PREFACE

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

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

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

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

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

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

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

Medicaid Fee-For-Service (FFS);
Peach Care for Kids (PCK);
CMOs: PeachState, Wellcare, and Amerigroup;
Medicare: Cahaba
State Health Benefit Plan (SHBP): UHC & Cigna;
BCBS of GA: PPO-Federal Employees Plan (FEP); Open Access HMO; Open Access Point of Service; Board of Regents/University System Employees
AETNA: PPO; HMO; Point of Service; Open Access; Medicare Advantage

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

BILLING POLICIES & PROCEDURES
Section 1

Provider Enrollment

1.1 Introduction
Providers must be enrolled as a qualified provider with a 3rd party payer before they can submit claims for reimbursement. This section provides guidance on the Enrollment Process.

1.2 Enrollment Process
New providers are now able to use the GHP’s Web Portal as a single source system to complete an electronic Georgia Medicaid enrollment and CMO credentialing. This system will collect and retain all required documentation needed for DCH and the CMOs to make an enrollment and/or credentialing determination AND allow new providers to upload their credentialing documents into the system. A joint application was created to alleviate redundancy in submitting information to multiple organizations.

Phase I of this ongoing project is for new providers that do not currently have an active and valid Georgia Medicaid number. Current Providers that are applying for new service locations or re-credentialing, are not part of this phase. These providers will be included in a later phase. The scope of this project is for credentialing only. Contact the respective CMO directly to request a contract for network participation.

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

✓ Go to https://www.mmis.georgia.gov/portal/default.aspx to submit application and ALL supporting documents including NPI confirmation letter and Tax ID information
✓ Complete all sections of the application
✓ The effective date on all documents should be within the required timeframe
✓ Respond promptly to any request for additional information or documents
✓ Each location where services are provided must be enrolled
✓ An Approval Notice with effective date of enrollment will be sent to Provider. If denied, notification explaining denial and the right to appeal is sent to Provider
✓ Federal regulations require that some Providers may have to pay an application fee prior to executing a provider agreement
✓ Providers must report any changes in information within 10 days to the Enrollment Unit or submit the change request online
To be considered as an in-network provider, health departments identified as a “facility” must enter into a contractual agreement with 3rd party payers to provide a limited range of services to covered members.

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

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

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

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

Information on Provider Enrollment for Medicare Part B can be found @ https://www.cahabagba.com/part-b/
Section 2

Insurance Eligibility & Verification

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

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

Important Steps that should be taken with every client at every visit:
- Copy the client’s primary and any secondary insurance cards
- Verify eligibility, policy status, effective date, type of plan and Exclusions
- Inform client of their responsibility for co-pays, coinsurances and deductibles
- Inform client of Waiver for non-covered services and payment options

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

In order to charge clients for non-covered services, a Waiver for Non-Covered Services with the following information must be provided to the client:
- Identify the service that is not covered
- Identify covered service that may be available in lieu of the non-covered service
- The cost of the service and payment arrangements
- The client must sign the Waiver indicating acceptance of the non-covered service and agreement to pay for the non-covered service

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

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

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

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

**2.3 WIC Eligibility**
Clients that come to the health department requesting WIC Services must provide proof of income for eligibility into the Program. Additional information and Income Guidelines can be found via the web @ [http://dph.georgia.gov/WIC](http://dph.georgia.gov/WIC)
Section 3
Coordination of Benefits

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

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

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

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

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

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

Crossover Claims: A Medicare crossover claim is any claim that is approved by Medicare and then sent to Medicaid for consideration of payment not to exceed the sum of the Medicare deductible, co pay, or coinsurance.
The claim must be approved by Medicare in order to be considered a crossover claim. “Approved” does not mean paid; sometimes the charges approved by Medicare are applied to the deductible. In these situations, the claim is approved, but no payment is made by Medicare.

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

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

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

<table>
<thead>
<tr>
<th>WHAT IF…the Medicaid Member is also eligible for Medicare?</th>
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<tbody>
<tr>
<td>SERVICE BY MEDICAID PROGRAM</td>
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<td>Health Check/Immunization</td>
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<tr>
<td>Family Planning</td>
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<tr>
<td>Perinatal Case Management/Pregnancy Related Services</td>
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<tr>
<td>Dental Services (Health Check, Adult)</td>
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<td>Adult Services/Immunizations</td>
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<td>Nurse Practitioner/Physician Services</td>
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<th>WHAT IF…the Medicaid Member is also eligible for other private insurance coverage?</th>
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<tr>
<td>SERVICE BY MEDICAID PROGRAM</td>
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<td>Health Check/Immunizations</td>
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<tr>
<td>Nurse Practitioner/Physician Services</td>
</tr>
<tr>
<td>Dental Services (Health Check, Adult)</td>
</tr>
</tbody>
</table>
The following tips will assist Providers in reducing payment delays attributed to COB-related problems:

1. **Ask All Patients about Secondary Insurance Coverage.** Collect and confirm primary and secondary insurance information at each visit.

2. **Know What Plans and Payers Need to Pay Claims.** Nearly all plans require a copy of the Explanation of Benefits (EOB) from the primary payer prior to paying a claim as the secondary payer. Most plans and payers publish their requirements and the information should be available in provider manuals, online, and by contacting physician/provider representatives.

3. **Primary & Secondary Payers:** The following rules are used determine the primary and secondary payer: a) The payer covering the patient as a subscriber will be the primary payer. b) If the patient is a dependent child, the payer whose subscriber has the earlier birthday in the calendar year will be the primary payer. This is known as the Birthday Rule.
Section 4

Claim Submission / Resubmission

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Submission</th>
<th>Appeals/Payment Disputes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td>6 months to submit clean claims</td>
<td>30 calendar days of the adjudication date of the EOP.</td>
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<tr>
<td>PeachState</td>
<td>6 months to submit clean claims</td>
<td>The claim must clearly be marked as “RESUBMISSION” and include the original claim number within 45 days following initial filing; Failure to mark the claim as a resubmission and include the claim number or EOP may result in the claim being denied as a duplicate, or exceeding the filing limit deadline.</td>
</tr>
<tr>
<td>Wellcare</td>
<td>6 months to submit clean claims</td>
<td>30 calendar days of the adjudication date of the EOP.</td>
</tr>
<tr>
<td>Medicaid</td>
<td>6 months from the date of service</td>
<td>Within 3 months of the month in which the denial occurred.</td>
</tr>
<tr>
<td>Medicare</td>
<td>6 months from the date of service</td>
<td>90 calendar days of the adjudication date of the EOB.</td>
</tr>
<tr>
<td>Cigna</td>
<td>6 months after the date of service</td>
<td>Appeals must be submitted in writing within 6 months of the date of the initial payment or denial notice or, if the appeal relates to a payment that was adjusted by CIGNA HealthCare, within 6 months from the date of the last payment adjustment.</td>
</tr>
<tr>
<td>UHC</td>
<td>6 months from the date of service</td>
<td>45 days after original submission.</td>
</tr>
<tr>
<td>BCBS</td>
<td>3 months from date of service</td>
<td>Request Claim Reconsideration. Appeals must be submitted within 12 months from the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA).</td>
</tr>
<tr>
<td>AETNA</td>
<td>6 months from date of service</td>
<td>45 days after original submission.</td>
</tr>
</tbody>
</table>

4.4 Appeals Process

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

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

BILLING & CODING: METHODOLOGIES & RATES
Section 5
Immunization Services

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

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

<table>
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<tr>
<th>Service Description</th>
<th>CPT Code</th>
<th>Modifier</th>
<th>ICD-9 DX</th>
<th>Rate</th>
<th>2013 RVU</th>
<th>Age Restriction</th>
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<td>MMRV, Measles, Mumps, Rubella, Varicella</td>
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<td>V06.8</td>
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<td>12mths-12yrs</td>
</tr>
<tr>
<td>IPV, Inactivated Polio (IPOL)</td>
<td>90713</td>
<td>EP</td>
<td>V04.0</td>
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<tr>
<td>Td, Tetanus, diphtheria toxoid, preservative free</td>
<td>90714</td>
<td>EP</td>
<td>V06.5</td>
<td>$0.00</td>
<td>0.59</td>
<td>7-18yrs</td>
</tr>
<tr>
<td>Tdap, Tetanus, diphtheria toxoid &amp; pertusis</td>
<td>90715</td>
<td>EP</td>
<td>V06.1</td>
<td>$0.00</td>
<td>0.98</td>
<td>7-18yrs</td>
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<tr>
<td>Varicella</td>
<td>90716</td>
<td>EP</td>
<td>V05.4</td>
<td>$0.00</td>
<td>2.23</td>
<td>1-18yrs</td>
</tr>
<tr>
<td>DTaP-Hep B-IPV (Pediarix)</td>
<td>90723</td>
<td>EP</td>
<td>V06.8</td>
<td>$0.00</td>
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<tr>
<td>Pneumococcal 23-Valent (Pneumovax 23)</td>
<td>90732</td>
<td>EP</td>
<td>V03.82</td>
<td>$0.00</td>
<td>1.93</td>
<td>2-18r</td>
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<tr>
<td>Meningococcal conjugate</td>
<td>90734</td>
<td>EP</td>
<td>V03.89</td>
<td>$0.00</td>
<td>2.88</td>
<td>2-18yrs</td>
</tr>
<tr>
<td>Hep B (Engerix-B)</td>
<td>90744</td>
<td>EP</td>
<td>V05.3</td>
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<tr>
<td>Hep B-Hib (COMVAX)</td>
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<td>EP</td>
<td>V06.8</td>
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## 5.2 EPSDT

### Ages 19 to 20 years

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CPT Code</th>
<th>Modifier</th>
<th>ICD-9 DX</th>
<th>Rate</th>
<th>2013 RVU</th>
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<tbody>
<tr>
<td>Vaccine Administration</td>
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</tr>
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<td>Immunization Admin, 1st or only component</td>
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<td>EP</td>
<td>V03.9</td>
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<td>Immunization Admin, intranasal or oral</td>
<td>90473</td>
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<td>V03.9</td>
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<td>0.76</td>
</tr>
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<td>EP</td>
<td>V03.9</td>
<td>$10.00</td>
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### Vaccines – County Supplied

<table>
<thead>
<tr>
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<th>Modifier</th>
<th>ICD-9 DX</th>
<th>Rate</th>
<th>2013 RVU</th>
</tr>
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<tbody>
<tr>
<td>Hep A, 2 dose</td>
<td>90632</td>
<td>EP</td>
<td>V05.3</td>
<td>$50.93</td>
<td>1.01</td>
</tr>
<tr>
<td>Hep A-Hep B (Twinrix)</td>
<td>90636</td>
<td>EP</td>
<td>V05.3</td>
<td>$95.69</td>
<td>2.78</td>
</tr>
<tr>
<td>HPV, Human Papilloma Virus (Gardasil)</td>
<td>90649</td>
<td>EP</td>
<td>V04.89</td>
<td>$144.93</td>
<td>3.85</td>
</tr>
<tr>
<td>Influenza, preservative free (Fluzone)</td>
<td>90656</td>
<td>EP</td>
<td>V04.89</td>
<td>$12.40</td>
<td>0.36</td>
</tr>
<tr>
<td>Influenza, quadrivalent, live, intranasal use (Flumist)</td>
<td>90672</td>
<td>EP</td>
<td>V04.81</td>
<td>$24.60</td>
<td>0.00</td>
</tr>
<tr>
<td>Influenza, quadrivalent (Fluarix)</td>
<td>90686</td>
<td>EP</td>
<td>V04.81</td>
<td>$19.41</td>
<td>0.00</td>
</tr>
<tr>
<td>MMR, Measles, Mumps, Rubella</td>
<td>90707</td>
<td>EP</td>
<td>V06.4</td>
<td>$57.34</td>
<td>1.52</td>
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<td>Td, Tetanus, diphtheria toxoid, preservative free</td>
<td>90714</td>
<td>EP</td>
<td>V06.5</td>
<td>$19.93</td>
<td>0.59</td>
</tr>
<tr>
<td>Tdap, Tetanus, diphtheria toxoid &amp; pertussis</td>
<td>90715</td>
<td>EP</td>
<td>V06.1</td>
<td>$33.35</td>
<td>0.98</td>
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<tr>
<td>Varicella</td>
<td>90716</td>
<td>EP</td>
<td>V05.4</td>
<td>$96.57</td>
<td>2.23</td>
</tr>
<tr>
<td>Pneumococcal 23-Valent (Pneumovax 23)</td>
<td>90732</td>
<td>EP</td>
<td>V03.82</td>
<td>$65.77</td>
<td>1.93</td>
</tr>
<tr>
<td>Meningococcal conjugate</td>
<td>90734</td>
<td>EP</td>
<td>V03.89</td>
<td>$113.60</td>
<td>2.88</td>
</tr>
<tr>
<td>Hep B, 3 dose schedule</td>
<td>90746</td>
<td>EP</td>
<td>V05.3</td>
<td>$59.71</td>
<td>0.71</td>
</tr>
<tr>
<td>Hep B, 4 dose, dialysis or immunosuppressed</td>
<td>90748</td>
<td>EP</td>
<td>V05.3</td>
<td>$119.42</td>
<td>1.70</td>
</tr>
</tbody>
</table>
### Medicaid Members 21 years and older may be eligible for State Supplied Vaccines

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

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CPT Code</th>
<th>ICD-9 DX</th>
<th>Rate</th>
<th>2013 RVU</th>
<th>Age Requirement</th>
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<tbody>
<tr>
<td>Vaccines – State Supplied</td>
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<tr>
<td>Hep A</td>
<td>90632</td>
<td>V05.3</td>
<td>$0.00</td>
<td>1.50</td>
<td>≥21yrs</td>
</tr>
<tr>
<td>HPV</td>
<td>90649</td>
<td>V04.89</td>
<td>$0.00</td>
<td>3.85</td>
<td>22-26yrs</td>
</tr>
<tr>
<td>Tdap</td>
<td>90715</td>
<td>V06.1</td>
<td>$0.00</td>
<td>0.98</td>
<td>≥56yrs</td>
</tr>
<tr>
<td>Hep B</td>
<td>90746</td>
<td>V05.3</td>
<td>$0.00</td>
<td>1.75</td>
<td>≥21yrs</td>
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## 5.4 Medicare – Part B

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CPT Code</th>
<th>ICD-9 DX</th>
<th>001 / 099 Rate</th>
<th>2013 RVU</th>
<th>Age Restriction</th>
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<td><strong>Vaccine Administration</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Admin. Influenza</td>
<td>G0008</td>
<td>V04.81</td>
<td>$24.41 / $22.30</td>
<td>0.76</td>
<td></td>
</tr>
<tr>
<td>Admin. Pneumococcal</td>
<td>G0009</td>
<td>V03.82</td>
<td>$24.41 / $22.30</td>
<td>0.76</td>
<td></td>
</tr>
<tr>
<td>Admin. Hep. B</td>
<td>G0010</td>
<td>V05.3</td>
<td>$24.41 / $22.30</td>
<td>0.76</td>
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</tr>
<tr>
<td><strong>Vaccines</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza, preservative free, Intradermal use</td>
<td>90654</td>
<td>V04.81</td>
<td>$18.92</td>
<td>0.56</td>
<td>18-64yrs</td>
</tr>
<tr>
<td>Influenza, preservative free</td>
<td>90655</td>
<td>V04.81</td>
<td>$17.24</td>
<td>0.48</td>
<td>6-35mths</td>
</tr>
<tr>
<td>Influenza, preservative free</td>
<td>90656</td>
<td>V04.81</td>
<td>$12.40</td>
<td>0.36</td>
<td>≥3yrs</td>
</tr>
<tr>
<td>Influenza</td>
<td>90657</td>
<td>V04.81</td>
<td>$6.02</td>
<td>0.18</td>
<td>6-35mths</td>
</tr>
<tr>
<td>Influenza, live, intranasal, quadrivalent</td>
<td>90672</td>
<td>V04.81</td>
<td>$24.60</td>
<td>0.69</td>
<td>2-49yrs</td>
</tr>
<tr>
<td>Influenza, derived from cell cultures (Flucelvax)</td>
<td>90661</td>
<td>V04.81</td>
<td>Pending</td>
<td>0.00</td>
<td>≥18yrs</td>
</tr>
<tr>
<td>Influenza, preservative free, high dose</td>
<td>90662</td>
<td>V04.81</td>
<td>$30.92</td>
<td>0.91</td>
<td>≥65yrs</td>
</tr>
<tr>
<td>Influenza, quadrivalent (Fluzone)</td>
<td>90685</td>
<td>V04.81</td>
<td>$23.23</td>
<td>0.00</td>
<td>6-35mths</td>
</tr>
<tr>
<td>Influenza, quadrivalent (Fluzone, Fluarix)</td>
<td>90686</td>
<td>V04.81</td>
<td>$19.41</td>
<td>0.00</td>
<td>≥3yrs</td>
</tr>
<tr>
<td>Influenza, preservative free (Flublok)</td>
<td>Q2033</td>
<td>V04.81</td>
<td>Pending</td>
<td>0.00</td>
<td>18-49yrs</td>
</tr>
<tr>
<td>Influenza, &gt;3yrs, (Afluria)</td>
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<td>V04.81</td>
<td>$11.54</td>
<td>0.34</td>
<td>≥3yrs</td>
</tr>
<tr>
<td>Influenza, &gt;3yrs, (FluLaval)</td>
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<td>V04.81</td>
<td>$9.58</td>
<td>0.29</td>
<td>≥3yrs</td>
</tr>
<tr>
<td>Influenza, &gt;3yrs, (Fluvirin)</td>
<td>Q2037</td>
<td>V04.81</td>
<td>$14.96</td>
<td>0.41</td>
<td>≥3yrs</td>
</tr>
<tr>
<td>Influenza, &gt;3yrs (Fluzone)</td>
<td>Q2038</td>
<td>V04.81</td>
<td>$12.04</td>
<td>0.35</td>
<td>≥3yrs</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>90732</td>
<td>V03.82</td>
<td>$49.73</td>
<td>1.93</td>
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</tr>
<tr>
<td>Hep B</td>
<td>90746</td>
<td>V05.3</td>
<td>$59.71</td>
<td>1.75</td>
<td></td>
</tr>
</tbody>
</table>

Pending Rate & will be EFFECTIVE 1/1/2014-7/31/2014

| Influenza, preservative free (Flublok) | 90673 | V04.81 | Pending | 18-49yrs |

Pending Rates and Effective Date of Service

| Influenza, quadrivalent (Fluzone) | 90687 | V04.81 | Pending | 6-35mths |
| Influenza, quadrivalent (Flulaval) | 90688 | V04.81 | Pending | ≥3yrs |
### 5.5 SHBP – UHC

**Vaccine Administration**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CPT Code</th>
<th>ICD-9 DX</th>
<th>Rate</th>
<th>2013 RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization Admin, single</td>
<td>90471</td>
<td>V03.9</td>
<td></td>
<td>0.76</td>
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<tr>
<td>Immunization Admin, each add./multiple</td>
<td>90472</td>
<td>V03.9</td>
<td></td>
<td>0.37</td>
</tr>
<tr>
<td>Immunization Admin, intranasal or oral</td>
<td>90473</td>
<td>V03.9</td>
<td></td>
<td>0.76</td>
</tr>
<tr>
<td>Immunization Admin, each add./multiple</td>
<td>90474</td>
<td>V03.9</td>
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<td>0.37</td>
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**Vaccines**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>CPT Code</th>
<th>ICD-9 DX</th>
<th>Rate</th>
<th>2013 RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB Skin Test</td>
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<td>V74.1</td>
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<tr>
<td>Rabies immune globulin</td>
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<td>V04.5</td>
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<td>6.07</td>
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<td>Hep A, adult</td>
<td>90632</td>
<td>V05.3</td>
<td></td>
<td>1.50</td>
</tr>
<tr>
<td>Hep A, pediatric, 2 dose</td>
<td>90633</td>
<td>V05.3</td>
<td></td>
<td>1.01</td>
</tr>
<tr>
<td>Hep A, pediatric/adolescent, 3 dose</td>
<td>90634</td>
<td>V05.3</td>
<td></td>
<td>1.06</td>
</tr>
<tr>
<td>Hep A-Hep B (Twinrix)</td>
<td>90636</td>
<td>V05.3</td>
<td></td>
<td>2.78</td>
</tr>
<tr>
<td>HIB, Hemophilus influenza, 4 dose</td>
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<td></td>
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<tr>
<td>HIB, Hemophilus influenza, 3 dose</td>
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<td>V03.81</td>
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<tr>
<td>HIB, Hemophilus b conjugate (ACTHIB), 4 dose</td>
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<td>V03.81</td>
<td></td>
<td>0.81</td>
</tr>
<tr>
<td>HPV, Human Papilloma Virus <strong>Male &amp; Female</strong></td>
<td>90649</td>
<td>V04.89</td>
<td></td>
<td>3.85</td>
</tr>
<tr>
<td>Influenza, Intradermal (18-64yrs)</td>
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<td>V04.81</td>
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<td>0.56</td>
</tr>
<tr>
<td>Influenza, preservative free</td>
<td>90655</td>
<td>V04.81</td>
<td></td>
<td>0.48</td>
</tr>
<tr>
<td>Influenza, preservative free, split virus, &gt;3 yrs</td>
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<td>V04.81</td>
<td></td>
<td>0.36</td>
</tr>
<tr>
<td>Influenza, split virus, 6-35 mths</td>
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<td>V04.81</td>
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<td>Influenza, &gt;3yrs</td>
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<tr>
<td>Influenza, live, intranasal, 2-49yrs</td>
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<td>V04.81</td>
<td></td>
<td>0.69</td>
</tr>
<tr>
<td>Influenza, split virus, preservative free, inc. antigen</td>
<td>90662</td>
<td>V04.81</td>
<td></td>
<td>0.91</td>
</tr>
<tr>
<td>Pneumococcal conjugate</td>
<td>90669</td>
<td>V03.82</td>
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<td>2.81</td>
</tr>
<tr>
<td>Pneumococcal conjugate 13 Valant (Prevnar 13)</td>
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<td>4.03</td>
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<tr>
<td>Influenza, quadrivalent live, intranasal use (Flumist)</td>
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<td>V04.81</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Rabies</td>
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<td>5.60</td>
</tr>
<tr>
<td>Rotavirus Vaccine, 3 dose, live</td>
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<td>V04.89</td>
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<td>2.28</td>
</tr>
<tr>
<td>Rotavirus Vaccine, 2 dose, live</td>
<td>90681</td>
<td>V04.89</td>
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<td>2.28</td>
</tr>
<tr>
<td>Influenza, quadrivalent, 6-35 mths (Fluzone)</td>
<td>90685</td>
<td>V04.81</td>
<td></td>
<td>0.00</td>
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<tr>
<td>Influenza, quadrivalent, ≥ 3 yrs (Fluzone, Fluarix)</td>
<td>90686</td>
<td>V04.81</td>
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<td>DTaP-IPV Booster (4-6yrs)</td>
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<tr>
<td>DTaP-Hib-IPV (Pentacel), 6wks-6yrs</td>
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<tr>
<td>MMR, Measles, Mumps, Rubella</td>
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<td>V06.4</td>
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</tr>
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<td>MMRV, Measles, Mumps, Rubella, Varicella</td>
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<td>V06.8</td>
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<td>4.05</td>
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<tr>
<td>IPV, Inactivated Polio</td>
<td>90713</td>
<td>V04.0</td>
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<tr>
<td>Td, Tetanus, diphtheria toxoid, preservative free, &gt;7yrs</td>
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<td>V06.5</td>
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<td>0.59</td>
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<tr>
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<td>V06.1</td>
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## 5.5 SHBP – UHC (Continued)

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<th>CPT Code</th>
<th>ICD-9 DX</th>
<th>Rate 2013</th>
<th>RVU 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella</td>
<td>90716</td>
<td>V05.4</td>
<td>2.23</td>
<td></td>
</tr>
<tr>
<td>DTaP-Hep B-IPV</td>
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<td>2.88</td>
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<tr>
<td>Zoster, live, &gt; 60 (Shingles)</td>
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<td>Hep B adult dosage</td>
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<tr>
<td>Hep B, dialysis or IM, 4 dose</td>
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<td>3.51</td>
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<td>Hep B-Hib (COMVAX)</td>
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## SHBP – UHC Medicare Enrollees

### Vaccine Administration

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### Vaccines

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<th>Rate 2013</th>
<th>RVU 2013</th>
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<tbody>
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<td>Influenza, split virus, preservative free, 6-35mths</td>
<td>90655</td>
<td>V04.81</td>
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<tr>
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<td>Influenza, split virus, preservative free, inc. antigen</td>
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NOTE: CIGNA WILL REIMBURSE 70% OF THE BILLED AMOUNT FOR CODES 90654 AND 90701. TO RECEIVE THE APPROPRIATE REIMBURSEMENT AMOUNT, BILL @ THE RATE LISTED BELOW. BASED ON THIS PERCENTAGE, REIMBURSEMENT IS APPROXIMATELY: $21.26 & $19.78 RESPECTIVELY.

### 5.6 SHBP – CIGNA

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### 5.6 SHBP – CIGNA (Continued)

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<td>Hep B, dialysis or IM, 4 dose</td>
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<td>Hep B-Hib (COMVAX)</td>
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### SHBP – CIGNA Medicare Enrollees

#### Vaccine Administration

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#### Vaccines

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<tr>
<td>Influenza, split virus, preservative free, &gt;3yrs</td>
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<td>Influenza, split virus, 6-35mths</td>
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<tr>
<td>Influenza, split virus, preservative free, inc. antigen</td>
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<tr>
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<td>V03.82</td>
<td>1.93</td>
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### 5.7 BCBS: PPO; HMO

#### Vaccine Administration

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#### Vaccines

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## 5.8 AETNA: PPO; HMO

### Vaccine Administration

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### Vaccines

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### 5.8 AETNA: PPO; HMO (Continued)

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### AETNA Medicare Advantage

#### Vaccine Administration

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#### Vaccines

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<th>ICD-9 DX</th>
<th>Rate</th>
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Section 6

Child Health Services

6.1 Methodologies

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

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

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

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

If abnormalities or preexisting problems occur during a HC visit that requires additional work to perform key components of an E/M service, code 99211 or 99212 along with the HC visit code. Add modifier EP and 25 to the E/M code to indicate a separately identifiable service.

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

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

DSPS is a Medicaid category of service solely for public health providers. County Boards of Health are enrolled as the qualified Medicaid provider of diagnostic, screening and
preventive services provided under the DSPS program. DSPS will pay providers for only one office visit per client, per date of service.

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

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

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

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

If a client receives a clinical (nurse) service and a nutritional counseling (dietician) service on the same day, the office visit code should reflect the appropriate level of service provided; the higher “enhanced” office visit.
### 6.2 Health Check Visits

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CPT Code</th>
<th>Modifier</th>
<th>Rate</th>
<th>2013 RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Periodic Healthcheck Visits</strong></td>
<td></td>
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<tr>
<td>New Screening: Normal/Abnormal; 0 days - 11 months</td>
<td>99381</td>
<td>EP</td>
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<td>New Screening: Normal/Abnormal; 12 months - 4 years</td>
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<tr>
<td>New Screening: Normal/Abnormal; 12 months - 3 years</td>
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<td>Established Screening: Normal/Abnormal; 12 months - 3 years</td>
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<td>EP, HA</td>
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<td><strong>Interperiodic Healthcheck Exam</strong></td>
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<td>EP</td>
<td>$62.71</td>
<td>3.18/3.14</td>
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<tr>
<td><strong>Interperiodic Vision &amp; Hearing</strong></td>
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<td>Interperiodic Vision: Normal/Abnormal</td>
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<td>Interperiodic Hearing, pure tone audiometry, air only</td>
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<td>Interperiodic Hearing, speech audiometry threshold</td>
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<td>Interperiodic Hearing, Abnormal/Referral</td>
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<td>Developmental Testing</td>
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<td>Tuberculin Skin Test</td>
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<td>Screening for developmental handicaps in early childhood (ASQ)</td>
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## 6.3 Children’s Intervention Services

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<th>Service Description</th>
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<th>Rate 2013</th>
<th>2013 RVU</th>
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<td><strong>Nursing Services</strong></td>
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<td>Medication Administration</td>
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<td>Treatment, includes assessment</td>
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<td>HA</td>
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<td><strong>Nutrition Services</strong></td>
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<td>Nutrition Evaluation</td>
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<td>Nutrition Services</td>
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<td><strong>Audiology Services</strong></td>
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<tr>
<td>Aural Rehabilitation</td>
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<td>UC, HA</td>
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<tr>
<td>Pure tone audiometry (threshold), air only</td>
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<td>HA</td>
<td>$15.63</td>
<td>0.95</td>
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<tr>
<td>Speech audiometry threshold</td>
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<td>HA</td>
<td>$13.38</td>
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<tr>
<td>Basic comprehensive audiometry; pure tone, air, bone, speech,</td>
<td>92557</td>
<td>HA</td>
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<td>Tympanometry (impedance testing)</td>
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<td>Acoustic reflex testing</td>
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<td>Conditioning play audiometry</td>
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<td>Evoked response (EEG) audiometry</td>
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<td>Automated Auditory Brainstem Response</td>
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<tr>
<td>Evoked Otacoustic Emissions-limited</td>
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<td>Evoked Otacoustic emissions, comprehensive, diagnostic eval</td>
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<td>HA</td>
<td>$70.52</td>
<td>0.97</td>
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<td><strong>Occupational Therapy Services</strong></td>
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<tr>
<td>Evaluation</td>
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<td>Aquatic Therapy</td>
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<td>Manual Therapy Techniques</td>
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<tr>
<td>Therapeutic Activities, Direct member contact</td>
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<td>Sensory Integrative Tech to enhance sensory processing</td>
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<td>Self Care/Home Management Training</td>
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<td>Community/Work Reintegration Training</td>
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<td>Physical Performance Test</td>
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<td><strong>Physical Therapy Services</strong></td>
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<td>Evaluation-Limit 1 per cal year</td>
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<td>Re-evaluation-Limit 1 every 180 days</td>
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<td>HA</td>
<td>$25.06</td>
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<td>Therapeutic Procedure, one or more areas</td>
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<td>HA</td>
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<td>Neuromuscular Reeducation of Movement</td>
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<td>Gait Training</td>
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<td>Ultrasound</td>
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### 6.3 Children's Intervention Services (Continued)

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<tr>
<th>Service Description</th>
<th>CPT Code</th>
<th>Modifier</th>
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<th>RVU</th>
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<td><strong>Speech-Language Pathology Services</strong></td>
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<td>Evaluation of Speech Language</td>
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<td>Speech Language Therapy; individual treatment</td>
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<td>Tympanometry</td>
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<td>Treatment of Swallowing Dysfunction and/or Oral Function</td>
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<td>HA</td>
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<td>Developmental Testing Extended</td>
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### 6.4 Early Intervention Case Management

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<td>Service Coordination</td>
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<td>Follow-up Service</td>
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### 6.5 DSPS

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<th>CPT Code</th>
<th>Rate 2013</th>
<th>RVU</th>
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<tbody>
<tr>
<td>Children 1st Care; CMS Care Mgmt; Nutritional Counseling; Ages &amp; Stages; Walk-In Svcs</td>
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<tr>
<td>New Problem Focused / Established Minimal</td>
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<td>1.29/0.60</td>
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<tr>
<td>New Expanded Prob. Focused / Established Problem Focused</td>
<td>99202 / 99212</td>
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<td>2.19/1.29</td>
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<tr>
<td>New Detailed Low Complexity / Established Expanded Problem Focused</td>
<td>99203 / 99213</td>
<td>$76.53 / $40.70</td>
<td>3.18/2.14</td>
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<tr>
<td>New Comprehensive Moderate / Established Detailed Moderate</td>
<td>99204 / 99214</td>
<td>$110.51 / $62.71</td>
<td>4.84/3.14</td>
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<td>New Comprehensive Complex / Established Comprehensive Complex</td>
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#### Home Visits

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<th>RVU</th>
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<tr>
<td>New / Established - Problem Focused</td>
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<tr>
<td>New / Established - Comprehensive</td>
<td>99344 / 99350</td>
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<td>New Comprehensive Complex</td>
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#### Special Services

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<td>Post hazard abatement</td>
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### 6.6 Nurse Practitioner & Physician Services

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<td>New Problem Focused / Established Minimal</td>
<td>99201/99211</td>
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<td>1.29/0.60</td>
</tr>
<tr>
<td>New Expanded Prob. Focused / Established Problem Focused</td>
<td>99202/99212</td>
<td>$54.57 / $29.67</td>
<td>2.19/1.29</td>
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<tr>
<td>New Detailed Low Complexity / Established Expanded Problem Focused</td>
<td>99203/99213</td>
<td>$76.53 / $40.70</td>
<td>3.18/2.14</td>
</tr>
<tr>
<td>New Comprehensive Moderate / Established Detailed Moderate</td>
<td>99204/99214</td>
<td>$110.51 / $62.71</td>
<td>4.84/3.14</td>
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<tr>
<td>New Comprehensive Complex / Established Comprehensive Complex</td>
<td>99205/99215</td>
<td>$137.12 / $93.46</td>
<td>5.99/4.20</td>
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Section 7

Women’s Health Services

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

Eligible clients are enrolled in one of three components of P4HB Waiver Program:
1. Family Planning - family planning related services
2. Inter-pregnancy Care - family planning and services for women who have delivered a VLBW baby
3. Resource Mother Outreach-inclusive of a specially trained case manager to women on traditional Medicaid plans who have delivered a VLBW baby

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

For additional information visit www.planning4healthybabies.org

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

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

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

Perinatal Case Management (PCM): A Comprehensive visit (T2022) can be provided and billed on the same date of service that PE eligibility is determined.
Tobacco Cessation Counseling for Pregnant Women: Policies and Procedures on Counseling visits are located in the Physician Services Manual, Section 903.18.

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

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

DISCLAIMER: Not all payers cover dispensing or administrative fees.
### 7.2 Family Planning

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CPT Code</th>
<th>Modifier</th>
<th>Rate</th>
<th>2013 RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal, Norplant, subsequent insertion of Nexplanon</td>
<td>11976</td>
<td>FP</td>
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<td>4.32</td>
</tr>
<tr>
<td>Insertion, Nexplanon</td>
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<td>FP</td>
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</tr>
<tr>
<td>Insertion, IUD</td>
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<td>FP</td>
<td>$62.48</td>
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</tr>
<tr>
<td>Urine pregnancy test by visual method (PubHlth)</td>
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<td>FP</td>
<td>$7.96</td>
<td>0.26</td>
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<td>New Brief Visit, Problem focused</td>
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<td>FP</td>
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<td>Paragard/Intrauterine copper contraceptive</td>
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<td>Mirena IUD</td>
<td>J7302</td>
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### 7.3 Perinatal Case Management

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<tr>
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<tr>
<td>Brief F/U</td>
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<tr>
<td>Extended F/U</td>
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<tr>
<td>Postpartum</td>
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### 7.4 Childbirth Education

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<td>Newborn Feeding (60 min)</td>
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### 7.5 Pregnancy Related Services

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<td>Visit #1 New</td>
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<td>Visit #2 Established</td>
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<td>Visit #3 Established</td>
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<td>Visit #4 Established</td>
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### 7.6 DSPS

<table>
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<tbody>
<tr>
<td>Maternity &amp; Delivery Care</td>
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<tr>
<td>Antepartum Care Only; 4-6 visits</td>
<td>59425</td>
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<tr>
<td>Antepartum Care Only; 7 or more visits</td>
<td>59426</td>
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<td>Postpartum Care Only (Separate procedure)</td>
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### 7.6 DSPS (Continued)

<table>
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<tr>
<td><strong>Radiology: Diagnostic Ultrasound</strong></td>
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<tr>
<td>Echography, pregnant uterus</td>
<td>76805</td>
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<tr>
<td>Echography, preg uterus, multiple gestation, after 1st trimester</td>
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<td>$231.23</td>
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<tr>
<td>Echography, preg. uterus, limited</td>
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<td>$78.03</td>
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<td>Echography, preg., follow-up or repeat</td>
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<tr>
<td><strong>Home Visits</strong></td>
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<tr>
<td>New / Established - Problem Focused</td>
<td>99341 / 99347</td>
<td>$50.30 / $39.65</td>
<td>1.59/1.60</td>
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<tr>
<td>New / Established - Expanded Prob. Focused</td>
<td>99342 / 99348</td>
<td>$72.33 / $60.65</td>
<td>2.29/2.42</td>
</tr>
<tr>
<td>New / Established - Detailed Complexity</td>
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</tr>
<tr>
<td>New / Established - Comprehensive</td>
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<td>New Comprehensive Complex</td>
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<tr>
<td><strong>Tobacco Cessation Services for Pregnant Women</strong></td>
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<tr>
<td>Smoking &amp; Tobacco use Cessation counseling visit; intermediate (3-10 min)</td>
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<tr>
<td>Intensive, greater than 10 minutes</td>
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<td>$20.71</td>
<td>0.79</td>
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<tr>
<td><strong>Preventive Medicine Counseling/Risk Factor Reduction</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Approximately 15 min. Individual Services</td>
<td>99401</td>
<td>$0.00</td>
<td>1.06</td>
</tr>
<tr>
<td>Approximately 30 min. Individual Services</td>
<td>99402</td>
<td>$0.00</td>
<td>1.80</td>
</tr>
<tr>
<td>Approximately 45 min. Individual Services</td>
<td>99403</td>
<td>$0.00</td>
<td>2.51</td>
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<tr>
<td>Approximately 60 min. Individual Services</td>
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<td>$0.00</td>
<td>3.21</td>
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<tr>
<td>Approximately 30 min. Group Services</td>
<td>99411</td>
<td>$0.00</td>
<td>0.49</td>
</tr>
<tr>
<td>Approximately 45 min. Group Services</td>
<td>99412</td>
<td>$0.00</td>
<td>0.63</td>
</tr>
<tr>
<td><strong>Presumptive Eligibility &amp; Women’s Health Medicaid Case Mgmt</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>New Problem Focused / Established Minimal</td>
<td>99201/99211</td>
<td>$35.13 / $17.46</td>
<td>1.29/0.60</td>
</tr>
<tr>
<td>New Expanded Prob. Focused / Established Problem Focused</td>
<td>99202/99212</td>
<td>$54.57 / $29.67</td>
<td>2.19/1.29</td>
</tr>
<tr>
<td>New Detailed Low Complexity / Established Expanded Problem Focused</td>
<td>99203/99213</td>
<td>$76.53 / $40.70</td>
<td>3.18/2.14</td>
</tr>
<tr>
<td>New Comprehensive Moderate / Established Detailed Moderate</td>
<td>99204/99214</td>
<td>$110.51 / $62.71</td>
<td>4.84/3.14</td>
</tr>
<tr>
<td>New Comprehensive Complex / Established Comprehensive Complex</td>
<td>99205/99215</td>
<td>$137.12 / $93.46</td>
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### 7.7 Nurse Practitioner & Physician Services

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<tr>
<th>Service Description</th>
<th>CPT Code</th>
<th>Rate</th>
<th>2013 RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal, Implanon</td>
<td>11976</td>
<td>$106.11</td>
<td>4.32</td>
</tr>
<tr>
<td>Diaphragm or cervical cap fitting with instructions</td>
<td>57170</td>
<td>$56.07</td>
<td>1.81</td>
</tr>
<tr>
<td>Colposcopy</td>
<td>57452</td>
<td>$69.12</td>
<td>3.26</td>
</tr>
<tr>
<td>Colposcopy with biopsy</td>
<td>57454</td>
<td>$89.33</td>
<td>4.59</td>
</tr>
<tr>
<td>Removal of IUD</td>
<td>58301</td>
<td>$72.99</td>
<td>2.87</td>
</tr>
<tr>
<td>New Problem Focused / Established Minimal</td>
<td>99201/99211</td>
<td>$35.13 / $17.46</td>
<td>1.29/0.60</td>
</tr>
<tr>
<td>New Expanded Prob. Focused / Established Problem Focused</td>
<td>99202/99212</td>
<td>$54.57 / $29.67</td>
<td>2.19/1.29</td>
</tr>
<tr>
<td>New Detailed Low Complexity / Established Expanded Problem Focused</td>
<td>99203/99213</td>
<td>$76.53 / $40.70</td>
<td>3.18/2.14</td>
</tr>
<tr>
<td>New Comprehensive Moderate / Established Detailed Moderate</td>
<td>99204/99214</td>
<td>$110.51 / $62.71</td>
<td>4.84/3.14</td>
</tr>
<tr>
<td>New Comprehensive Complex / Established Comprehensive Complex</td>
<td>99205/99215</td>
<td>$137.12 / $93.46</td>
<td>5.99/4.20</td>
</tr>
</tbody>
</table>
Section 8

Adult Health Services

8.1 Methodologies

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

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

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

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

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

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

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

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

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<thead>
<tr>
<th>Service Description</th>
<th>CPT Code</th>
<th>Rate</th>
<th>2013 RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>STD; TB; SHAPP; Ryan White; Nutritional Counseling; Walk In Services</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>New Problem Focused / Established Minimal</td>
<td>99201/99211</td>
<td>$35.13</td>
<td>1.29/0.60</td>
</tr>
<tr>
<td>New Expanded Prob. Focused / Established Problem Focused</td>
<td>99202/99212</td>
<td>$54.57</td>
<td>2.19/1.29</td>
</tr>
<tr>
<td>New Detailed Low Complexity / Established Expanded Problem Focused</td>
<td>99203/99213</td>
<td>$76.53</td>
<td>3.18/2.14</td>
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<tr>
<td>New Comprehensive Moderate / Established Detailed Moderate</td>
<td>99204/99214</td>
<td>$110.51</td>
<td>4.84/3.14</td>
</tr>
<tr>
<td>New Comprehensive Complex / Established Comprehensive Complex</td>
<td>99205/99215</td>
<td>$137.12</td>
<td>5.99/4.20</td>
</tr>
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<td>Radiologic examination, chest; single view frontal</td>
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<td>Pathology &amp; Laboratory</td>
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<td></td>
</tr>
<tr>
<td>Handling, conveyance of specimen to lab</td>
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<td>Routine venipuncture or finger/heel/ear stick for collection of specimen(s)</td>
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<td>Urinalysis, by dip stick/tablet reagent, non-automated with microscopy</td>
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<td>Non-automated without microscopy</td>
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<td>Urine pregnancy test by visual method</td>
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<td>0.26</td>
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<td>Blood, occult; feces</td>
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<td>Cholesterol, serum or whole blood, total</td>
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<td>Glucose; quantitative</td>
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<td>Home Visits</td>
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<td>New / Established - Problem Focused</td>
<td>99341 / 99347</td>
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<td>1.59/1.60</td>
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<tr>
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<td>99342 / 99348</td>
<td>$72.33</td>
<td>2.29/2.42</td>
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<tr>
<td>New / Established - Detailed Complexity</td>
<td>99343 / 99349</td>
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<td>3.76/3.67</td>
</tr>
<tr>
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<td>5.23/5.10</td>
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<tr>
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<td>$0.00</td>
<td>1.06</td>
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<tr>
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<tr>
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<td>3.21</td>
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<tr>
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<td>Approximately 45 min. Group Services</td>
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### 8.3 Targeted Case Management for Adults w/ AIDS

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CPT Code</th>
<th>Modifier</th>
<th>Rate</th>
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</tr>
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<tbody>
<tr>
<td>New Client Comprehensive Assessment</td>
<td>T2023</td>
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<tr>
<td>Extended Follow-up</td>
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<td>TS, U1</td>
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<tr>
<td>Brief Follow-up</td>
<td>T2023</td>
<td>TS</td>
<td>$42.00</td>
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### 8.4 MEDICARE PREVENTIVE SERVICES

<table>
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<th>Service Description</th>
<th>CPT Code</th>
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<tbody>
<tr>
<td>Nurse Practitioner</td>
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<tr>
<td>New Problem Focused / Established Minimal</td>
<td>99201/99211</td>
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<td>1.29/0.60</td>
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<tr>
<td>New Expanded Prob. Focused / Established Problem Focused</td>
<td>99202/99212</td>
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<td>2.19/1.29</td>
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<tr>
<td>New Detailed Low Complexity / Established Problem Focused</td>
<td>99203/99213</td>
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<td>3.18/2.14</td>
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<tr>
<td>New Comprehensive Moderate / Established Detailed Moderate</td>
<td>99204/99214</td>
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<td>4.84/3.14</td>
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<tr>
<td>New Comprehensive Complex / Established Comprehensive Complex</td>
<td>99205/99215</td>
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<td>5.99/4.20</td>
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<tr>
<td>Diabetes Self-Management Training</td>
<td>G0108</td>
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<td>1.53</td>
</tr>
<tr>
<td>Diabetes, self-mgmt training svcs, Individual (30 min)</td>
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<td>0.41</td>
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<tr>
<td>Diabetes Screening</td>
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<td></td>
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<tr>
<td>Blood Glucose Test</td>
<td>82947</td>
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<tr>
<td>Post glucose dose; includes glucose</td>
<td>82950</td>
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<tr>
<td>Glucose Tolerance Test (GTT)</td>
<td>82951</td>
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<td>0.52</td>
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<tr>
<td>Screening Pap Test &amp; Pelvic Exam</td>
<td>G0101</td>
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<tr>
<td>Cervical or vaginal cancer screening; pelvic &amp; clinical breast exam</td>
<td>Q0091</td>
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<td>1.35</td>
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<tr>
<td>Screening Pap smear; obtaining, preparing and conveyance of smear to lab</td>
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<tr>
<td>Screening Mammograms</td>
<td></td>
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<tr>
<td>Computer-aided detection (Use 77057 in conjunction w/ 77052)</td>
<td>77052</td>
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<td>0.30</td>
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<tr>
<td>Screening mammography, bilateral, 2 views</td>
<td>77057</td>
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<td>2.40</td>
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<tr>
<td>Screening mammogram, bilateral, all views</td>
<td>G0202</td>
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<td>4.08</td>
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<tr>
<td>Colorectal Cancer Screening</td>
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<tr>
<td>Cancer screening; fecal occult blood test, consecutive collection w/ 1 determination</td>
<td>82270</td>
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<tr>
<td>Cancer screening; fecal occult blood test, 1-3 simultaneous</td>
<td>G0328</td>
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## 8.4 MEDICARE PREVENTIVE SERVICES (Continued)

<table>
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<tbody>
<tr>
<td><strong>Smoking Cessation</strong></td>
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<tr>
<td>Cessation counseling visit; intermediate, greater than 3 min up to 10 min</td>
<td>99406</td>
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<tr>
<td>Cessation counseling visit; intensive, greater than 10 min</td>
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<tr>
<td><strong>HIV Screening</strong></td>
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<tr>
<td>Infectious antibody detection, EIA technique, HIV-1 and/or HIV-2 screening</td>
<td>G0432</td>
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<td>0.55</td>
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<tr>
<td>Infectious antibody detection, ELISA technique, HIV-1 and/or HIV-2 screening</td>
<td>G0433</td>
<td></td>
<td>0.55</td>
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<tr>
<td><strong>Registered Dietician</strong></td>
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<tr>
<td><strong>Medical Nutrition Therapy</strong></td>
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<tr>
<td>Initial Assessment, Individual (15 min)</td>
<td>97802</td>
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<td>1.04</td>
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<tr>
<td>Re-assessment, Individual (15 min)</td>
<td>97803</td>
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<td>0.90</td>
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<tr>
<td>Group assessment, 2 or more individuals, each (30 min)</td>
<td>97804</td>
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<td>0.46</td>
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<tr>
<td>Re-assessment, 2nd referral in 1st yr, Individual (15 min)</td>
<td>G0270</td>
<td></td>
<td>0.90</td>
</tr>
<tr>
<td>Re-assessment, 2nd referral in 1st yr, Group, 2 or more individuals, each (30 min)</td>
<td>G0271</td>
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<td>0.46</td>
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<tr>
<td><strong>Diabetes Self-Management Training</strong></td>
<td></td>
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<tr>
<td>Diabetes, outpatient self-mgmt training svcs, individual, (30 min)</td>
<td>G0108</td>
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<td>1.53</td>
</tr>
<tr>
<td>Diabetes, outpatient self-mgmt training svcs, Group, 2 or more individuals, (30 min)</td>
<td>G0109</td>
<td></td>
<td>0.41</td>
</tr>
</tbody>
</table>

*Please refer to the Adult Health Methodologies Section for the link to find current rates based on your service locality.*
Section 9

Dental Services

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

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

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

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

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CPT Code</th>
<th>HC</th>
<th>A</th>
<th>P</th>
<th>Rate</th>
<th>2013 RVU</th>
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</thead>
<tbody>
<tr>
<td>Periodic Oral Evaluation - established patient</td>
<td>D0120</td>
<td>●</td>
<td></td>
<td></td>
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<tr>
<td>Limited oral Evaluation - problem focused</td>
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<td>●</td>
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<td>0.85</td>
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<tr>
<td>Comprehensive Oral Evaluation - new or established patient</td>
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<td></td>
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<td>0.88</td>
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<tr>
<td>Intraoral - complete series (including bitewings)</td>
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<td>●</td>
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<td></td>
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<td>1.47</td>
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<tr>
<td>Intraoral - periapical first film</td>
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<td>●</td>
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<td>0.29</td>
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<td>Intraoral - periapical, each additional film</td>
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<td>●</td>
<td>●</td>
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<td>$10.35</td>
<td>0.27</td>
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<tr>
<td>Intraoral - Occlusal Film</td>
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<td>0.47</td>
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<td>Bitewing, single film</td>
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<td>0.29</td>
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<tr>
<td>Bitewing, two films</td>
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<td>Bitewing, four films</td>
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<td>Panoramic Option</td>
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<td>Prophylaxis - child</td>
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<td>topical fluoride varnish</td>
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<td>topical application of fluoride</td>
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<td>Sealant - per tooth</td>
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<td>Space maintainer - fixed unilateral</td>
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<td>space maintainer-fixed-bilateral</td>
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<td>Space maintainer - removable bilateral</td>
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<td>Amalgam - one surface</td>
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<td>1.62</td>
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<tr>
<td>Amalgam - three surfaces</td>
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<td>●</td>
<td>●</td>
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<td>1.62</td>
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<tr>
<td>Amalgam - four or more surfaces, primary or permanent</td>
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<td>●</td>
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<td>●</td>
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<td>Resin-based composite - one surface, anterior</td>
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<td>1.98</td>
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<td>Resin-based composite - one surface, posterior</td>
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<td>●</td>
<td></td>
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<td>1.81</td>
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<tr>
<td>Resin-based composite - two surfaces, posterior</td>
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<td>●</td>
<td>●</td>
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<td>Resin-based composite - two surfaces, posterior</td>
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<td>●</td>
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<tr>
<td>Resin-based composite - four or more surfaces, posterior</td>
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<tr>
<td>Resin-based composite - four or more surfaces, posterior</td>
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<tr>
<td>Re-cement Crowns</td>
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<td>Prefabricated stainless steel crown - primary tooth</td>
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<td>3.33</td>
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<td>Prefabricated resin crown - composite Crown</td>
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<td>3.54</td>
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<td>Prefabricated esthetic coated stainless steel crown, primary</td>
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<td>Sedative Fillings</td>
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<td>Pin Retention per tooth in addition to restoration</td>
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<td>●</td>
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### 9.2 HEALTHCHECK (HC); ADULT (A); PREGNANT (P)

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<th>CPT Code</th>
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<th>P</th>
<th>Rate</th>
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<td>Comprehensive Periodontal</td>
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<td>Resin based composite, 4+ anterior</td>
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<td>2.95</td>
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<td>Prefabricated post and core in addition to crown</td>
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<tr>
<td>Therapeutic pulpotomy (excluding final Restoration)</td>
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<td>●</td>
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<td>1.81</td>
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<tr>
<td>Pulpal Debridement, Primary and Permanent Teeth</td>
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<td>●</td>
<td></td>
<td></td>
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<td>1.99</td>
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<tr>
<td>Anterior (excluding final restoration)</td>
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<td>$77.64</td>
<td>7.52</td>
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<tr>
<td>Anterior (excluding final restoration)</td>
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<td>9.21</td>
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<tr>
<td>Bicuspids (excluding final restoration)</td>
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<td>9.21</td>
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<tr>
<td>Apicoectomy/periradicular surgery - anterior</td>
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<td>●</td>
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<td>$229.81</td>
<td>8.49</td>
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<tr>
<td>Apicoectomy/periradicular surgery (each additional root)</td>
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<td>●</td>
<td></td>
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<td>3.60</td>
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<tr>
<td>Gingivectomy or Gingivoplasty - four or more contiguous teeth</td>
<td>D4210</td>
<td>●</td>
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<td>6.63</td>
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<td>Gingival flap procedure, including root planning</td>
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<td>Gingival flap, including root planning 1-3 teeth</td>
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<td>4.86</td>
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<td>Osseous Surgery (including flap entry and closure)</td>
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<td>Pedicle soft tissue graft procedure</td>
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<td>●</td>
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<td>9.95</td>
</tr>
<tr>
<td>Periodontal Scaling &amp; root planning 4+ teeth</td>
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<td>Periodontal scaling 1-3 teeth</td>
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<td>Complete denture maxillary</td>
<td>D5110</td>
<td>●</td>
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<td>Adjust Complete Denture - maxillary</td>
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<td>Replace broken teeth - per tooth</td>
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<td>Surgical removal of erupted tooth</td>
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<td>Removal of impacting tooth - soft tissue..</td>
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<td>Tooth re-implantation and/or stabilization</td>
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<td>Biopsy of oral tissue - soft</td>
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<td>Removal of benign cyst or tumor/lesion diameter greater than over 1.25cm</td>
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<td>Removal of lateral exostosis (maxilla or mandible)</td>
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<td>Incision and drainage of abscess - extraoral soft tissue</td>
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<td>●</td>
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<td>Removal of reaction-producing foreign bodies of musculoskeletal system</td>
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<td>Partial ostectomy/sequestrectomy for removal of non-vital bone.</td>
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<td>Maxilla -open reduction (teeth immobilized, if present)</td>
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<td>●</td>
<td>●</td>
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<td>Maxilla - closed reduction (teeth immobilized, if present)</td>
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<td>●</td>
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<td>$645.45</td>
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<td>Mandible - open reduction (teeth immobilized, if present)</td>
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<td>●</td>
<td>●</td>
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<td>Mandible - closed reduction (teeth immobilized, if present)</td>
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<td>●</td>
<td>●</td>
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<td>Closed Reduction of dislocation</td>
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<td>Complicated suture greater than 5cm</td>
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<td>Appliance Removal incl removal of archbar</td>
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<td>Comprehensive Orthodontic Treatment of Adolescent Dentition</td>
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<td>Pre-Orthodontic treatment visit</td>
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### 9.2 HEALTHCHECK (HC): ADULT (A); PREGNANT (P)

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<th>P</th>
<th>Rate</th>
<th>2013 RVU</th>
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<tbody>
<tr>
<td>Periodic Orthodontic treatment visit (as part of contract)</td>
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<td>Palliative (emergency) treatment of dental pain, minor procedure</td>
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<td>Local Anesthesia (not in conjunction with other services &amp; procedures)</td>
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<td>Deep Sedation/General Anesthesia - first 30 minutes</td>
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<td>Deep Sedation/General Anesthesia - each additional 15 minutes</td>
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<td>Analgesia, anxiolysis, inhalation of nitrous oxide</td>
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<td>Intravenous conscious sedation - first 30 minutes</td>
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<td>Office Visit After Regularly Scheduled Hours</td>
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Section 10

Miscellaneous Services

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

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<th>SELF-PAY SERVICES</th>
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<td>CPR Certification Services</td>
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<tr>
<td>DNA Collection Services</td>
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<tr>
<td>Drug Testing Collection Services</td>
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<td>Fax Medical Records</td>
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<td>General Lab Services</td>
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<td>Health Check Services</td>
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<td>I-693 Form Completion</td>
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<td>International Travel Services</td>
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<tr>
<td>Lice and Scabies Checks</td>
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<tr>
<td>Pregnancy Tests</td>
</tr>
<tr>
<td>Prepare Immunization &amp; Hearing, Vision, Dental Certificates w/o service</td>
</tr>
<tr>
<td>Refugee Screening Services</td>
</tr>
<tr>
<td>Sports Physicals w/ Certificate</td>
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<td>SSI Services</td>
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Fees for these services are set by the local County Boards of Health.
Section 11

Appendices

11.1 Component Requirements for Office/Home Visits

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

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

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

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

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

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

### Office or Other Outpatient Services

#### Patient: New

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#### History and Exam (#1 and #2)

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<tr>
<td>Expanded Problem Focused</td>
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<tr>
<td>Detailed</td>
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<tr>
<td>Comprehensive</td>
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#### Medical Decision Making (#3)

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<td>Moderate</td>
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#### Presenting Problem (Severity) (#1)

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<tr>
<td>Low to Moderate</td>
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<td>Moderate</td>
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<td>Moderate to High</td>
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#### Counseling and Coordination of Care (#2 and #3)

See E/M Guidelines

#### Typical Face-to-Face Time (#4)

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### Office or Other Outpatient Services

#### Patient: Established

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#### History and Exam (#1 and #2)

<table>
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<th>Required Key Components</th>
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<tr>
<td>Expanded Problem Focused</td>
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<tr>
<td>Detailed</td>
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#### Medical Decision Making (#3)

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<tr>
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#### Presenting Problem (Severity) (#1)

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<td>Self-Limited or Minor</td>
</tr>
<tr>
<td>Low to Moderate</td>
</tr>
<tr>
<td>Moderate to High</td>
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#### Counseling and Coordination of Care (#2 and #3)

See E/M Guidelines

#### Typical Face-to-Face Time (#4)

<table>
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<tr>
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## Component Requirements for Home Visits

### Home Services

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### History and Exam (#1 and #2)

| Problem Focused | Expanded Problem Focused | Detailed | Comprehensive | X | X |

### Medical Decision Making (#3)

| Straightforward | Low | Moderate | High | X | X |

### Presenting Problem (Severity) (#1)

| Low          | Moderate | High | Unstable/Significant New Problem | X |

### Contributory Factors

<table>
<thead>
<tr>
<th>Counseling and Coordination of Care (#2 and #3) See E/M Guidelines</th>
<th>Typical Face-to-Face Time (#4)</th>
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<tr>
<td>Minutes</td>
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### Interval History and Exam (#1 and #2)

| Problem Focused | Expanded Problem Focused | Detailed | Comprehensive | X | X |

### Medical Decision Making (#3)

| Straightforward | Low | Moderate | Moderate to High | X | X |

### Presenting Problem (Severity) (#1)

| Self-Limited or Minor | Low to Moderate | Moderate to High | Moderate to High/Unstable/ Significant New Problem | X | X |

### Counseling and Coordination of Care (#2 and #3) See E/M Guidelines

<table>
<thead>
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<td>Minutes</td>
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...
11.2 RELATED LINKS

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


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

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

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

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


Wellcare:  http://georgia.wellcare.com

CIGNA:  https://cignaforthcp.cigna.com/wps/portal

UHC:  https://www.unitedhealthcareonline.com/

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

AETNA:  http://www.aetna.com/
### 11.3 ACRONYMS

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<td>ADA</td>
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<tr>
<td>CIS</td>
<td>CHILDREN INTERVENTION SERVICES</td>
</tr>
<tr>
<td>CMO</td>
<td>CARE MANAGEMENT ORGANIZATION</td>
</tr>
<tr>
<td>CMS</td>
<td>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</td>
</tr>
<tr>
<td>COB</td>
<td>COORDINATION OF BENEFITS</td>
</tr>
<tr>
<td>COS</td>
<td>CATEGORY OF SERVICE</td>
</tr>
<tr>
<td>CPT</td>
<td>CURRENT PROCEDURAL TERMINOLOGY</td>
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<td>DOS</td>
<td>DATES OF SERVICE</td>
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<td>DSPS</td>
<td>DIAGNOSTIC, SCREENING AND PREVENTIVE SERVICES</td>
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<tr>
<td>EDI</td>
<td>ELECTRONIC DATA INTERCHANGE</td>
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<td>EXPLANATION OF MEDICARE BENEFITS</td>
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<td>EPSDT</td>
<td>EARLY &amp; PERIODIC SCREENING DIAGNOSIS &amp; TREATMENT</td>
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<td>FFS</td>
<td>FEE-FOR-SERVICE</td>
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<tr>
<td>HC</td>
<td>HEALTH CHECK</td>
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<tr>
<td>HCPCS</td>
<td>HEALTHCARE COMMON PROCEDURE CODING SYSTEM</td>
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<tr>
<td>HIPAA</td>
<td>HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT</td>
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<tr>
<td>ICD-9</td>
<td>INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH EDITION</td>
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<td>NPI</td>
<td>NATIONAL PROVIDER IDENTIFIER</td>
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<td>PCM</td>
<td>PERINATAL CASE MANAGEMENT</td>
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<td>PPO</td>
<td>PREFERRED PROVIDER ORGANIZATION</td>
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<td>TPA</td>
<td>THIRD PARTY ADMINISTRATOR</td>
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<td>TPL</td>
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<tr>
<td>UB</td>
<td>UNIFORM BILLING</td>
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DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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<thead>
<tr>
<th>DISTRICT 1-1 ROME</th>
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<tbody>
<tr>
<td>Bartow</td>
<td>Julie Payne</td>
</tr>
<tr>
<td>Floyd</td>
<td>1309 Redmond Rd., Rome, GA 30165</td>
</tr>
<tr>
<td>Polk</td>
<td>Phone: 706-295-6746</td>
</tr>
<tr>
<td>Catoosa</td>
<td>Cynthia Mann</td>
</tr>
<tr>
<td>Gordon</td>
<td>100 W. Walnut Ave, Dalton, GA 30702</td>
</tr>
<tr>
<td>Walker</td>
<td>Phone: 706-272-2125 ext. 315</td>
</tr>
<tr>
<td>Chattooga</td>
<td>Anita Holsenbeck</td>
</tr>
<tr>
<td>Haralson</td>
<td>1280 Athens St., Gainesville, GA 30507</td>
</tr>
<tr>
<td>Dade</td>
<td>Phone: 770-531-2562</td>
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<td>Paulding</td>
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<thead>
<tr>
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<tbody>
<tr>
<td>Cherokee</td>
<td>Lisa Stevens</td>
</tr>
<tr>
<td>Gilmer</td>
<td>1650 County Services Pkwy, Marietta, GA 30008</td>
</tr>
<tr>
<td>Fannin</td>
<td>Phone: 770-739-3214</td>
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<tr>
<td>Gordon</td>
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<td>Pickens</td>
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<tr>
<td>Fulton</td>
<td>LaShonna Jackson</td>
</tr>
<tr>
<td></td>
<td>99 Jesse Hill Jr. Dr., Atlanta, GA 30303</td>
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<tr>
<td>Clayton</td>
<td>Barbara Woodson</td>
</tr>
<tr>
<td></td>
<td>1117 Battlecreek Rd., Jonesboro, GA 30236</td>
</tr>
<tr>
<td></td>
<td>Phone: 678-479-2228</td>
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<tr>
<td>Newton</td>
<td>2570 Riverside Parkway, Lawrenceville, GA 30045</td>
</tr>
<tr>
<td>Rockdale</td>
<td>Phone: 678-442-6884</td>
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<td>Dekalb</td>
<td>Parecia Benson</td>
</tr>
<tr>
<td></td>
<td>455 Winn Way, Decatur, GA 30031</td>
</tr>
<tr>
<td></td>
<td>Phone: 404-294-3830</td>
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<tr>
<td>Butts</td>
<td>Beth Crocker</td>
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<tr>
<td>Fayette</td>
<td>122-A Gordon Commercial Dr., LaGrange, GA 30240</td>
</tr>
<tr>
<td>Lamar</td>
<td>Phone: 706-298-7715</td>
</tr>
<tr>
<td>Lamar</td>
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<tr>
<td>Heard</td>
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<tbody>
<tr>
<td>Bleckley</td>
<td>Tina Chavis</td>
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<tr>
<td>Dodge</td>
<td>2121-B Bellevue Rd., Dublin, GA 31021</td>
</tr>
<tr>
<td>Montgomery</td>
<td>Phone: 478-275-6545</td>
</tr>
<tr>
<td>Wheeler</td>
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<tr>
<td>DISTRICT 5-2 MACON</td>
<td>State Address</td>
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<tr>
<td>------------------</td>
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</tr>
<tr>
<td>Baldwin Hancock</td>
<td>201 Second St, Suite 1100, Macon, GA 31201</td>
</tr>
<tr>
<td>Bibb Houston</td>
<td>1916 N. Leg Rd., Bldg D, Augusta, GA 30909</td>
</tr>
<tr>
<td>Crawford Jasper</td>
<td>2100 Comer Ave., Columbus, GA 31904</td>
</tr>
<tr>
<td>Putnam Jones</td>
<td>312 N. Patterson St., Valdosta, GA 31605</td>
</tr>
<tr>
<td>Twiggs Peach</td>
<td>PO Box 547, 327 Sunset Ave, Newton, GA 39870</td>
</tr>
<tr>
<td>Washington Wilkerson</td>
<td>150 Scranton Connector, Brunswick, GA 31525</td>
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<table>
<thead>
<tr>
<th>DISTRICT 6 AUGUSTA</th>
<th>State Address</th>
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<tbody>
<tr>
<td>Burke Jeffers</td>
<td>201 Second St, Suite 1100, Macon, GA 31201</td>
<td>Jefferson</td>
<td>31201</td>
<td>478-751-6026</td>
</tr>
<tr>
<td>Columbia Jenkins</td>
<td>1916 N. Leg Rd., Bldg D, Augusta, GA 30909</td>
<td>Jenkins</td>
<td>30909</td>
<td>706-667-4262</td>
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<tr>
<td>Emanuel Lincoln</td>
<td>2100 Comer Ave., Columbus, GA 31904</td>
<td>Lincoln</td>
<td>31904</td>
<td>706-321-6206</td>
</tr>
<tr>
<td>Glascock Muscogee</td>
<td>312 N. Patterson St., Valdosta, GA 31605</td>
<td>Muscogee</td>
<td>31605</td>
<td>229-333-7585</td>
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<thead>
<tr>
<th>DISTRICT 7 COLUMBUS</th>
<th>State Address</th>
<th>City</th>
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</thead>
<tbody>
<tr>
<td>Chattahoochee Harris</td>
<td>201 Second St, Suite 1100, Macon, GA 31201</td>
<td>Harris</td>
<td>31201</td>
<td>478-751-6026</td>
</tr>
<tr>
<td>Clay Macon</td>
<td>1916 N. Leg Rd., Bldg D, Augusta, GA 30909</td>
<td>Macon</td>
<td>30909</td>
<td>706-667-4262</td>
</tr>
<tr>
<td>Crisp Marion</td>
<td>2100 Comer Ave., Columbus, GA 31904</td>
<td>Marion</td>
<td>31904</td>
<td>706-321-6206</td>
</tr>
<tr>
<td>Dooly Muscogee</td>
<td>312 N. Patterson St., Valdosta, GA 31605</td>
<td>Muscogee</td>
<td>31605</td>
<td>229-333-7585</td>
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<tr>
<th>DISTRICT 8-1 VALDOSTA</th>
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<td>PO Box 547, 327 Sunset Ave, Newton, GA 39870</td>
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<td>229-333-7585</td>
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<td>Cook Lee</td>
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<td>Paula Brown, Project Officer (15th floor)</td>
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