health agency may not render home health services to a member under both categories of service at the same time.

NOTE: Skilled Nursing visits provided by CCSP private home care providers are outside the scope of home health care and are not subject to the prior use of 50 home health visits.

Home Delivered Services provided to SOURCE members must be provided by approved providers (hospitals, home care and home health agencies, etc.) who participate in the SOURCE program. SOURCE Case Management Providers will maintain ongoing coordination with home health agencies, ensuring effective and non-duplicative home health services for members. SOURCE members must meet the eligibility criteria outlined in Chapter 700 of this manual to receive home health visits under the HH program (Category of Service 200). A home health agency may not render home health services to a member under both categories of service at the same time.

604. Independent Care Waiver Program and Traumatic Brain Injury Program

Medicaid eligible members enrolled in the Independent Care Waiver Program (ICWP) will receive their first 50 skilled visits through the Home Health Program. ICWP members must meet the eligibility criteria outlined in Chapter 700 to receive home health services. Alliant Health Solutions (AHS) and case manager determine the need for home health services and incorporate these visits into the Plan of Care (POC) and update the Participant Assessment Form (PAF).

ICWP members who need more than 50 visits of services will receive the additional visits reimbursed under ICWP. These visits are also incorporated into the POC and PAF by AHS and the case manager. A home health agency may not render home health services to a member under both categories of service at the same time. To research a member's enrollment in waiver programs, contact GHP Inquiry Unit at 1-800-766-4456. Instructions for referral of patients between home health and ICWP/TBI are contained in Section 805.

605. NOW/COMP Waiver

Members enrolled in the NOW/ COMP developmental disability waivers need not exhaust the first 50 visits afforded under the Home Health program.

606. GAPP

Skilled nursing visits provided by GAPP provided outside the scope of home health care services are not subject to the prior use of 50 home health visits. Services that would be considered duplicative of Home Health Services are not allowed.

607. PeachCare for Kids

A home health agency can provide home health services to children enrolled in PeachCare for Kids. The home health agency must follow the policies and procedures outlined in the Home Health Services Manual.

608. Record Keeping Requirements

It is the responsibility of all Georgia Department of Community Health (DCH) enrolled providers to ensure the health records of Medicaid members are documented accurately and maintained in compliance with both state, federal and national laws. Providers are responsible for being aware of record keeping requirements as outlined by the Centers for Medicare & Medicaid Services (CMS), Georgia DCH, other program affiliated associations and Health Insurance Portability and Accountability Act (HIPAA) guidelines. The Georgia DCH recommends the following record keeping guidelines. These recommendations should be considered basic - a minimum standard for each provider's practice. It is not inclusive of all record keeping requirements and providers will be responsible for any additional documentation requested in the event of audits.

608.1. Records should include:

608.1.1. A complete medical file on each patient containing sufficient information to validate the diagnosis and to establish the basis upon which treatment is given.

608.1.2. A care plan that includes clear and specific coordination with all providers involved in the treatment of the individual. It should include (but not be limited to) individualized expectations, prescribed services, service frequency, scope and duration and goals to be achieved.

608.1.3. Progress notes that are legible, detailed, complete, signed and dated.

608.1.4. All documentation requiring signatures must be legible, original and

belong to the person creating the signature. If illegible, the name should be printed as well as signed. All signatures must be dated the actual date signed. Rubber stamp signatures are not acceptable. Electronic signatures are acceptable in certain circumstances. See Part I Policies and Procedures for Medicaid/PeachCare for Kids, Section106, General Conditions of Participation.

608.1.5. If corrections are needed, they should be made by striking one line through the error, writing the correction, and including the initials of the person making the correction along with the date the correction is made. White-out cannot be used for corrections.

608.1.6. Records should be documented in 'real time' and should not be backdated.

608.2. At a minimum, member records should include but not be limited to the following:

608.2.1. Individual's name and/or other information related to their identification (SS#, Medicaid ID, etc.…)

608.2.2. Date and time of admission

608.2.3. Admitting Diagnosis

608.2.4. Verified Diagnosis

608.2.5. The name, address and telephone number of the responsible party to contact in an Emergency

608.2.6. Appropriate authorizations and consents for medical procedures

608.2.7. Medical necessity of the service being provided

608.2.8. Results of testing and/or assessments

608.2.9. Records or reports from previous or other current providers, including previous assessments

608.2.10. Documented correlation between assessed need and care plan

608.2.11. Documentation of treatment that supports billing

608.2.12. Financial and insurance information

608.2.13. Pertinent medical information

608.2.14. Physicians' progress notes

608.2.15. Nurses' notes

608.2.16. Practitioner and case management notes

608.2.17. Clear evidence that the services billed are the services provided

608.2.18. Treatment and medication orders

608.2.19. Date and time of discharge or death

608.2.20. Condition on discharge

Chapter 700: Special Eligibility Conditions

701. Special Member Eligibility Criteria

The Medicaid Home Health Program is based on the philosophy of family and patient participation in providing patient care. Families and patients are expected to be taught care which can be rendered reasonably and safely by non-medical persons.

701.1. Acceptance of Patients for Medicaid Coverage

701.1.1. Patient admittance to home health services shall be based on a physician (who attends to the patient in acute, post-acute settings, or as a medical visit) certifying a patient's eligibility for home health benefits based on their face-to face contact with and assessment of the patient. The physician must document that there has been a face-to-face encounter with the patient to certify the need for Medicaid home health services to a member. The physician may not have a financial relationship as defined in 42CFR411.351 with the HH agency to which he or she is referring patients. Additionally, the physician must document if an allowed non-physician practitioner (NPP) working in collaboration with the physician has the face-to-face encounter with the patient, i.e. nurse practitioner or clinical nurse specialist, or a certified nurse midwife, or a physician assistant, under the supervision of the physician. The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care. In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan. The initial documentation must include record of the face-to-face encounter, initiate the orders (used in the treatment plan of care) for home health services, and may "hand off" the patient to his or her community-based physician. The community-based physician must review and sign off on the plan of care to indicate agreement with the certifying physician. Thereafter, a face-to-face encounter with the member is not necessary unless there is a change in condition.

An expectation that the care and services are medically reasonable and necessary for the treatment of an illness or injury, and the services can be met adequately by the agency in the patient's place of residence.

Home Health skilled and home health aide services are medically necessary and appropriate when the patient's medical records accurately justify a medical reason that the services should be provided in the patient's home instead of a physician's office, clinic, or other out-patient setting, according to one or more of the following guidelines:

701.1.1.1. Because of the patient's illness, injury, or disability, going to a physician's office, clinic, or other outpatient setting for the needed service would create a medical hardship for the patient. Any statement on the plan of care regarding such medical hardship must be supported by the totality of the patient's medical records.

701.1.1.2. Examples of medical hardship include:

701.1.1.2.1. A patient who requires ambulance transportation

701.1.1.2.2. A patient in severe pain

701.1.1.2.3. A patient with bilateral upper extremity loss who is unable to open doors, use handrails or perform other activities, and needs help to leave his residence

701.1.1.2.4. A patient for whom leaving the home is likely to cause an exacerbation of his condition, and a patient who experiences shortness of breath that significantly hinders travel

701.1.1.2.5. A diabetic patient is wheelchair bound due to bilateral BK amputations and makes only infrequent trips from his residence because of medical complications.

701.1.1.2.6. Examples of conditions that in themselves are not considered creating a medical hardship include:

701.1.1.2.7. The need to use portable oxygen

701.1.1.2.8. Walking with a limp or the need to use an assistive device such as a cane, walker or wheelchair

701.1.1.2.9. A wheelchair-bound patient who regularly drives a specially equipped vehicle to travel outside of the home is not considered to have a medical hardship; The need for routine transportation is not considered a medical hardship--assistance with transportation to medical appointments is available through the county departments of social services

701.1.1.2.10. The common need for a child to be supervised by an adult when outside the home also does not in itself justify providing care in the home.

701.1.2. Going to a physician's office, clinic, or other outpatient setting for the needed service is contraindicated by the patient's documented medical condition. The patient's condition is so fragile or unstable that the physician states that leaving the home is undesirable or detrimental under the circumstances.

701.1.2.1. Examples include:

701.1.2.1.1. A newborn infant up to six weeks of age who has acute care needs or who is at medical risk,

701.1.2.1.2. A patient just had surgery and has resultant weakness and pain. Because of her condition, her physician restricts certain activities and allows getting out of bed for only a short period of time,

701.1.2.1.3. A patient with severe arteriosclerotic heart disease must avoid all stress and physical activity,

701.1.2.1.4. A patient with a medical condition that requires protection from exposure to infections, and

701.1.2.1.5. A patient who is just out of the hospital after major surgery.

701.1.3. Going to a physician's office, clinic, or other outpatient setting for needed service would interfere with the effectiveness of the service.

701.1.3.1. Examples include:

701.1.3.1.1. A young child who would not benefit from outpatient therapy because of extreme fear of the hospital where the out-patient setting is located

701.1.3.1.2. A patient living in an area where travel to outpatient therapy would require an hour or more travel

701.1.3.1.3. A patient who needs a service repeated at frequencies that would be difficult to

accommodate in the physician's office, clinic, or other out-patient setting, such as daily IV infusions or daily insulin injections

701.1.3.1.4. A patient who needs regular and p.m. catheter changes and having Home Health in place will prevent emergency room visits for unscheduled catheter changes due to dislodgment or blockage

701.1.3.1.5. A patient who, because of the patient's illness, injury or disability, including mental disorders, has demonstrated past failure to comply with going to a physician's office, clinic, or other outpatient setting for the needed service, and has suffered or has a high probability of suffering adverse health consequences as a result, including use of emergency room and hospital admissions.

701.1.3.1.6. A patient who is newly diagnosed with end stage renal disease has been prescribed a specialized diet with severe restrictions. Due to the patient's limited ability to understand from standard diet teaching only, it is necessary for the nurse to teach in the home to use examples of foods available to the patient. It will also be necessary to teach and train the caregivers in the home who will prepare the food. Attempting the teaching outside of the home setting would interfere with the effectiveness of teaching this patient and caregivers.

701.1.3.1.7. A patient has an abdominal wound dehiscence. The wound care is extensive and requires irrigation and packing twice a day. The care will be accomplished by the patient's caregivers. The caregivers need to observe the nurse performing the dressing changes more than once for teaching and they need to be observed by the nurse for assessment of understanding. They also need to learn sterile technique and how to prepare a

sterile field in the home environment. Due to the extensive teaching needed, along with observation, teaching is most effectively accomplished in the home.

701.1.3.1.8. A patient who requires use of assistive devices specifically customized for the patient's home environment (bath chairs, shower grab bars) requires training on the use of those devices in the home for the training to be effective.

701.1.3.1.8.1. A referral from the patient's primary care or the attending physician for members

701.1.3.1.8.2. A written Plan of Care established and periodically reviewed by the attending physician

701.1.3.1.8.3. Continued supervision of the patient by the attending physician at least every sixty-two (62) days or every two (2) months

701.1.3.1.8.4. Absence or inability of significant others to provide the services

701.1.3.1.9. This does not mean, for example:

701.1.3.1.9.1. Caregiver works

701.1.3.1.9.2. Caregiver and/or patient is noncompliant with the treatment regimen, keeping medical appointments and/or assisting with medication compliance and med pack setups

701.1.3.1.9.3. Caregiver uncomfortable or unwilling to provide

care

701.1.3.1.9.4. Lack of transportation to a treatment facility, physician's office or another outpatient facility

701.1.3.1.9.5. Ineligibility for Medicare home health coverage

Patients shall not be denied service based on their age, sex, race, religion or national origin.

701.1.3.2. The home health agency must maintain the signed and dated physician orders (Plan of Care) for all services to be rendered to each Medicaid patient and for which the provider proposes to seek Medicaid reimbursement. If the physician fails to date his or her signature, the home health agency must indicate the date they received the plan of care.

702. Place of Residence

A patient's place of residence for home health services is the patient's home. "Home" means a house, apartment, condominium, trailer or other non-institutional structure used primarily for shelter. It does not include a hospital, daycare facility, skilled nursing facility, nursing facility, school, corrections facility, training center, or an intermediate care facility for the mentally retarded. Services provided in settings other than the home are not considered home health services and are not reimbursable under the Home Health program. Services must be provided in the member's place of residence.

Chapter 800: Prior Approval

801. General

The Division will reimburse the Medicaid Home Health agency provider for a maximum of fifty (50) visits per calendar year for eligible Medicaid members that meet the requirement. The eligible member will receive the first fifty (50) Home Health visits through the home health state plan benefits. Additional visits after the 50th may be covered under the skilled home health provisions for the CCSP, SOURCE, or ICWP waivers. The member's Home Health visits must be medically necessary, and documentation must support medical necessity. Visits more than 50 may also be provided to children for Early and Periodic Screening, Diagnostic, and Treatment (formerly EPSDT) for eligible Medicaid and PeachCare members if medically necessary. The service is Medicaid's comprehensive, preventive and treatment child health program for individuals under the age of 21. Georgia Medicaid provides and reimburses the Treatment aspect of children's EPSDT services under Home Health concurrently with other programs, such as Laboratory, Children Intervention Services (CIS), GAPP, other Waiver Services, Physicians, and Hospitals as medically necessary. A maximum of up to twenty- five (25) additional Home Health visits require prior approval from the Division. The providing agency must follow the procedures according to Section 803 of this chapter.

Home Health visits are subject to daily limitations of the allowed procedure code units for that day. Daily limits for the allowed procedure codes are S codes, a maximum of 6 units per day; G codes, a maximum of 3 units per day; "9" codes for evaluation, re-evaluation and/ or treatment limitations are equal to one (1) Visit. The daily limits are counted as one (1) Visit per the S, G, and "9" codes for a maximum of 50 visits for 21 years of age and older per calendar year and possibly up to 75 visits for individuals under the age of 21 years of age per calendar year. Please see Appendix J for additional information.

802. Medicare/Medicaid Eligible

Refer to Chapter 900 regarding coverage of services for individuals discharged from Medicare and admitted to Medicaid.

803. Maximum Visits

The Division will reimburse for a maximum of fifty (50) visits per member per calendar year for Medicaid eligible individuals. Home health services exceeding fifty (50) visits per calendar year may be covered, when such services are requested by a physician and determined to be medically necessary at the discretion of the Division for children under the age of 21. The request for services exceeding fifty (50) visits per calendar year must be received by the Division fifteen (15) business days before the maximum visits are exhausted. The physician must document medical necessity in a letter of request written to the Division, requesting the number of visits exceeding fifty (50) that are medically necessary for the remainder of the calendar year. The additional visits cannot exceed twenty-five (25) visits per member per calendar year. The home health agency must document in the Division's standard letter for consideration of request for additional visits on the Additional Visit Request Form (found on page VIII-3 of this section). The home health agency must use the form as the front page for all request(s). The home health agency must include the Physician's letter, the current Plan of Care (POC) and/or Home Health Certification and Plan of Treatment, MHN ID number and the last month of nursing notes with the Additional Visit Request Form. Both the form letter and other required documents should be submitted together to the following address:

The Georgia Department of Community Health
Home Health Program Specialist 19th Floor
Division of Medical Assistance
2 Martin Luther King Jr Drive, SE, East Tower,
Atlanta, Georgia 30334

The Division will notify the provider, in writing, of its decision and the procedure to be used when submitting claims. All claims submitted by Home Health agency(s) are subject to be audited. Any claims submitted and reimbursed by Medicaid but determined to be over the 75 visits allowed per calendar year will be recouped by the Division.

Additional Visit Request to Division of Medical Assistance (DMA) for Home Health Services to members under 21 years of age

From: _____ _____
Home Health Agency Provider Number

Date: _____

For: _____ _____
Member Name/ Date of Birth Member Medicaid MHN ID Number

This member will exceed fifty (50) visits per this calendar year on/or about_____. This request for services exceeding 50 visits per calendar year should be received by the Division fifteen (15) business days prior to exceeding 50 calendar year limit.

The additional visit request for _____ visit(s) is medically necessary, and the physician's documentation for medical necessity, dated _____ is enclosed in this request to the Division.

Also included in this request is:

Number of visits completed prior to date of this request: _____.

Current Plan of Care or Plan of Treatment _____ dated _____.

Home Health Certification, signed by M.D. _____ dated _____.

I understand that the Division will notify this agency of its decision and the procedure to be used when submitting claims.

Comments: _____

_____

_____

_____ _____
HHA Representative's Signature Date of Request

_____
HHA Representative's Contact Number
DMA 01/01/2012

803.1. Out-of-State Providers and Service Limitations

Out-of-state providers not enrolled in the Georgia Medicaid program as participating providers will be reimbursed for covered services provided to Georgia members while out-of-state if the claim is received within twelve months from the month of service, and if at least one of the following conditions is met:

803.1.1. The service was prior authorized by the Division; or

803.1.2. The service was provided as a result of an emergency or life-endangering situation occurring out of state.

Note: When a Georgia Medicaid member requires home health services from an out-of-state enrolled Home Health Agency, the payment rate for covered charges will not exceed 65% of the Georgia Medicaid Home Health maximum allowable amounts.

The referring in-state provider is required to request prior approval by documenting in writing the medical necessity of obtaining services out-of-state and providing the name and address of the out-of-state medical provider.

Alliant Health Solutions (AHS) prior approves the Out of State Services including Home Health visits associated with the care of the Out of State patient as part of the ancillary services necessary for the care of the patient temporarily living outside of Georgia. The Home Health visits are included and covered under the umbrella of the original AHS prior approval (Rev. 10/2018)

Requests for prior approval or questions regarding out-of-state services must be directed to:

AHS Out-Of-State
PO Box 105329
Atlanta, GA 30348

800-766-4456 (Toll free)

Out-of-state claims submitted for reimbursement must have a copy of the authorization letter attached if services were prior authorized or medical justification if the services were due to an emergency or life-endangering situation.

804. Community Care Services Program (CCSP) Referrals

804.1. Referral from Home Health Service to Community Care

804.1.1. Upon determination that a patient may be appropriate for Community Care Services, the agency should:

804.1.1.1. Notify the local Area Agency on Aging Community Care Assessment team for a telephone screening before the 50-visit limit is exhausted.

804.1.1.2. Request the patient be assessed by the care coordination

team for CCSP services.

804.1.2. If approved for service by the care coordination team, the patient will be admitted to CCSP (contingent on availability of CCSP funds). The care coordinator will notify a home health agency currently enrolled in CCSP to arrange for the necessary services.

804.2. Referral from Community Care to Home Health Services under CCSP

804.2.1. After admission to CCSP the Care Coordinator will broker home health services to the patient who requires these services. Home health agencies must be currently enrolled as a CCSP provider to render these services to CCSP patients.

804.2.2. The care coordinator requests the specific service and frequency for home health services under the direction of the physician.

804.2.3. When the CCSP enrolled home health agency accepts the referral, the care coordinator sends a standard admission packet to the agency.

804.2.4. The agency sends a Community Care Notification Form (CCNF) to notify the CCSP care coordinator of the date services began. The care coordinator generates a Service Authorization Form (SAF) to authorize services.

804.2.5. The CCSP enrolled home health agency uses the CCNF to notify the care coordinator prior to the patient exhausting the 50th home health visit. The care coordinator will generate and forward a new SAF to authorize visits beyond the first 50.

804.2.6. The CCSP enrolled home health agency uses the CCNF to report significant changes in the patient condition to the CCSP care coordinator.

NOTE: For CCSP members, the provider uses the Level of Care page and CCSP care plan. The area coordinator manages and authorizes skilled home health visits more than 50 on the SAF.

805. Independent Care Waiver Program (ICWP) Traumatic Brain Injury (TBI) Referrals

805.1. Referral from Home Health Service to Independent Care Waiver

805.1.1. Upon determination that a patient may be appropriate for Independent Care Waiver services, the agency should:

805.1.1.1. Assist the patient to contact the Alliant Health Solutions (AHS) to initiate the intake information process before the 50th visit limit is exhausted.

805.1.1.2. AHS will conduct a face-to-face assessment of the patient to determine eligibility for ICWP services.

If the patient meets the eligibility criteria for ICWP services by AHS and the Division, the patient will be admitted to ICWP (contingent on availability of ICWP funds) or placed on the waiting list for services. When the patient is admitted to ICWP, AHS will assist the patient in selecting a case manager. The case manager will notify a home health agency currently enrolled in ICWP to arrange for the necessary services.

805.2. Referral from Independent Care Waiver Services to Home Health Services

805.2.1. After admission to ICWP, AHS will develop and approve the initial Plan of Care (POC) to include home health services to the member who requires these services. The case manager assists the member in selecting service providers and develops the Individual Plan of Care, indicating the specific service and frequency approved on the Initial Plan of Care and submits the Individual Plan of Care to AHS for authorization (Rev. 10/2018)

805.2.2. AHS and the case manager will refer the member to a Home Health Agency and provide the agency with a copy of the approved Initial Plan of Care and authorized Individual Plan of Care.

805.2.3. The agency follows the ICWP Part II policies and procedures outlined in Chapters700 and 900 for ICWP members receiving the first fifty (50) home health visits. A copy of the approved initial Plan of Care and authorized Individual Plan of Care must be submitted to the home health agency with the referral.

805.2.4. The home health agency must notify AHS and the case manager the home health visit. Prior to the patient exhausting the 50 visits.

805.2.5. All services must be identified in and coordinated around the initial Plan of Care approved by AHS.

NOTE: No home health service shall be reimbursed which is not listed on the approved Initial Plan of Care and authorized Individual Plan of care.

Chapter 900: Scope of Services

901. Admission Requirements

Patient admission to the Home Health (HH) program shall be based on the Department's expectation that the care and services are medically reasonable and necessary for the treatment of an illness or injury as indicated by the physician's orders; the patient's file documentation must support medical necessity for the home health visits Georgia Medicaid recipients that meet the requirement for a nursing facility level of care will receive the first fifty home health visits through the home health state plan benefit. The 51st visit may be covered under the skilled home health provisions for waiver services for eligible members.

Effective 04/01/2011, a referring physician must document that there has been a face-to-face encounter with the patient within 90 days prior to or 30 days after to certify Medicaid home health services to a member. The referring physician must document the face-to-face encounter has occurred on the form used for certification of home health services, see Section 701 of this manual. Medicaid recertification continues to be required every 60 days. A face-to-face encounter is not required by the community-based physician for continuing/re-certifying HH services. There are similar requirements in place for Durable Medical Equipment (DME); please see the Part II DME manual (see Appendix N).
The following services are covered in the Home Health Services program when provided to eligible members in their place of residence and when such services have been ordered by a physician in a plan of care. **Members must have been discharged from or exhausted Medicare benefits prior to reimbursement by Medicaid. Providers cannot claim both Medicare & Medicaid services at the same time.**

NOTE: Members must meet the eligibility criteria established in Chapter 700, Section 701.1 of this manual to receive home health services.

902. Skilled Nursing Services

Skilled nursing services, as outlined in the Official Code of Georgia Annotated (O.C.G.A.) Section 43-26-1, are covered on a part-time or intermittent basis.

902.1. Nursing services must be medically reasonable and necessary for treatment of an illness or injury based on the member's unique condition and individual needs and must be performed by a registered nurse in accordance with the plan of care. In certain cases, some skilled nursing services may be provided by a LPN under the supervision of the registered nurse. In determining whether a service must be performed by a registered nurse, consideration must be given to the inherent complexity of the services, the condition of the patient, and the patient's needs. There are other instances where the nature of the service and the condition of the patient will affect whether the services can only be performed safely and effectively by a registered nurse. For example, giving a bath is not a covered nursing service unless the patient's condition is so severe that it would be unsafe for the service to be performed by anyone other than a registered nurse.

902.1.1. Services Which May Be Provided by A Registered Nurse Include but are not limited to:

902.1.1.1. Initial evaluation visit.

902.1.1.2. Re-evaluation of patient's nursing needs.

902.1.1.3. Initiation of plan of care and necessary revisions.

902.1.1.4. Initiation of appropriate preventive and rehabilitative nursing procedures.

902.1.1.5. Preparation of clinical and progress notes.

902.1.1.6. Coordination of services.

902.1.1.7. Informing the physician and other personnel of changes in the patient's condition and needs.

902.1.1.8. Patient and family teaching; and

902.1.1.9. Supervising and teaching other nursing personnel.

902.1.2. Services Which May Be Provided by A Licensed Practical Nurse (LPN) Include:

902.1.2.1. Any services in accordance with and outlined in the Official Code of Georgia Annotated (O.C.G.A), Section 432630 through 39.

902.1.3. Services Which May Not Be Provided by A Licensed Practical Nurse (LPN) include:

902.1.3.1. The initial evaluation visit.

902.1.3.2. Initiation of the plan of care; or

902.1.3.3. Home health aide supervisory visits.

902.2. Provision of Skilled Nursing Services

Justification and medical necessity for skilled nursing visits must be clearly documented in the home health certification and Plan of Care ordered by the attending physician and meet the Division’s provision for skilled nursing care. The Plan of Care must be specific to the patient’s diagnosis and reflect specific nursing interventions. Vague and general descriptions are not acceptable as sole justification for such services.

NOTE: Skilled nursing services will not be covered for members who received skilled nursing services under Medicare and have been discharged as stable.

Provision of skilled nursing services should adhere to medical necessity according to the following:

902.2.1. Nursing visits ordered by the physician for observation and assessment of a member's condition is covered at the Division's discretion on a

limited and short-term basis when documentation indicates complications or developments of further acute episodes would develop requiring the physician or nurse's service to evaluate the need to change the plan of care. If a member's condition remains stable or where there is evidence that the condition has a long-standing pattern, nursing visits for observation and assessment will not be covered. Members or family members must be taught to observe for signs and symptoms of possible complications which should be reported to the physician or the nurse. Frequent visits when no changes are anticipated will not be covered. Conditions which may justify observation and assessment services as described above include, but are not limited to:

902.2.1.1. Angina

902.2.1.2. Malabsorption Syndrome

902.2.1.3. Crohn's Disease

902.2.1.4. C.O.P.D.

902.2.1.5. Ulcerative Colitis

902.2.1.6. Dehydration

902.2.1.7. Fecal Impaction

902.2.1.8. Renal Diseases

902.2.1.9. Hypertension - Document most recent blood pressure reading (within previous 30 days)

902.2.1.10. Congestive Heart Failure

902.2.2. Skilled nursing visits for management and evaluation of the patient's care plan are covered at the Division's discretion on a limited and short-term basis where multiple underlying documented conditions and complications exist requiring that only a registered nurse can ensure that essential non-skilled care is achieving its purpose. The complexity of the necessary unskilled services which are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety based on the patient's overall condition. Documentation describing the complex care must be included in the plan of care.

902.2.3. Skilled nursing visits for teaching or training activities are covered at the Division's discretion on a limited and short-term basis when the teaching and/or training is appropriate to the member's functional loss, illness, or injury. Teaching and/or training activities must include a time frame in the plan of care when goals will be accomplished. Documentation in the

medical record of teaching and/or training activities must reflect the member's or caregiver's ability to comprehend and progress. Teaching and/or retraining for an appropriate period may be covered at the Division's discretion on a limited and short-term basis when there is a change in caregivers, the procedure, or the member's condition that requires teaching, or where the patient, family or caregiver is not properly performing the task. Teaching and/or training activities will not be covered when the patient, family or caregiver will not or is not able to learn or be trained. Documentation in the patient's Plan of Care must reflect the member and/or caregiver's ability to comprehend and progress.

Teaching and training activities which require the skill of a licensed nurse includes, but are not limited to the following:

902.2.3.1. Self-administration of injectable medications or a complex range of medications.

902.2.3.2. Diabetic teaching.

902.2.3.3. Self-administration of medical gasses.

902.2.3.4. Complex wound care.

902.2.3.5. Ostomy care.

902.2.3.6. Self-catheterization.

902.2.3.7. Self-administration of enteral feedings.

902.2.3.8. Care and maintenance of intravenous or central lines and administration of medications through such lines.

902.2.3.9. Bowel and bladder training.

902.2.3.10. Performance of the activities of daily living when the member or care giver must use special techniques and adaptive devices due to a loss of function.

902.2.3.11. Safe transfer techniques.

902.2.3.12. Proper body alignment and positioning and turning techniques of a bed-bound member.

902.2.3.13. Ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss.

902.2.3.14. Prosthesis care and gait training.

902.2.3.15. Use and care of braces, splints and orthotics and

associated skin care.

902.2.3.16. Proper care and application of any specialized dressings or skin treatments.

902.2.3.17. Preparation and maintenance of a therapeutic diet; and

902.2.3.18. Proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.

902.2.4. Skilled nursing visits for the administration of medications (intravenous, intramuscular, or subcutaneous injections and infusions) for safe and effective treatment of an illness or injury are covered when appropriate to the treatment of an illness, injury or functional loss of a member and the caregiver is unable to learn or perform the procedure.

902.3. An agency providing this skilled nursing service must document in the Plan of Care the reason for the member or caregiver's inability to administer the medication and/or the reason for the non-availability of a care giver. When a caregiver is in the home; the documentation must indicate the reason the care giver is not able to administer the medication. The agency must specify the individual who will be responsible for administering the medication during the RN's absence. The plan of care must indicate a time frame when the member or caretaker will administer the medication independently. This includes administering insulin or prefilling insulin syringes. Skilled nursing services for newly diagnosed diabetics for administration of medications must include the results of a fasting blood sugar (FBS) obtained by venipuncture in the Plan of Care thirty (30) days from the start of care date. Fasting blood sugar values obtained by glucometer testing will not be accepted. Refer to Section 901.2 (F) for the policy on skilled nursing visits for venipuncture. Nursing visits to perform glucometer testing are not covered as it does not require the skill of a nurse to perform these tests.

902.4. Administration of Vitamin B-12 injections is medically necessary for a limited number of medical conditions. Conditions include, but are not limited to:

902.4.1. Pernicious Anemia.

902.4.2. Megaloblastic Anemia.

902.4.3. Fish Tapeworm Anemia.

902.4.4. Certain Gastrointestinal Disorders.

902.4.5. or Certain Neuropathies.

902.5. Skilled nursing visits for the administration of Synagis injections for prevention of Respiratory Synctial Virus (RSV) are covered for high risk and prematurely born infants (26 to 36 weeks) and toddlers during the RSV season (September to April) up to the age of two (2) years old as approved by the Federal Drug Administration (FDA). Synagis is indicated for prevention of serious lower respiratory tract disease caused by

respiratory syncytial virus (RSV) in pediatric patients at high risk of RSV disease.

Infants must meet one (1) or more of the following criteria to receive Synagis injections administered in the home by a Home Health Agency.

902.5.1. Infants born at thirty-two to thirty-five (32-35) weeks gestation.

902.5.2. Who are less than six (6) months old at the onset of the RSV season; and

902.5.3. Who have at least one (1) environmental risk factor (passive tobacco smoke exposure, day care, siblings, persistent hospitalization on an inpatient basis).

902.5.4. Infants less than two (2) years of age at the onset of RSV season whom are symptomatic and/or require day medications for congenital heart disease.

902.5.5. Skilled nursing visits for Synagis injections are not covered for children over the age of two (2) and do not meet the established criteria.

902.5.6. Skilled nursing services associated with home phototherapy for members with neonatal jaundice (hyperbilirubinemia) will be reimbursed within the first thirty (30) days of life when a Durable Medical Equipment Company does not provide the phototherapy service (all-inclusive of equipment, related supplies and a certified nurse). An agency providing skilled nursing services associated with home phototherapy must document the name of the equipment vendor in the Plan of Care. The physician is responsible for assessing the appropriateness of home phototherapy and for determining the length of time the infant is to be under the lights based on serum bilirubin levels and clinical condition of the infant. The maximum fee is the home health agency reimbursable rate, all inclusive of the phototherapy equipment, related supplies, and a certified nurse to collect a daily bilirubin level. Coverage is for a maximum of four (4) consecutive days. Phototherapy service may not be provided and billed in the Durable Medical Equipment program when provided in the home health program. The home health agency must assure that the parent or caregiver is trained in the safe and effective use of the home phototherapy equipment. The Division does not reimburse for home phototherapy until the member is discharged from the hospital.

Skilled nursing visits for venipuncture are covered when the collection of the specimen cannot be performed during regularly scheduled absences from the home and is necessary for the monitoring of therapeutic blood levels of medications, monitoring of blood counts and electrolyte levels when affected by the member's medication regimen and related to the member's illness or medical condition.

902.5.6.1. Documentation of lab values for the previous three (3) months must be contained in the Plan of Care. If the member is a new home health patient, documentation of one (1) lab result within the previous thirty (30) days

from the start of care date must be contained in the Plan of Care.

902.5.6.2. When lab values are within the normal limits of accepted values for three (3) consecutive specimen collections, skilled nursing visits for venipuncture will no longer be covered.

902.5.7. Skilled nursing visits for the administration of oral medications, eye drops/creams, topical ointments/creams, vaginal and/or rectal suppositories/creams, and filling of medicine packs are not covered. Exceptions are only granted in specific circumstances at the Division's discretion. Factors considered in granting an exception include, but are not limited to:

902.5.7.1. Patient and/or caregiver unable to provide the care due to a function physical motor impairment.

902.5.7.2. Mental impairment.

902.5.7.3. Complexity of the patient's medical condition.

902.5.7.4. Nature and number of medications prescribed; and

902.5.7.5. Complexity of a surgical procedure for which care is ordered.

Documentation in the Plan of Care must include the specific circumstances that require a licensed nurse to administer medications of this type and/or fill medication packs. A timeframe indicating when the patient and/or caregiver will be able to administer these type medications or treatments must be included on the Plan of Care.

Skilled nursing visits to assess and monitor medication compliance are not covered in the home health program.

902.5.8. Provision of intermittent or part-time skilled nursing services for the preceding services are covered as defined. The following conditions and services are covered at the Division's discretion:

902.5.8.1. Nasogastric tube and percutaneous tube feedings (including gastrostomy and jejunotomy tubes), replacement, adjustment, stabilization, suctioning and teaching.

902.5.8.2. Nasopharyngeal and tracheostomy aspiration

902.5.8.3. Catheter care (urethral or suprapubic) insertion and replacement (every 30 days for Foley or 60-90 for

silicone catheters) and irrigation.

902.5.8.4. Ostomy care and providing immediate post-operative care.

902.5.8.5. Wound care when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury.

902.5.8.6. Heat treatments.

902.5.8.7. Initial phases of regimen involving the administration of medical gases.

902.5.8.8. Rehabilitative nursing procedures; and

902.5.8.9. Insertion, removal, and maintenance of intravenous access devices.

902.5.9. Effective 4/1/20, home health agencies will be allowed to administer Exondys 51 for the treatment of Duchenne Muscular Dystrophy in the patient's home after the patient has received the medication in the physician's office for a period of three months.

NOTE: Exondys 51 must be administered by a healthcare professional.

The physician will need to request another prior authorization through the web portal for administration through home health. The request should include a "Plan of Care" from the physician which should include what should be done in the case of an anaphylaxis reaction that can be associated with the administration of Exondys 51, the name of the home health agency that will be administering Exondys 51, and the name of the specialty pharmacy that will dispense Exondys 51. The physician should also include in the request his/her attestation that the "Plan of Care" has been provided to both the home health agency and the specialty pharmacy.

The specialty pharmacy will be responsible for maintaining a Medication Administration Record (MAR) that will include:

902.5.9.1. Fill date and prescription number(s).

902.5.9.2. Name, title, and name of location of person requesting fill for Exondys 51.

902.5.9.3. Date of administration.

902.5.9.4. Name and credentials of person administering Exondys 51.

Once a home health request for Exondys 51 has been approved, DCH will forward the MAR to the specialty pharmacy. The MAR must be filled out completely by the time the pharmacy dispenses the medication to the home health agency. The previous fill must be completely documented in the patient's MAR before the next fill is to be dispensed. Auto-refills or auto-shipments are not allowed and dispensing of Exondys 51 must only occur once specifically requested.

The home health agency must schedule an appointment before going out to administer Exondys 51. The home health agency is responsible for providing the date of administration and the name and credentials of person administering Exondys 51 (#3 and #4 of the MAR above) to the specialty pharmacy.

903. Home Health Aide Services

Official Code of Georgia Annotated (O.C.G.A.) Section 31-6-2 Home health aide services are covered when the member has a moderate to severe functional physical impairment related to the member's illness or medical condition resulting in the limited ability or inability of the member to perform instrumental activities of daily living (IADL's) such as dressing and undressing, management of clothing, elimination, grooming, hygiene, mobility, ambulation, ability to prepare and eat meals, and ability to administer medications properly. The limited ability or inability of a member to perform grooming and bathing tasks alone does not necessitate the use of home health aide services. Services must be provided in accordance with the plan of care, with written instructions for patient care and supervision provided by a registered nurse or therapist as appropriate.

903.1. Documentation must be provided in the Plan of Care of the member's functional physical impairment and the level of current functioning when performing instrumental activities of daily living (IADL's).

903.2. The Plan of Care must include a time frame when goals for performance of instrumental activities of daily living (IADL'S) will be met. Home health aide services will not be covered for members who received home health aide services under Medicare and have been discharged as stable.

903.3. Home health aide services may be provided directly by the home health agency or by contractual arrangement.

903.4. Services Which May Be Provided by A Home Health Aide Include:

903.4.1. Personal care (e.g., bath, hair shampoo, special foot care).

903.4.2. Performance of simple procedures as an extension of therapy services such as range-of-motion exercises and ambulation assistance.

903.4.3. Assistance with (not administration of) medications that are ordinarily self-administered and have been ordered by the physician.

903.4.4. Reporting of changes in the patient's condition and GHP.

903.4.5. Completion of appropriate records; and

903.4.6. Incidental household chores which are essential to the member's health care at home (e.g., preparation and service of therapeutic meals, dusting for patients with respiratory ailments, and changing bed linens for incontinent patients).

903.5. Supervision of the Home Health Aide

A registered nurse must make a supervisory visit to the patient's residence at least once every two (2) weeks. Two weeks is defined as fourteen (14) calendar days. If the fourteenth day of the two-week period falls on a Saturday, Sunday or legal holiday, the supervisory visit must occur on the Monday immediately following or in the case of a holiday, the next business day to be in compliance with the policy. The purpose of the supervisory visit is to determine whether treatment goals are being met and assure that quality patient care is being rendered.

The supervisory visit will cover the two-week period preceding the visit. The supervisory visit may include observation of the home health aide.

When only home health aide services are being furnished to a patient, a registered nurse must make a supervisory visit to the patient's residence at least once every sixty (60) days. If the sixtieth day falls on a Saturday, Sunday, or legal holiday, the supervisory visit must occur on the Monday immediately following or in the case of a holiday, the next business day to be in compliance with the policy. When utilizing this supervisory frequency, the supervisory visit must occur when the aide is furnishing patient care. The supervisory visit will cover the sixty (60) day period immediately preceding the visit.
A record of the supervisory visit must be dated and documented by an R.N. in a narrative note in the patient's clinical record.

Any home health aide services rendered outside the supervisory period are not reimbursable and must not be billed to the Division. Costs incurred for the registered nurse visits to evaluate, supervise, or instruct home health aides are considered administrative costs and are not separately reimbursable as a visit.

904. Therapy Services

Therapy Services, as outlined in the Official Code of Georgia Annotated (O.C.G.A) Section 31-6-2

Physical, speech and occupational therapy services may be provided by the home health agency directly or under contractual arrangement. These services may be provided by a licensed therapist, or a licensed therapist assistant supervised by a licensed therapist in accordance with the plan of care specifying the amount, frequency and duration of the procedure and modalities to be used. **Coverage of therapy services in the home health setting require that qualified therapists measure and document therapy effectiveness.** When services are provided through contract with another entity, the home health agency must retain administrative and supervisory responsibility for the delivery of these services. Therapy services rendered by individually enrolled therapists, or through the Children's Intervention Services (CIS) Program or through the Children's Intervention School

Services (CISS) Program are not reimbursable under the home health program.

Therapy services will not be covered for patients who obtained therapy services under Medicare and have been discharged as stable.

904.1. Services Which May Be Provided by A Licensed Physical, Speech or Occupational Therapist Include:

904.1.1. Assisting the physician in evaluating the patient's level of functioning.

904.1.2. Developing the plan of care and making routine revisions as needed.

904.1.3. Preparing progress notes on a timely basis for their discipline; and

904.1.4. Advising and consulting with other agency personnel regarding changes in the patient's condition (Rev. 10/2017).

All services rendered by a licensed therapist must be necessary for the patient's condition and be necessitated by a level of complexity that requires such services be performed by a licensed therapist or licensed therapist assistant under the supervision of a licensed therapist. A maintenance program shall be developed for the performance of simple procedures which could be safely and effectively provided by the member, family or home health aide.

904.2. Physical Therapy Services Include:

904.2.1. Therapeutic exercise programs including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance and increased range of motion.

904.2.2. Gait evaluation and training; and

904.2.3. Transfer training and instructions in care and use of wheelchair, braces, prostheses, etc. (Rev. 01/2016)

904.3. Speech Therapy Services:

Effective 04/01/2014, there are four new speech service codes that replace the procedure code 92506. Procedure Code 92507 continues to be billable.

904.3.1. The following codes are added to the billing list:

904.3.1.1. 92521 - Evaluation of speech fluency (e.g., stuttering, cluttering).

904.3.1.2. 92522 - Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria).

904.3.1.3. 92523 - with evaluation of language comprehension and expression (e.g., receptive and expressive language); and

904.3.1.4. 92524 - Behavioral and qualitative analysis of voice and

resonance.

904.3.2. Speech Therapy Services include:

904.3.2.1. Evaluating and recommending appropriate speech and hearing services.

904.3.2.2. Providing necessary rehabilitative services for patients with speech, hearing or language disabilities; and

904.3.2.3. Providing instructions for the patient and family to develop and follow a speech pathology program.

904.3.3. Occupational Therapy Services Include:

904.3.3.1. Teaching skills that will assist the patient in the management of personal care, including bathing, dressing and cooking/meal preparation.

904.3.3.2. Assisting in improving the individual's functional abilities.

904.3.3.3. Teaching adaptive techniques for activities of daily living; and

904.3.3.4. Working with upper extremity exercises.

904.4. Supervision of Therapist Assistant

A licensed therapist must be responsible for always providing adequate supervision of the therapist assistant(s). The licensed therapist must:

904.4.1. Meet with the assistant no less than once weekly to review all cases being treated.

904.4.2. Document all meeting with the assistant.

904.4.3. Make an on-site supervisory visit to each patient being treated by the assistant as appropriate based on the need to alter the treatment plan and no less than every sixth treatment.

904.4.4. Document the on-site visits and indicate instructions given to the physical.

904.4.5. Therapist assistant; and

904.4.6. Always be available to the assistant for advice, assistance and instructions.

Services Which May Not Be Provided by A Therapist Assistant Include:

904.4.7. The initial patient evaluation; and

904.4.8. Initiation of the plan of care. Costs incurred for licensed therapist visits to supervise a therapist assistant are considered administrative costs and are not separately reimbursable as a visit.

NOTE: See Section 801 for General Information and Appendix J for Home Health Services National Code Table and Instructions for Billing.

905. The Clinical Record

905.1. The home health agency must establish and maintain a current clinical record on all patients admitted to the agency that substantiates the services billed to Medicaid. These records must include at a minimum:

905.1.1. Appropriate patient identifying information including current directions to the patient's home.

905.1.2. Name of patient's attending physician.

905.1.3. Pertinent past and current findings.

905.1.4. A plan of care signed and dated by the attending physician at least every sixty (60) days or every two (2) months (or more often if patient's condition changes) which includes drug, dietary, treatment.

905.1.5. Signed and dated clinical notes written by the close of the business day immediately following the day the service was rendered by the providing member of the health team and incorporated no less often than weekly.

905.1.6. Documentation reflecting home health aide services (if applicable), and supervision of aides every two (2) weeks.

905.1.7. Copies of summary reports sent to the physician at least every sixty (60) days or every two (2) months; and

905.1.8. A discharge summary when applicable.

905.2. Certification and Plan of Care

An individual plan of care must be developed for each patient in consultation with the agency staff and other attending professionals. The plan should address all pertinent diagnoses, mental status, types of service and equipment required, frequency of visits, expected duration of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications, treatments, safety measures, discharge planning, appropriate goals and other pertinent items. Orders for PRN services must be specific to a diagnosis and require the skills of a licensed health care professional. The total plan of care is reviewed by the attending physician and the home health personnel as often as the severity of the patient's condition requires. The plan of care certifies the need for continuation or discontinuation of home health services. This must be done at least every sixty (60) days or every two (2) months. Drugs and treatments are to be administered by agency staff only as ordered by the physician. The nurse or therapist must record and sign verbal orders and obtain the

physician's signature.

NOTE: There is no substitute for this Plan of Care.

905.3. Clinical Notes

The clinical record must include clinical notes written after each visit or contact with the patient. The notes should be incorporated into the record weekly. These notes should be written by appropriate personnel providing the service(s). These written notes should include all information pertaining to the patient. Any problems reported by a patient or family must be addressed in these notes. Clinical notes must be maintained on a continuous basis and reflect ongoing assessment of the patient's condition.

905.4. Summary Report

The summary report is a report of the patient's condition, change or progress, new problems identified, patient's vital signs, complaints, descriptions of wounds, etc. It must reflect the need for continuation or adjustment of services rendered. The summary report must be sent to the physician at least every sixty (60) days or every two (2) months and should reflect the need for re-certification of the plan of care or the termination of services. The summary report must address each service rendered. The Division or its designee has the right to periodically review the need for continuation of services.

906. On-Site Reviews and Audits

To ensure compliance with the policies and procedures set forth in this manual, representatives of the Division will conduct on-site reviews and audits of home health agencies enrolled with the Division. The reviews and audits will be conducted to determine whether services provided have been accurately and completely reported, whether all services reported have been performed and whether the services provided meet currently accepted standards of quality. The on-site reviews will include but are not limited to in-agency reviews of clinical and billing records and in-home patient assessments. The Division generally will try to provide twenty-four (24) hour notice prior to on-site reviews or audits; however, on-site reviews and audits may be done with no prior notice.

Reports of the on-site reviews and audits will be forwarded to each agency by the Division. Upon receipt of the report, each agency will have twenty (20) calendar days from the date of the report to respond to the on-site review. Failure to comply with the provisions of this manual may lead to adverse actions including suspension or termination from the program. Audit response time will be outlined in the cover letter which will accompany the audit report.

906.1. The Division has no objection to agency personnel accompanying the Divisional representative(s) on home visits; however, the following guidelines must be observed:

906.1.1. DMA representative and agency personnel will travel in separate cars.

906.1.2. Time and place of visits are at the total discretion of the DMA representatives; and

906.1.3. Agency personnel must not interfere with the interview process.

907. Non-Covered Services

907.1. The following are non-covered services in the Home Health Program:

907.1.1. Medical Social Services.

907.1.2. Use of home health aide for chore services.

907.1.3. Meals-on-wheels.

907.1.4. Audiology services.

907.1.5. Private duty nurses.

907.1.6. Efforts made by home health agencies to render services to patients not at home.

907.1.7. Services provided without a physician's authorization.

907.1.8. Services that are not contained in the plan of care.

907.1.9. Skilled nursing and home health aide services to members receiving Model Waivered Services, Exceptional Children's Services or GAPP services.

907.1.10. Services rendered to a member receiving medical day care services under the Waivered Home Care Program.

907.1.11. Therapy services rendered to a member receiving physical, speech or occupational therapy by an individually enrolled therapist or through the Children's Intervention Services Program or through the Children's Intervention School Services program.

907.1.12. Services rendered to an individual receiving Medicare covered home health services.

907.1.13. Phototherapy services (including equipment, supplies and skilled services) when provided and reimbursed in the Durable Medical Equipment program.

907.1.14. Services rendered which fail to comply with all terms and conditions of the provider's Statement of Participation and the provisions of this manual.

907.1.15. Newborn teaching and assessment and Health Check type visits.

907.1.16. Postpartum follow-ups and assessments.

907.1.17. Home Health Services for social issues.

907.1.18. Home Health Services to monitor and assess compliance with the treatment regimen.

907.1.19. Skilled nursing visits to assess and monitor medication compliance; and

907.1.20. Skilled nursing visits to children greater than two (2) years of age for administration of Synagis.

907.1.21. The cost associated with the preparation and signing of orders and plan of care by a physician is a non-allowable cost and is not reimbursable under the Home Health program, nor are these services billable physician services since they are functions generally considered to be part of the usual physician/patient referral mechanism.

908. Supplies

Medical supplies are items that, due to their therapeutic or diagnostic characteristics, are essential in enabling agency personnel to conduct home visits or to carry out effectively the care the physician has ordered for the treatment or diagnosis of the patient's illness or injury. The individual agency's reimbursement rate calculated by the Division's reimbursement methodology includes medical supplies used by the patient, provider, or other practitioners under arrangement on behalf of the agency (other than physicians). These supplies are customarily used in small quantities during most home health visits, are usually included in the staff's supplies and are not designated for a specific patient. This supply cost does not include those supplies that are specifically ordered by the physician or are essential to agency personnel to effectuate the plan of care.

908.1. Supplies considered included in the agency reimbursement rate are, but not limited to:

908.1.1. Dressings and Skin Care

908.1.1.1. Swabs, alcohol preps, and skin prep pads.

908.1.1.2. Tape Removal Pads.

908.1.1.2.1. Cotton Balls.

908.1.1.2.2. Adhesive and paper tape.

908.1.1.2.3. Non-sterile applicators; and

908.1.1.2.4. 4 X 4's.

908.1.1.2.5. Incontinent skin care products to prevent skin breakdown.

908.1.2. Infection Control Precautions

908.1.2.1. Non-sterile gloves.

908.1.2.2. Aprons.

908.1.2.3. Masks; and

908.1.2.4. Gowns

908.1.3. Blood Drawing Supplies

908.1.4. Incontinence Supplies

908.1.4.1. Incontinence Briefs and Chux covered in the normal course of a visit.

908.1.5. Other

908.1.5.1. Thermometers.

908.1.5.2. Tongue depressors.

908.1.5.3. Band-aids.

908.1.5.4. Lancets.

908.1.5.5. Blood Glucose strips.

908.1.6. All supplies identified in the plan of care that are not designated for a specific patient or related to a chronic condition for which the patient is admitted.

When the supplies listed in the above examples are required in quantity, for recurring need and are included in the plan of care for a specific patient, these supplies would be considered a separate billable. This could include but is not limited to tape and 4 X 4's for major dressings.

If a home health agency determines the supplies are too costly and excessive to be included in the visit, the agency could make a request for consideration to an enrolled Medicaid DME provider for prior approval for the supplies. This would be coordinated between the home health agency and the DME provider. The DME provider would bill Medicaid.

The plan of care must reflect all supplies considered covered in the agency reimbursement rate, related to the plan of care, unrelated to the plan of care and those that would be considered a separate billable. Failure to identify medical supplies on the plan of care that are considered included in the reimbursement rate does not relieve the agency from the obligation to comply with policy requirements. If a patient has acquired medical supplies prior to the Medicaid home health start of care date, the agency is not required to duplicate the medical supplies. The agency must determine if the patient's medical supplies are
clinically appropriate. If the patient prefers to use their own medical supplies after having been offered appropriate supplies by the home health agency, the agency is obligated to honor the patient's choice. If the patient prefers to have the agency provide the medical supplies while the patient is under a Medicaid home health plan of care, then the agency is obligated to furnish the supplies. The agency may not require the patient obtain or use medical supplies from any other source. It is the responsibility of the agency to document the patient's decision to accept or to decline the agency

furnished medical supplies.

908.2. Medical supplies that are considered separate billables must meet the following criteria:

908.2.1. The agency follows a consistent practice pattern for Medicaid and other patients receiving the item.

908.2.2. The supply is directly identifiable to an individual patient.

908.2.3. The cost of the item can be identified and accumulated in a separate cost center; and

908.2.4. The item is furnished at the direction of the patient's physician and is specifically identified in the plan of care.

908.3. These supplies must be specifically ordered by the physician or the physician's order for services must require the use of the specific supplies to be effectively furnished. The cost of these supplies is excluded from the reimbursement rate.

Examples of separately billable medical supplies include, but are not limited to the following:

908.3.1. Dressings/Wound Care

908.3.1.1. Sterile Dressings.

908.3.1.2. Sterile gauze and toppers.

908.3.1.3. Kling and Kerlix rolls.

908.3.1.4. Telfa pads.

908.3.1.5. Eye pads.

908.3.1.6. Sterile solutions, ointments.

908.3.1.7. Sterile applicators; and

908.3.1.8. Sterile gloves.

908.3.2. I. V. Supplies (includes tubing, syringes, IV catheter, sterile solutions, access ports, change kits, etc.).

908.3.3. Ostomy Supplies

908.3.4. Catheters and catheter supplies

908.3.4.1. Foley catheters, condom catheters; and

908.3.4.2. Drainage bags, irrigation trays, syringes.

908.3.5. Enemas and Douches

908.3.6. Syringes and needles for medication injections

Consider other items that are often used by persons who are not ill or injured to be medical supplies only where the item is recognized as having the capacity to serve a therapeutic or diagnostic purpose in a specific situation and the item is required as a part of the actual physician-prescribed treatment of a patient's existing illness or injury. These items could be supplies covered in the agency reimbursement rate or considered separate billables. Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and rendered by the patient or caregiver. These items must be part of the plan of care in which the home health staff is actively involved. Supplies such as needles, syringes, and catheters that require administration by a nurse should not be left in the home between visits.

Chapter 1000: Basis For Reimbursement

1001. Reimbursement Methodology

Each home health agency is reimbursed a specific rate per visit for covered services. The specific rate per visit is based on the total of the agency's inflated base rate, any efficiency incentive applicable to the agency and a supply rate. The base rate, efficiency incentive and supply rate is subject to ceilings. Effective for dates of service July 1, 2003, reimbursement rates will be reduced by 10%.

1001.1. Rates, incentives, and ceilings are determined as follows:

1001.1.1. Each agency's base rate is calculated using data contained in an electronic copy of its as-filed Medicare cost report or audited Medicaid cost report for that agency's base period. An inflation percentage is applied to the base period data and the resulting inflated base period cost per visit is the agency's base rate. The inflation percentage and base period are set by the Department.

1001.1.2. Each agency is classified into one of the following categories: hospital-based, freestanding urban, and freestanding rural. For each category the 75th percentile of inflated base period cost per visit is determined. This amount is the base rate ceiling for agencies in that category.

1001.1.3. An efficiency incentive may be added to the base rate for an agency as follows:

1001.1.3.1. If an agency's base rate is less than or equal to the base rate ceiling in the agency's category, the difference between the base rate and the ceiling is multiplied by 20%, and the product (not to exceed $1.76) is added to the base rate. The total of base rate plus incentive shall not exceed the base rate ceiling for the agency's category.

1001.1.4. The supply cost per visit for each agency is based on data contained in the as filed or audited Medicaid cost report for that agency's base period. An inflation percentage will be applied to base period data to determine each agency's inflated supply cost per visit. The inflation percentage and base period for supply costs are set by the Department Inflated base period supply costs per visit for each agency are arrayed on a statewide basis and the 75th percentile cost from that array is the supply rate. The supply rate is added to each agency's base rate plus any applicable efficiency incentive.

1001.1.5. The reimbursement rate for each freestanding agency shall not exceed the base rate ceiling for that agency's category plus the supply rate. The reimbursement rate for each hospital-based agency will be calculated as noted in paragraphs (a) through (d) and shall not exceed the maximum rate noted in paragraph (f) below.

1001.1.6. For purposes of setting the maximum rate per visit for hospital-based agencies, the Department has established two subcategories: Urban hospital-based and rural hospital-based. The maximum rate per visit for each agency in these subcategories is determined by adding a hospital-based adjustment amount to the freestanding urban and freestanding rural based rate ceilings.

The adjustment is calculated as follows:

1001.1.6.1. The mean of the agencies' inflated base period cost per visit will be calculated for each of the subcategories. A percentage of the mean for each subcategory will be calculated and added to the base rate ceiling for the corresponding freestanding urban or rural category, plus the supply rate to establish the maximum rate for hospital-based agencies in that subcategory.

1001.1.6.2. Each hospital-based agency will be reimbursed the lesser of its rate calculated as noted in paragraphs (a) through (d), or the maximum rate per visit for its subcategory.

1001.1.6.3. Assignment to a subcategory is determined according to the criteria outlined in the section labeled classification of agencies.

1001.1.7. Reimbursement rates will be adjusted for home health agencies which provide certain home delivered services to community-care recipients. The rate adjustment will be calculated using the home health reimbursement methodology above, and the calculation will include both home health and home delivered services utilization data for the base period.

Reimbursement rates will be adjusted only for those agencies currently enrolled and providing services in the community care home-delivered services program and for which at least nine months of cost and utilization data exists for the base period. Home health agencies which discontinue the provision of home-delivered services will be subject to a reduction in their reimbursement rate.

1001.1.8. Effective for dates of service July 1, 1994, and after, a $3.00 recipient copayment is required for all home health visits. If less than one hour is billed by provider (the rate is paid at 15 minutes equal to 25% of rate per increment), the co-payment is prorated also. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are not required to pay the co-payment. Emergency services and family planning services are also exempt from a co-payment.

1001.2. Cost Reports

Each agency must submit an electronic copy of its as-filed Medicare cost report and a completed Medicaid Cost Data Form (see Appendixes C, D, and M) to DCH_NIR@dch.ga.gov. These

documents must be received by the Department within one hundred fifty (150 days) after each agency's fiscal year end. A Parent agency with subunits and branch offices must also complete a Parent Office Cost Data Form (see section 601.12 and Appendix M).

If the Medicare electronic cost report and Medicaid Cost Data Form have not been received after these one hundred fifty (150 day) periods, a rate reduction of 10% on the current rate will be imposed. This rate reduction will remain in effect through the final day of the month in which the cost information is received.

If the information is received after any fraction of a month beyond the one hundred fifty (150 day) period, the rate reduction of 10% will be applied for the entire month. If an agency's cost information is not received by the time the Department establishes individual provider rates and determines the percentiles and rate ceilings, that agency will be assigned the lesser of its current rate or the lowest rate in the State for the appropriate category, less applicable incentive, as established by the rate-setting process. If the agency's cost information is received after rates are established, the Department will calculate a rate based on the information received and retroactively and prospectively adjust the agency's previously assigned rate only if it is greater than the calculated rate. The agency's rate will remain in effect until the next rate adjustment period, as determined by the Department. Failure to submit cost information may result in suspension or termination of the agency from the Medicaid Home Health program.

An agency's Medicaid cost report is subject to review or audit by the Department or its agent(s) in accordance with CMS-15-1 principles of reimbursement and Medicaid policies and procedures. The agency's reimbursement rate will be adjusted (if necessary) for the period for which the rate was effective as a result of the review or audit performed. Percentile and rate ceilings as initially established will not be adjusted based upon subsequent audits. An agency may appeal any audit adjustments and rates resulting there from using the administrative review procedures outlined in home health policy manual.

1002. Nonallowable Costs

1002.1. Effective for the determination of reasonable costs used in the calculation of rates initially established on and after April 1, 1991, the costs outlined below are nonallowable for Medicaid purposes:

1002.1.1. Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials.

1002.1.2. Memberships in civic organizations.

1002.1.3. Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care.

1002.1.4. Vehicle depreciation or vehicle lease expense more than the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limits shall not apply to specialized patient transport vehicles (e.g. ambulances).

1002.1.4.1. Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is related to patient transport is non-allowable.

1002.1.4.2. Fifty percent (50%) of professional dues for national, state, and local associations.

1002.1.4.3. Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgment or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable.

1002.1.4.4. Advertising costs that are (a) for fund-raising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities; (d) for public image improvement; or (e) related to government relations or lobbying.

Information on these non-allowable costs will be obtained by the Department or its agent at the time of review or audit of the agency.

The agency's reimbursement rate will be adjusted (if necessary) for the period for which the rate was effective as a result of the review or audit performed. Percentile and rate ceilings as initially established will not be adjusted based upon subsequent audits. An agency may appeal any audit adjustments and rates resulting there from using the Department's Administrative Review Procedures.

1002.2. Cost Report Due Date Extension

An agency may request an extension of time for submission of the Medicare and Medicaid cost information beyond the revised due dates based on the 150-day period only by written request to the Department. Such request must be received prior to the due date of the cost report information and will be granted only if the provider's operations are "significantly adversely affected" because of the circumstances beyond the provider's control (i.e., a flood or a fire that causes the provider to halt operations).

A request for extension must include a copy of any extension granted by the Medicare

intermediary, and the reason(s) an extension is being requested. The Department will review each written extension request and, if approved, will specify the revised due date of the cost information. If the cost information is not received by this revised date, an agency's rate will be reduced as described in Subsection 1001.1. The request for extension must be submitted to: Program Manager, Non-Institutional Reimbursement Section, P.O. Box 38440, Atlanta, Georgia 30334.

1002.3. New Agencies

A new agency will be reimbursed a rate equal to the statewide average reimbursement rate for the appropriate category, as of the effective date of enrollment of the new agency. This new agency rate will be reimbursed until a cost report for a base period (minimum nine months) on which an agency-specific rate per visit can be based, is received by the Department. There will not be a cash settlement determination for new agencies.
A new agency is defined as an agency established by the initial issuance of a Certificate of Need (CON), Medicare certification, and state license; it is reimbursed as described in paragraph a) above. An agency formed as a result of a merger, acquisition, other change of ownership, business combination, etc., is not a new agency. Each agency of this type will maintain the reimbursement rate it was assigned prior to the transaction. When rates are subsequently adjusted, the appropriate cost report for the base period (as determined by the Department) will be used as a basis for determining the agency's rate.

1002.4. Agencies with Insufficient or Un-Auditable Cost Data

If an existing agency submits cost data for its fiscal year that corresponds to the base period and the fiscal year is for an insufficient period (as determined by the Department but usually a period of less than nine (9) months), that cost data will not be used in establishing the percentile and rate ceilings for the appropriate category and in calculating the statewide supply rate per visit. However, the data will be used to calculate a rate per visit using the methodology previously described. A free-standing agency's actual reimbursement rate in this instance will be the lesser of the calculated rate per visit (including applicable incentive) or the 75th percentile for the appropriate category, calculated exclusive of the agency's insufficient cost data, plus the statewide supply rate per visit, also calculated exclusive of the agency's insufficient cost data. A hospital-based agency's actual reimbursement rate in this instance will be the lesser of the calculated rate per visit (including applicable incentive) or the maximum rate per visit for the appropriate hospital-based subcategory, calculated exclusive of the agency's insufficient cost data, plus the supply rate per visit, also calculated exclusive of the agency's insufficient cost data. There will be no cash settlement for existing agencies with insufficient cost data for the base year.

Existing agencies with cost data which cannot be audited for the fiscal year that corresponds to the base period will be omitted from the rate setting process and assigned the lowest rate in the state for the applicable category until the appropriate records are made available to verify (audit) the cost information.

1002.5. Amended Medicare and Medicaid Cost Data

An agency may submit an amended electronic Medicare cost report and Medicaid Cost Data Form after the initial submission for the most recent fiscal year. An amended report

and cost data form must be received by the Department no later than ninety (90) days after the due date of the initial report and form, or ninety (90) days after any due date extension granted by the Department pursuant to Subsection 1001.3. The amended Medicare report must support the amended Medicaid cost data form. The due date of the initial report and cost data form is contained in Subsection 1001.1.

1002.6. Availability of Records

Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Department or its agents.

1003. Appeal of Reimbursement Rates

1003.1. Providers may submit written appeals concerning their reimbursement rates as initially established, or as adjusted based upon an audit or review by the Department or its agents. Only the following will be accepted as a basis for appeal:

1003.1.1. Evidence that the cost report figures used to determine the base rate and supply rate contained an error on the part of the Department or its agents.

1003.1.2. Evidence that the Department made an error in calculating the agency's reimbursement rate; or

1003.1.3. Evidence that the Department is not complying with its stated policies in determining the base rate, incentive, or supply rate per visit.

In addition, an agency may submit written appeals concerning audit adjustments made by the Department or its agents as a result of on-site audits or desk reviews.

An agency's appeal request must be submitted within thirty (30) days of the date of the rate notification and audit adjustments letter to DCH_NIR@dch.ga.gov.

The appeals process for reimbursement rates and audit adjustments will follow the administrative review procedures outlined in Part I of this manual, Section 503.

1004. Provider Return on Equity

The Department does not reimburse providers for return on equity.

1005. Classification of Agencies

1005.1. For reimbursement purposes Home Health agencies will be classified as follows:

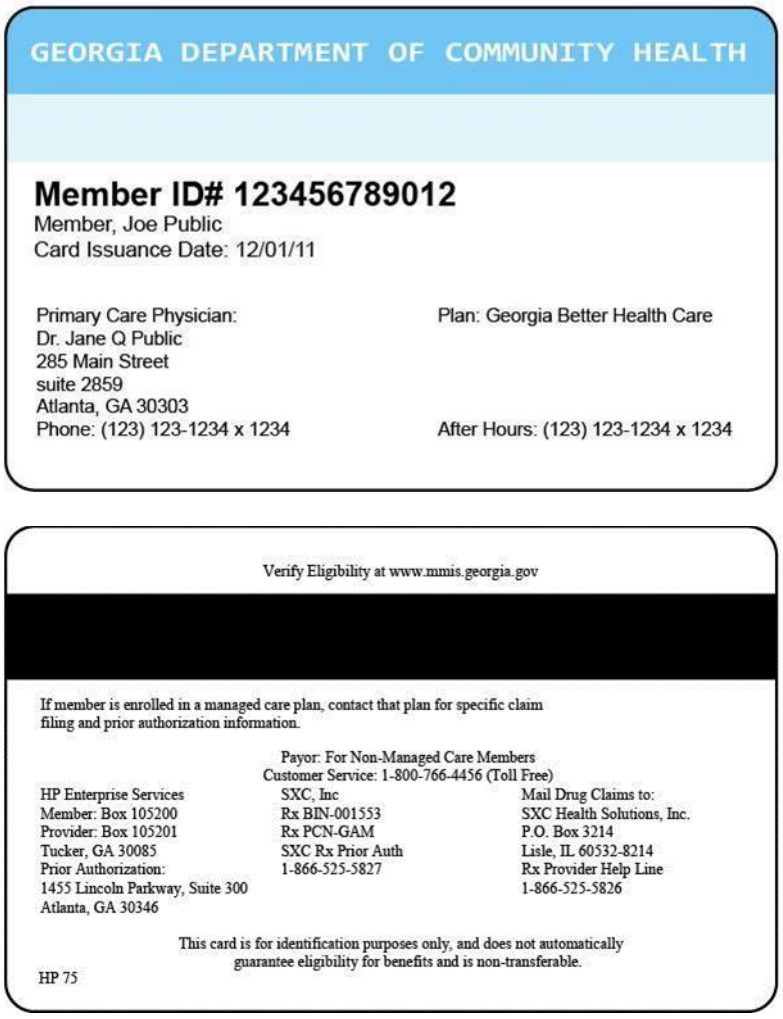
1005.1.1. Urban - Agency located in a Metropolitan Statistical Area, as evidenced by documentation on file with the Department, including, but not limited to, the address on the Medicare cost report received by the Department or the fiscal intermediary.

1005.1.2. Rural - An agency located in a non-Metropolitan Statistical Area, as evidenced by documentation on file with the Department, including, but not limited to, the address on the Medicare cost report received by the Department or the fiscal intermediary.

1005.1.3. Hospital-based - An agency classified as hospital-based for Medicare purposes will be considered hospital-based for Medicaid purposes. Hospital-based agencies will be further categorized as urban or rural using the criteria in (a) and (b) above. Agencies retrospectively classified as hospital-based by Medicare will not be classified retrospectively as hospital-based by the Department. The agency will be notified of the prospective effective date.

Agencies which submit Medicare cost reports with addresses different from the address on the Statement of Participation on file with the Department will have their cost reports returned for verification. If the agency uses the address on the Medicare cost report for Medicare purposes, this same address will be utilized in designation of a location for rate setting purposes for the Department.

Appendix A
Medicaid Member Identification Card Sample



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Member ID# 123456789012
Member, Joe Public
Card Issuance Date: 12/01/11

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

Plan: Georgia Better Health Care

After Hours: (123) 123-1234 x 1234

Verify Eligibility at www.mmis.georgia.gov

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: 1-800-766-4456 (Toll Free)

HP Enterprise Services
Member: Box 105200
Provider: Box 105201
Tucker, GA 30085
Prior Authorization:
1455 Lincoln Parkway, Suite 300
Atlanta, GA 30346

SXC, Inc
Rx BIN-001553
Rx PCN-GAM
SXC Rx Prior Auth
1-866-525-5827

Mail Drug Claims to:
SXC Health Solutions, Inc.
P.O. Box 3214
Lisle, IL 60532-8214
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.

HP 75

Appendix B
Definitions

Clinical Note - A dated and signed written notation by the providing member of the health team of a contact with a patient containing a description of signs and symptoms, treatment and drugs given, the patient's reaction, and any changes in physical or emotional condition.

Division - Georgia Division of Medical Assistance.

Plan of Care - An individual plan written, signed, and reviewed at least every sixty (60) days or every two (2) months by the patient's physician prescribing items and services for the patient's condition.

Progress Note - A dated and signed written notation by the providing member of the health team, summarizing facts about care and the patient's response during a given period of time.

Physician - An individual who is currently licensed to practice medicine in the State of Georgia.

Date of Receipt - the date when the document is received by the Division or its contractor.

DFCS - Department of Family and Children Services.

DHR - Department of Human Resources.

Visit - A personal contact in the residence of a patient made for the purpose of providing a covered service. One visit is counted each time a covered service is rendered in the patient's home. Dates of all home visits must be recorded in the patient's record. With the implementation of the Health Insurance Portability and Accountability Act (HIPAA) and the National Code Set (NCS), the definition of time for a visit is one (1) hour. Any covered service rendered in the patient’s home that is in an increment less than the defined time limit of one (1) hour will be counted as a fraction of a visit when determining the calendar year service limit and should be billed accordingly. Fractions of visits cannot be less than fifteen (15) minute increments.

PRN - A skilled visit provided outside the approved visit frequency. PRN must be in the Plan of Care and justified as reasonable and necessary in accordance with treatment for the specified diagnosis. PRN aide visits are not reimbursable.

Appendix C
Home Health Cost Data Form (Free Standing)

APPENDIX C
HOME HEALTH COST DATA FORM (FREE STANDING)

PROVIDER NAME: _____

MEDICAID PROVIDER NUMBER: _____

COST REPORTING PERIOD - FROM: _____ TO: _____

I. VISITS BY DISCIPLINE

	(1) Medicaid Home Health	(2) Agency Total Home Health
Skilled Nursing - RN		
Skilled Nursing - LPN		
Physical Therapy		
Physical Therapy Assistant		
Occupational Therapy		
Certified Occupational Therapy		
Speech-Language Pathology		
Medical Social Services		
Home Health Aide Services		
Total	-	-

(1) Enter information from agency's records.

(2) Enter information from CMS Form 1728, Worksheet C, Cost Per Visit Computational, Part I, Column 3, Lines 1-9.

II. COST INFORMATION

	(1) Agency Total Home Health
Skilled Nursing - RN	
Skilled Nursing - LPN	
Physical Therapy	
Physical Therapy Assistant	
Occupational Therapy	
Certified Occupational Therapy	
Speech-Language Pathology	
Medical Social Services	
Home Health Aide Services	
Total	-

Enter information from CMS Form 1728, Worksheet C, Cost Per Visit Computational, Part I, Column 2, Lines 1-9.

III. MEDICAL SUPPLIES BILLED TO PATIENTS

(1) Total Agency Cost _____
(2) Total Charges _____
(3) Ratio of Cost to Charges (RCC) _____
(4) Medicaid Charges _____
(5) Medicaid Cost (RCC x Medicaid Charges) -

(1) (2) (3) Enter information from CMS Form 1728 Worksheet C, Part II Other Patient Services, Line 11, Columns 1, 2, and 3, respectively.
(4) Enter information from agency's records.

_____
Officer or Administrator of Agency

_____
Title

_____
Date

DCH-601-FS (2/2024)

Appendix D
Home Health Cost Data Form (Hospital-Based)

APPENDIX D
HOME HEALTH COST DATA FORM (HOSPITAL-BASED)

PROVIDER NAME: _____

MEDICAID PROVIDER _____

COST REPORTING PERIOD - FROM: _____ TO: _____

I. VISITS BY DISCIPLINE

	(1) Medicaid Home Health	(2) Agency Total Home Health
Skilled Nursing		
Physical Therapy		
Occupational Therapy		
Speech-Language Pathology		
Medical Social Services		
Home Health Aide Services		
Total	-	-

(1) Enter information from agency's records.

(2) Enter information from CMS Form 2552, Worksheet H-3, Part I, Column 4, Lines 1-6.

II. COST INFORMATION

	(1) Agency Total Home Health
Skilled Nursing - RN	
Physical Therapy	
Occupational Therapy	
Speech-Language Pathology	
Medical Social Services	
Home Health Aide Services	
Total	-

Enter information from CMS Form 2552, Worksheet H-3, Part I, Column 3, Lines 1-6.

III. MEDICAL SUPPLIES BILLED TO PATIENTS

(1) Total Agency Cost _____

(2) Total Charges _____

(3) Ratio of Cost to Charges (RCC) _____

(4) Medicaid Charges _____

(5) Medicaid Cost (RCC x Medicaid Charges) -

(1) (2) (3) Enter information from CMS Form 2552 Worksheet H-3, Part I, Line 15, Columns 2, 3, and 4, respectively.

(4) Enter information from agency's records.

_____
Officer or Administrator of Agency

_____
Title

_____
Date

DCH-600-HB (2/2024)

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

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

i. Georgia Families Overview:

https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

ii. Georga Families 360 Overview:

https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

iii. Non-Emergency Medical Transportation Overview:

https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

Appendix F
Co-Payment

A. Co-Payment

Effective with dates of service July 1, 1994, and after, the Division is implementing a $3.00 copayment for each home health visit.

i. The copayment does not apply to the following members:

1. Pregnant women
2. Members under 21 years of age
3. Hospice care members
4. Woman diagnosed with breast or cervical cancer and receiving Medicaid under the Women's Health Medicaid Program, aid categories 245 and 800 only. This change is effective January 1, 2007. It applies to all services rendered, beginning January 1, 2007, and thereafter.

ii. The copayment does not apply to the following services:

1. Emergency services
2. Family Planning services
3. Waiver services
4. Dialysis

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

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

v. The Division may not be able to identify all members who are exempt from the copayment. Therefore, providers should identify the members by entering the following indicators in field 24(I) of CMS-1500 claim form:

1. P = Pregnant
2. S = Nursing facility members
3. H = Hospice

4. E = Emergency services

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

vii. A $3.00 copay should apply to each date of service as opposed to each unit. More than one copay should not apply on the same date of service (Rev. 07/2018).

NOTE:
See Section 1305. Reimbursement Note in Part II, Policies and Procedures for Home Delivered Services manual for clarification of cost share requirements related to CCSP members.

PeachCare for Kids® Co-payments: For children ages 6 and over, the following copayments apply for fee for service and CMOs:

Category of Service	Co-Payment
Ambulatory Surgical Centers / Birthing	$3.00
Durable Medical Equipment	$2.00
Federally Qualified Health Centers	$2.00
Free Standing Rural Health Clinic	$2.00
Home Health Services	$3.00
Hospital-based Rural Health Center	$2.00
Inpatient Hospital Services	$12.50
Oral Maxillofacial Surgery	Cost-Based
Orthotics and Prosthetics	$3.00
Outpatient Hospital Services	$3.00
Pharmacy - Preferred Drugs	$0.50
Pharmacy - Non-Preferred Drugs	Cost-Based
Physician Assistant Services	Cost-Based
Physician Services	Cost-Based
Podiatry	Cost-Based
Vision Care	Cost-Based
Cost-Based Co-Payment Schedule	
Cost of Service	Co-Payment
$10.00 or less	$0.50
$10.01 to $25.00	$1.00

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

Appendix G
Notice of Your Right to a Hearing

You have the right to a hearing about this decision. To have a hearing, you must ask for one in writing. You should send a copy of the attached letter in 30 days or less to this address:

Department of Community Health Legal Services Section Department of Medical Assistance 2 Martin Luther King Jr Dr. SE, East Tower
Atlanta, GA 30334

If you want to keep your services, you must send a written request for a hearing before the date that your services change.

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to help you. You may be able to get legal help at no cost. If you want a lawyer to help you, you may call one of these numbers:

Georgia Legal Services Program
1-800-498-9469
(Statewide legal services, EXCEPT for the counties served by Atlanta Legal Aid)

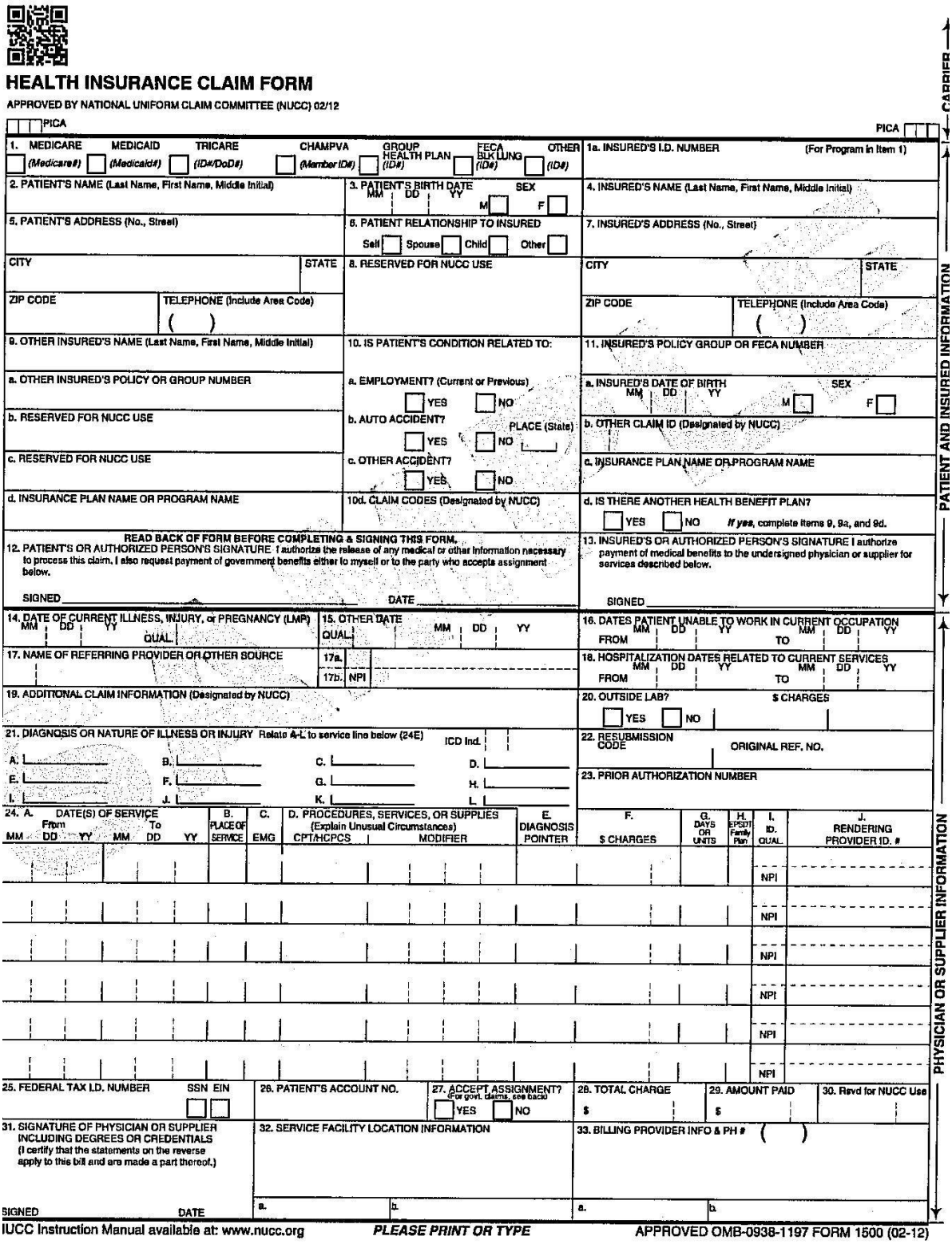
Georgia Advocacy Office
1-800-537-2329
(Statewide advocacy for persons with disabilities or mental illness)

Atlanta Legal Aid
(404) 377-0701 (DeKalb/Gwinnett Counties)
(770) 528-2565 (Cobb County)
(404) 524-5811 (Fulton County)
(404) 669-0233 (So. Fulton/Clayton County)

State Ombudsman Office
1-888-454-5826
(Nursing Home or Personal Care Home)

You may also ask for free mediation services by calling 404-656-9090. Mediation is another way to solve problems without a hearing. If you cannot solve the problem with mediation, you still have the right to a hearing.

Appendix H
New CMS 1500 Claim Form (version 02/12)



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( ) a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Appendix H-1
Health Insurance Claim Form 1500 Instructions

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

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."

Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/Gainwell Technologies:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier

Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?)
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)." Removed the arrow and text in the righthand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier." **FOR DCH/Gainwell Technologies: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date)**.
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).

Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/Gainwell Technologies:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "**RESERVED FOR LOCAL USE**" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/Gainwell Technologies:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate **acceptable values (0, 9)**. ICD-9 diagnoses (CM) codes = value
	9; or ICD -10 diagnoses (CM) codes = value 0. **(Do not bill ICD 10 code sets before October 1, 2015.)**
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines

Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. F **FOR DCH/Gainwell Technologies**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

Appendix I
Home Health Services National Code Table

Description	**National Code** Effective **08/15/2004**	**Description**	**Rate**
***Skilled Nursing**	**S9123**	Nursing Care in home by registered nurse, per hour. (Use for general nursing care only, not to be used when CPT codes 99500-99600 or S codes S9802-S9803 can be used)	Provider specific
	S9124	Nursing care in home by a licensed practical nurse, per hour	Provider specific
***Home Health Aide**	**S9122**	Home health aide or certified nursing assistant, providing care in the home, per hour	Provider specific
***Physical Therapy**	**G0151**	Services of physical therapist in home health setting, each 15 min.	Provider Specific

Effective January 1, 2017 **<u>Physical Therapy</u>** **97161** **97162** **97163** **<u>Physical Therapy</u>** **97164**	**<u>Evaluation</u>** – Low complexity Moderate complexity High complexity **Re-evaluation** of physical therapy established plan of care requiring: i. An examination (including a review of history and use of standardized tests and measures. ii. A revised plan of care (based on use of standardized patient assessment instrument and/or measurable assessment of functional outcome).	Provider Specific
Effective January 1, 2014 **<u>Speech Therapy</u>** **92521** **92522** **92523** **92524** **92507**	**Evaluation of:** i. Speech Fluency. ii. Speech Sound Production. iii. Speech Sound Production with Evaluation of Language Comprehension and Expression. iv. Behavioral and Qualitative Analysis of Voice and Resonance. v. <u>Treatment</u> of speech, language, voice, communication and/or auditory processing disorder (includes aural rehabilitation); individual.	Provider specific Provider Specific
<u>Occupational Therapy</u> **G0152**	Services of occupational therapist in home health setting, each 15 min.	Provider Specific

Effective January 1, 2017 **<u>Occupational Therapy</u>** **97165** **97166** **97167** **<u>Occupational Therapy</u>** **97168**	**<u>Evaluation</u>** – Low complexity Moderate complexity High complexity **Re-evaluation** of occupational therapy established plan of care requiring: i. An assessment of changes in patient functional or medical status, along with a revised plan of care. ii. An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals. iii. A revised plan of care (a formal re-evaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required).	Provider Specific Provider Specific

A. Instructions for National Code Billing:

i. The above listed codes are taken from the National Code Table. These codes are Health Insurance Portability and Accountability Act (HIPAA) compliant. Effective with dates of service beginning August 15, 2004, utilize these codes when submitting home health claims (CMS 1500).

1. "S" codes are codes utilized for one (1) hour increments which equal 1 unit of Skilled Nursing Services. Example: 2 units= 2 hours.

2. "G" codes are codes utilized for 15-minute increments which equal 1 unit of Therapy. Therapy increments are to be billed at a maximum of 45 minutes, not to exceed three (3) units per visit. Example: 3 units= 45 mins.

"S" and "G" codes must be billed on a single detail line per claim. Claim detail line 'dates of service' cannot span one month to the next.

"97" and "92" codes are codes utilized for one (1) unit which equal 1 unit per day visit of either

evaluation, re-evaluation or analysis, and does not indicate the time span of the visit. Example: 1 unit= 1 visit.

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

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

Appendix J
COS 200 – Home Health Services Program – Addition of Branch Location

To enroll an additional location, Home Health Providers will need to log onto the MMIS web portal using their username and password and complete the "Additional Location Application" (Rev. 07/2017).

Appendix K
Health Care Providers

GEORGIA DEPARTMENT OF COMMUNITY HEALTH HOME HEALTH CARE SERVICES
PARENT OFFICE COST DATA FORM

FOR THE PERIOD _____ THROUGH _____

PARENT NAME: _____ ADDRESS: _____

MEDICAID #: _____ TELEPHONE: _____

PURPOSE

The purpose of this form is to provide summary cost information from the Medicare Parent Office Cost Statement (Form HCFA-287) for the parent office, each Georgia home health care branch and any other component(s) of the parent office organization.

INSTRUCTIONS

Columns 1 and 2, lines 1-7, should list all Georgia home health care branches receiving services from the parent office organization and the related Medicaid provider numbers. Column 3, lines 1-7 should report the total parent office costs allocated to the Georgia home health care branches. The amount to place on each line is the sum of the direct allocations (Schedule E), functional allocations (Schedule F), and pooled allocations (Schedule H), for each Georgia home health care branch as reported in the Medicare Parent Office Cost Statement. These amounts should agree with the amounts shown as parent office costs on each provider cost report unless the parent office and the home health care branches have nonconcurrent year ends. Line 8 should report the sum of the direct, functional and pooled allocations for all other components of the chain organization. The sum of Column 3, lines 1-8, should equal the total parent office allowable expenses reported on Schedule B, column 3, line 25, of the Medicare Parent Office Cost Statement.

GEORGIA HOME HEALTH CARE BRANCHES	MEDICAID #	TOTAL PARENT OFFICE COST ALLOCATED TO COMPONENTS
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8. OTHER COMPONENT (S)		
TOTAL PARENT OFFICE ALLOWABLE COSTS		$ -

CERTIFICATION

I hereby certify that I have attached a complete and accurate copy of the Medicare Parent Office Cost Statement (Form HCFA- 287 or equivalent) filed with the Medicare Intermediary and will forward a copy of the final settled cost report to the Department of Community Health as soon as it is settled. I understand that this cost data form and its attachments are subject to audit by the Department or its agents.

SIGNATURE: _____ DATE: _____

NAME: _____ TITLE: _____

Appendix L
Durable Medical Equipment Face-To-Face Encounters

The Georgia Department of Community Health (the Department) in accordance with the Affordable Health Care for All Americans Act, Section 6407, and in addition to compliance with other applicable policy, requires a face-to-face encounter with patients before physicians may certify eligibility for durable medical equipment (DME) under the Georgia Medicaid program. It is a condition of reimbursement that providers evaluating, prescribing, providing or in any other manner supplying durable medical equipment must comply with the Medicaid policy requirements and documentation standards for face-to-face encounter for initial and replacement equipment, supplies and modifications. This banner message supplements the December 8, 2010, banner message to DME providers about the face-to-face encounter requirements.

A face-to-face evaluation is defined as a visit during which the patient is seen by a treating physician, nurse practitioner or clinical nurse specialist working in collaboration with the physician, or a physician assistant under the supervision of the physician during which the specific need for the equipment is addressed. The face-to-face encounter must occur during the six months preceding the written order for DME and the examination must be completed prior to any examination performed by a DME provider. The face-to-face encounter may be made through the use of tele-health technology with billing the appropriate Evaluation and Management (E&M) code.

The history and physical examination by the physician or other medical professional and the results of the face-to-face evaluation must be recorded in the patient's medical record including associated medical and diagnosis information which supports the medical need for the requested product and/or services. A prescription for DME cannot be reimbursed by the Department unless it is written after the face-to-face evaluation has occurred and the medical evaluation is completed.

The prescription and attestation statement documenting the face-to-face encounter must be sent to the equipment supplier within 30 days after the completion of the evaluation. The DME supplier must complete all steps that may be necessary to obtain documentation that the face-to-face encounter has occurred as a part of the confirmation of the order. The date of the face-to-face encounter must be specifically set forth in the documentation in the member file with the DME supplier. All documentation must be retained in the member's record for a minimum of five (5) years and made available to the Department upon request.

Through Alliant Health Solutions (AHS), the Department's quality improvement organization, providers must attest to a face-to-face encounter on all prior authorization requests. An attestation statement must be submitted which requires a Yes or No response and the date of the patient's last office visit. Prior authorizations may be approved for 12 months. A face-to- face encounter is required every six months during the 12-month prior authorization period. Long-term rentals require a face-to-face encounter every 6 months (Rev. 10/2018).

A separate examination for each subsequent DME item prescribed is not necessary if the medical justification for the item that is ordered is directly related and has been previously established in the clinical findings of the prescriber through a face-to-face encounter that was conducted within the previous six months by the prescriber. Standard and customary repairs associated with the regular usage of equipment are excluded from the face-to-face requirement.

Orders and prescriptions for expendable items like oxygen or drugs are excluded from the face-to-face requirement, however, these products remain subject to applicable benefit coverage and limitations for those products.

The Department announced the face to face-to-face encounter requirement in a banner message published in December 2010 which has allowed providers time to establish internal processes for compliance with this requirement The Department will look for appropriate documentation of the encounter by July 1, 2011. Please

reference sections 901, 902.7, and 902.4 of Part II DME Manual for more information.

A. Frequently Asked Questions

i. Is the Face-to-Face required on all DME or just the ones requiring PA's? It is required for all DME.

ii. Is it sufficient to document the face-to-face encounter by adding a line to the physician order/certificate of medical necessity which would be completed by the physician or his office with the date of the face-to-face encounter? Yes.

iii. Is it sufficient to document in the patient's record that the patient has verified that they have seen the physician on the date of the RX for this equipment? No.

iv. Do we need to obtain a copy of the chart notes for the Face-to-Face in case of an audit? No.

v. The existing Medicaid O2 CMN requests "Date last seen by Physician". The "Date last seen by Physician" must be within 90 days of the initial or recertification date. Does the new Face to Face policy overrule current policy? Certain DME items may have more stringent requirements. The requirements for the item and the face-to-face requirement will apply.

vi. Does the face-to-face evaluation requirement apply to items such as Mic-Key extensions and CPAP supplies which may be needed for the duration of the member’s life? Yes.

vii. Does the face-to-face requirement apply to repairs such as a wheelchair that is broken? Normal and customary repairs to equipment will not require a face-to-face encounter. Repairs that exceed normal and customary repairs may be reviewed by the Department retrospectively for compliance with the face-to-face encounter requirement and other applicable policy.

viii. Does the face-to-face encounter requirement apply to long term rentals that extend beyond six months? Yes, the physician will need to verify that the rental is still necessary.

ix. If new and/or additional equipment is ordered after the physician has seen the member is a face-to-face encounter required? If new and/or additional equipment is ordered a face-to-face encounter with clinical findings specific to that equipment must have occurred during the six-month period preceding the written order.

x. How is the face-to-face encounter handled if a member has multiple PAs with renewals due at different times because the equipment/supplies were ordered at different times? The prescribing provider can evaluate multiple concerns at one visit. Only encounter during the preceding six-month period preceding the order is required.

xi. Would a member have to see a prescribing provider prior to the therapist approving the supplies for CPAP although the manual allows for the Respiratory Therapist or Sleep Technician to sign and date the CMN after the initial rental of the CPAP unit? Yes.

If you have any concerns or questions regarding this banner message or the DME Program, please contact Program Director for the Medical Policy Unit at 404-657-7180.

Appendix M
Provider Preventable Conditions, Never Events, and Hospital Acquired Conditions

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

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

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

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

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

Appendix N
General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) providers

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

Effective 4/1/2014, DCH began editing claims submitted through the web, EDI and on CMS1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. Effective 6/1/2014, the ordering, prescribing and referring information became a mandatory field and claims that did not contain the information as required by policy began to deny.

Effective May 1, 2015, the Department will only accept electronic claims. Any paper claims submitted to the fiscal agent for payment will be returned to the provider. Please refer to the Medicaid and PeachCare for Kids Part I Policies and Procedures manual, Section 112, for more information."

A. For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

B. For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

Appendix O
Screening, Brief Intervention, and Referral of Treatment (SBIRT) Services

On July 1, 2017, SBIRT services codes were opened and allowed for reimbursement from Georgia Medicaid. SBIRT is an evidence-based approach to identifying individuals who use alcohol and other drugs at risky levels and providing intervention before more serious long-term effects occur. The goal is to reduce and prevent related health consequences, disease, accidents and injuries.

A. Why SBIRT?

i. Provides for uniformity/consistency of language, questions, and methods.

ii. More than twenty years of research supports screening and brief intervention as effective approaches in reducing substance use.

iii. The majority of U.S. states use SBIRT and are having positive results. Georgia covers the SBIRT codes effective July 1, 2017, in listed categories of services below.

iv. Early intervention results in decreased long term, intensive substance abuse services which saves lives and money.

v. Used by paraprofessionals as well as clinicians, SBIRT is non-confrontational and positive and can be utilized in multiple settings.

vi. States like Wisconsin and Texas have built on its clinical success and have demonstrated its cost-effectiveness, reducing hospital costs and emergency room visits.

vii. The SBIRT screening tool has been successfully implemented during a five-year pilot project in two hospitals in Georgia, resulting in a decrease in substance use among participants.

B. The SBIRT procedure codes are open in GAMMIS in the following areas:

010 Inpatient Hospital	070 Outpatient Hospital
080 Swing Bed	200 Home Health
430 Physician	740 Adv. Nurse Practitioners
431 Physician Assistant	

Procedure Codes	Reimbursement	Definition	Time
99408	$33.41	Alcohol and/or substance abuse structured screening and brief intervention services	15 – 30 Minutes
99409	$65.51	Alcohol and/or substance abuse structured screening and brief intervention services	Greater than 30 minutes

C. These services may be provided by the following practitioner levels:

i. Physicians

ii. Physician Extenders

iii. Advanced Nurse Practitioners

Appendix P
Radiological Services

Codes for radiological services have three formats: professional component, technical component, and complete procedure. Not all procedures have all three components. In general, these components should be used as follows:

A. Professional Component: (26 modifier)

i. Radiology services should be billed as professional component when:

1. The physician provides only the professional service for the procedure; or

2. The service is provided in a hospital; or

3. The technical portion of the service is performed by someone other than the physician's salaried employee.

B. Technical Component: (TC modifier)

i. Radiology services should be billed as technical component when the physician is providing the technical portion of the service only. This component has very limited application under current Medicaid policy.

C. Radiology Component (FX modifier)

D. Complete Procedure

i. To bill for complete radiological procedures, which include charges for actually processing and developing the x-ray (technical component), and evaluating the x-ray (professional component), submit the codes as defined in the CPT without a modifier.

ii. The physician may bill for complete procedure when one of the conditions outlined in Part II Physician's Manual, Section 601.5 of is met.

iii. When billing for multiple identical radiology services performed on the same date of service, charges must be placed on only one line of the claim form with the number of X-rays taken being placed in the "unit" space. To bill for identical bilateral procedures where there is not an all-inclusive code bill the procedure code with a 50 modifier' on one line indicating one unit of service. Use of the 50 modifiers will ensure correct payment for both procedures using the one code. However, if there is an all-inclusive procedure code for a bilateral procedure, the all-inclusive charge for the procedure will be reimbursed at the lower of 100% of the allowed amount or the submitted charge.

E. Computerized Tomography - (CAT SCANS)

F. Low Osmolar Contrast Media

Payment will be made for medically necessary low osmolar (non-trast material (LOCM) used in conjunction with intrathecal, intra-arterial, and intravenous radiological procedures when provided for non-hospital patients. The physician's medical records must support the medical necessity of low osmolar contrast material.

i. The following procedure codes must be used when billing for Low Osmolar Contrast Media:

1. Q9960 High Osmolar Contrast Material, 200-249 mg/ml Iodine Concentrate, per ml (replacement for A4645).

2. Q9961 High Osmolar Contrast Material, 250-299 mg/ml, Iodine Contrast, per ml (replacement for A4645).

3. Q9962 High Osmolar Contrast Material, 300-349 mg/ml, Iodine Concentration, per ml (replacement for A4646).

4. Q9963 High Osmolar Contrast Material, 350-399 mg/ml, Iodine Contrast Material Concentration, per ml (replacement for A4646).

5. Q9965 Low Osmolar Contrast Material, 100-199 MG/ML Iodine Concentration, per ML (replaces Q9946)

G. Magnetic Resonance Imaging (MRI)

Medically necessary MRI is covered by the Division when CT scans or SPECT procedures are not definitive or appropriate. Only one MRI per day will be paid without submission of documentation for medical necessity. Reimbursement for follow-up visits by the radiologist is included in the reimbursement for the MRI. Please note that only enrolled Medicaid providers may be reimbursed for MRI procedures.

CT scans or MRIs that do not require contrast, or are of a lower acuity, may be done under the general supervision of the physician. CT scans and MRIs that require contrast, or are at an increased level of acuity, must be performed under the direct supervision of the physician.

H. Portable X-Ray and CT scan

Effective July 1, 2017, the Department of Community Health provides payment of medically necessary portable diagnostic x-ray and CT scan services to Medicaid eligible members who are unable to travel to radiological facilities.

Specific diagnostic radiology services for an eligible member may be provided in a Home Community Based Services, Skilled Nursing Facility Services, in Home Health and Hospice Services to include the member's home by an enrolled portable x-ray provider. The X-ray and CT scan services are only considered for payment when they are medically necessary and ordered by the member's physician. Portable x-ray services are allowable only in-Home Community Based Services, Skilled Nursing Facility Services, in Home Health and Hospice Services (POS 31,32 or 33) or in a home setting (POS 12) as medically necessary and appropriate, and under the supervision of a physician.

GA Medicaid does not reimburse for technical components for these services as a separate part of the service. Providers billing for these services must bill a full component only. GA Medicaid will not reimburse for set-up fee of the equipment (Level II HCPCS code Q0092).

Transportation of portable x-ray equipment is reimbursable only when the equipment used is transported to the location where x-ray services are provided. GA Medicaid will not reimburse for the transportation of the portable x-ray equipment when the x-ray equipment is stored at a facility for use as needed.

GA Medicaid will only pay for single transportation payments per trip to a facility or location for a single

date of service. Therefore, providers should make every effort to schedule all members at a single location during a single trip to that location. If more than one member at the same location is x-rayed, the portable X-ray transportation fee is allocated among the members who receive portable X-ray services in a single trip.

GA Medicaid reimburses procedure code R0075 (Transportation of portable X-ray equipment), per trip to facility or location for portable X-ray providers, more than one member seen. The Division also reimburse procedure code R0070 (Transportation of portable X-ray equipment), per trip to facility or location, one member seen.

i. When submitting a claim for procedure code R0075, the provider is required to use a modifier to indicate the total number of Medicaid members served at the location. The provider is required to submit a separate claim for each Medicaid member. A claim with procedure code R0075 will be denied if it is submitted without an appropriate modifier. Each claim for a single location and data of service must indicate the same X-ray transportation procedure code and modifier for all members seen during that visit.

    1. R0070 Portable x-ray equipment and personnel to the member's home or nursing home, per trip to a facility or other location.

    2. R0075 Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one member seen, per trip to facility or location.

    3. The following modifiers are to be billed with R0075:

        (a) Modifiers:

            (i) (no modifier if one patient served)

            (ii) UN - Two patients served

            (iii) UP - Three patients served

            (iv) UQ - Four patients served

            (v) UR - Five Patients served

            (vi) US - Six or more patients served

The written order must be written and ordered by the member's primary care physician before any portable or mobile x-rays and /or CT scan services are provided. The claim for reimbursement must indicate the name of the physician who ordered the service before payment may be made.

Portable X-ray services may be provided to a member in his or her place of residence. The member place of residence is defined by the Division of Medicaid as the member's own dwelling, a residential care facility or nursing facility. Portable X-ray services are not covered in hospital settings.

NOTE: GA Medicaid will only pay for a single transportation payment per trip to a facility or location for a single date of service. Therefore, providers should make every effort to schedule all members at a single location during a single trip to that location.

All providers, including their staff, contracted staff and volunteers must comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements. The portable x-ray provider is responsible for determining that a member is Medicaid eligible on the date of service.

ii. Portable x-ray providers must keep the following records for each member for a period of at least 7 years:

1. A copy of the written, signed and dated order by the member's physician,

2. The date of the x-ray examination,

3. The name of the physician who performed the professional interpretation of the procedure, and

4. The date the radiograph was sent to the physician.

iii. Portable x-ray providers will not be reimbursed for the following services:

1. Procedures involving fluoroscopy,

2. Procedures involving the use of contrast media,

3. Procedures requiring the administration of a substance to the member, the injection of a substance, or the spinal manipulation of the member,

4. Procedures requiring special technical competency and/or special equipment or materials,

5. Routine screening procedures such as annual physicals,

6. Procedures which are not of a diagnostic nature, e.g., therapeutic x-ray treatments, and

7. Annual x-rays.

iv. Fee Schedule

1. Information regarding the Fee Schedule to be used for Portable X-rays and CT scan can be obtained on www.gammis.com following the links under "Provider Manual", "Provider Information", and "Fee Schedules."

I. Mammography

All mammograms must be performed at a state certified center, and the results must be interpreted by a physician certified by the American Board of Radiology, or the American Osteopathic Board of Radiology, or certified as qualified to interpret the results of mammograms as determined by the Secretary of Health and Human Services. Contact the office below with questions on obtaining certification.

Office of Regulatory Services
Health Care Services
Georgia Department of Community Health
2 Martin Luther King Jr Dr. SE, East Tower
Atlanta, GA 30334
(404) 657-5407

The Division must have an update and valid copy of your certification. Please fax new certification to Gainwell Technologies Technology at 1-866-483-1044 or 1-866-483-1045 or forward to:

Prior Authorization & Pre-Certification
AHS
PO Box 105329 Atlanta, Georgia 30348
800-766-4456 (toll free) (Rev. 10/2018)

When billing for mammography on the CMS 1500 claim form, enter the radiology center's 6digit certification number on field 24a, with the preceding EW qualifier. Please refer to Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual for billing instructions.