PART II

POLICIES AND PROCEDURES
for
PSYCHOLOGICAL AND THERAPY SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: April 1, 2025

TABLE OF CONTENTS

Policy Revision Record
from 2024 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
04/01/2025	Appendix B	Updated Appendix B with the reimbursement rates for procedure codes 96100, 98016, M0064, and Q3014.	M	N/A
01/01/2025	N/A	There are no revisions for this quarter.	N/A	N/A
10/01/2024	Appendix J	I have included a detailed appendix with links to the websites for Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation (NEMT).	A	N/A

[1] The revisions outlined in this Table are from July 1, 2024, to current. For revisions prior to July 1, 2024, please see prior versions of the policy.

601. Special Conditions of Participation

601.1. In addition to those conditions of participation outlined in the Part I Policies and Procedures for Medicaid/PeachCare for Kids policy manual, Section 106, a Psychologist, Marriage and Family Therapist, Licensed Social Worker, and Counselor, Professional must:

601.2. Hold a current and valid license as a Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, Professional as required under Georgia Code Chapter 39 as amended.

601.3. Agree to bill the Department for only those services rendered by the enrolled Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, Professional or under direct supervision of the enrolled Psychologist. Please reference section 805 for restrictions on reimbursement for Auxiliary Personnel.

601.4. Direct supervision applies only to the salaried employees of Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, and Professional such as technicians, and assistant, etc., but does not apply to another Psychologist or individual practitioner who is eligible to enroll as a direct provider of services in a covered Medicaid program.

601.5. Agree to maintain records as necessary to demonstrate program compliance; and must submit or make records available to the Department upon request for a minimum of five (5) years from the date(s) the service(s).

601.6. Agree not to bill for adjunctive services provided in a nursing facility unless prescribed by the Medicaid member's attending and prescribing physician as documented in the patient's medical record. Adjunctive services are defined as services provided by a physician or licensed practitioner other Psychological and Therapy Services than the patient's primary care physician who is legally responsible for the medical care of the patient. The attending and prescribing physician's name must appear on the patient's medical record.

601.7. Have a private practice which meets the following criteria:

601.7.1. Services rendered are the responsibility of the Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, Professional are free of any administrative or professional control of an employer such as a physician, institution, agency, etc.

601.7.2. The persons treated are the Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, Professional own patients; and

601.7.3. The Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, and Counselor, Professional have the right to bill directly for collect and retain payment for services.

Chapter 700: Special Eligibility Conditions

701. Eligibility Requirements

Psychological and therapy services are available exclusively to members under the age of twenty-one (21).

Chapter 800: Prior Approval

801. Services Requiring Prior Approval or Hospital Pre-Certification

As a condition of reimbursement, the Division requires certain services or procedures to be approved prior to the time of rendering. Prior approval pertains to medical necessity only; the patient must be Medicaid-eligible at the time the service is rendered

Prior approval requests can be submitted via the web portal (www.mmis.georgia.gov) secure home page link: Prior Authorization/Medical Review Portal/Enter and Edit Authorization Request. The Medicaid Request for Outpatient Psychotherapy Services form should be submitted thirty (30) days prior to the exhaustion of the initial 24 units of therapy. Failure to obtain the required prior approval will result in denial of reimbursement.

If approved, the requested service is assigned an authorization number. The authorization number should be included on the CMS 1500 claim form in Field 23.

Authorizations are valid for six (6) months from the date of the final determination.

Providers have six (6) months from the date of service to bill for services rendered.

Chapter 900: Scope of Services

901. General

Psychological and Therapy services are defined as services involving the application of recognized principles, methods, and procedures of the science and profession of psychology, such as, but not limited to, diagnosing and treating mental and nervous disorders, interviewing, administering and interpreting tests of mental abilities, aptitudes, interests, and personality characteristics for such purposes as psychological classification or evaluation, or for education or vocational placement, or for such purposes as psychological counseling, guidance, or readjustment. Services are subject to the limitations described in Sections 802 and 804 without regard to diagnosis, type of illness or condition.

902. Covered Services

Psychological and Therapy Services are covered only for members under twenty-one years of age. Reimbursement for Psychological and Therapy Services is limited to no more than twenty-four (24) units per member, per calendar year. When the Department has made payment for twenty-four units (24) of Psychological and Therapy Services no further payment will be made without prior authorization. The annual twenty-four-unit limitation will apply to any combination of current procedure terminology CPT codes 96130, 96131,96132, 96133, 96136, and 96137 (psychological diagnostic interview, evaluation and testing), 90832 (individual psychotherapy), 90834, 90837 (effective 8/1/2013) and 90853 (group psychotherapy). Codes 90832, 90834 and 90837 cannot be billed together and each count as one unit. (Rev. 01/2019)

903. Psychological Testing

Psychological testing (includes psych diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS) per hour of the psychologist's or physician's time, both face to face time administering test to the patient and time interpreting these test results and preparing the report. This may include history, mental status, disposition, psychometric, projective and/or developmental test, consultations with referral sources and other evaluation and interpretation of hospital records or psychological reports and other accumulated data for diagnostic purposes (with written report). The medical record must indicate the presence of mental illness for which psychological testing is indicated as in aid in diagnosis and therapeutic planning. The record must also show test performed, scoring, and interpretation as well as time involved. Only the Psychologist can make the selection and interpretation of psychological tests. The Psychologist must personally interview the patient when a diagnosis is made or is requested. In any written report, including psychological evaluations, the Psychologist must approve and sign the report. If the Psychologist's salaried employee does not participate in the actual writing of a report, but does administer and/or score psychological tests, the salaried employee is not required to sign the report, but his or her name must be listed as the person who participated in the collection of the data in the report. When the salaried employee personally participates in the writing of any report, then both the Psychologist and the salaried employee must sign the report. CPT codes 96130, 96131, 96132, and 96133 (Testing Evaluation Services) can only be billed and reimbursed by the enrolled Psychologist (Category of Service 570).

904. Psychiatric Diagnostic Procedure

Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations the evaluation may include communication with family or other

sources and review and ordering of diagnostic studies. (Rev. 04/01/2023)

CPT Code	Description
90791	Psychiatric diagnostic evaluation

905. Psychotherapy

Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with thirty minutes face-to with the patient. This service is rendered in conjunction with continuing diagnostic evaluation as indicated, including psychoanalysis, insight orientation,
behavior modification, supportive psychotherapy or other techniques.

CPT Code	Description
90832	Psychotherapy, 30 minutes with patient
90834	Psychotherapy, 45 minutes with patient
90837	Psychotherapy, 60 minutes with patient

906. Health Behavior Assessment and Intervention

Health Behavior Assessment and Intervention (HBAI) services Health behavior assessment and intervention services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems.

The patient's primary diagnosis is physical in nature and the focus of the assessment and intervention is on factors complicating medical conditions and treatments. These codes describe assessments and interventions to improve the patient's health and well-being utilizing psychological and/or psychosocial interventions designed to ameliorate specific disease-related problems. (Rev. 01/2024)

CPT Code	Description
96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
96158	Health behavior intervention, individual, face-to-face initial 30 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96164	Health behavior intervention, group (2 or more patients), face-to-face. initial 30 minutes
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

907. Other Psychotherapy

Insight oriented behavior modifying and/or supportive psychotherapy other than a multiple family group. This is a psychotherapy session in which there are no related patients in the session. Group therapy does not include socialization, music therapy, recreational activities, art classes, excursions, sensory, stimulation or eating together. Services are limited to a maximum of one (1) unit per date of service, per member and can only be provided by the enrolled Psychologist.

CPT Code	Description
90853	Group psychotherapy (other than of a multiple-family group)

908. Guidelines for Selection of Group Therapy Patients

908.1. Patients must be alert, oriented to date, time and place and able to communicate;

908.2. Patients must not have loss of contact with reality or personality disintegration;

908.3. Patients with disabilities who need assistance, such as sign language for the deaf, must be provided the assistance required to allow them to participate in a meaningful manner in the group;

908.4. Patients cannot be related to any other member of the group.

909. Group Size

909.1. Group therapy sessions must be limited to no more than ten (10) patients.

910. Patient Records Requirements

Each patient's chart (medical record) must contain at a minimum the following information:

910.1. The patient's name, diagnosis, and goals to be achieved in individual or group therapy

910.2. The date and length of the therapy session (start and end time);

910.3. A statement summarizing the progress made toward reaching the projected goals; and

910.4. Charts and records must be in English.

911. Non-Covered Services

The following services are not reimbursable to Psychologists:

911.1. Sensitivity training, encounter groups, or workshops;

911.2. Sexual competency training;

911.3. Education testing and diagnosis (NOTE: Educational testing may be deemed medically necessary in a comprehensive workup when performed as a result of mental illness

psychiatric disease: however, it is not reimbursable when performed to only test the member's IQ.)

911.4. Marriage counseling or guidance;

911.5. Biofeedback;

911.6. Transcutaneous nerve stimulation;

911.7. Hypnotherapy;

911.8. Adult Psychological and Therapy Services (21 years of age and over) see Physicians Services (COS 430)

911.9. Psychological and Therapy Services rendered through, by or in mobile units and/or facilities other than the psychologist's office, acute care hospitals, schools, psychological intensive care facilities approved by DHR, and nursing facilities. A mobile unit shall not constitute a Psychologist's office;

911.10. Telephone referrals or consultations; and

911.11. The Division of Medicaid does not directly reimburse psychological and psychiatric services rendered to individuals enrolled in the PRTF.

912. Auxiliary Personnel

The Department has no provision for direct enrollment of, or payment to, salaried auxiliary personnel employed by the Psychologist, such as technicians, therapists, mental health professionals, and other aides not enrolled in the Georgia Medicaid program. However, the Department will reimburse the Psychologist for services when the salaried employees of the Psychologist assist in rendering services and the charges are billed as part of the charge for the overall service provided by the Psychologist and other licensed behavioral health professionals. The services of the salaried personnel should be limited to providing evaluation and testing under the direct supervision of the Psychologist.

Employed auxiliary personnel may be part-time or full-time employees of the enrolled Psychologist. In order to satisfy the employment requirement, the auxiliary personnel must receive a W-2 form the Psychologist must pay the FICA. Services provided by auxiliary personnel not employed by the Psychologist are
not covered.

Direct supervision by the Psychologist does not mean the Psychologist must be present in the same room; however, the Psychologist must be present at the site of the services and be immediately available to aid and direction throughout the time the services are performed.

The Department will not reimburse for psychotherapy (individual or group) performed by anyone other than the enrolled licensed Psychologist.

913. Nursing Home Referral Requirements

Covered nursing home patients (those under twenty-one years old) must be referred by their attending physician. The referral must be in writing and identify the patient referred and the Psychologist who will provide the service. The referral must be maintained in the patient's chart.

914. Site of Service Differential

Services that are primarily performed in office settings will be subject to a reimbursement reduction when performed in an inpatient, outpatient, emergency, or ambulatory surgery setting. The reduced reimbursement is calculated as part of RBRVS and is updated annually.

Chapter 1000: Basis for Reimbursement

1001. Reimbursement Methodology

The Division will pay the lower of the physician's lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date(s) of service, the lowest price charged to other third-party payers or the statewide maximum allowable reimbursement amount allowed for the procedure code reflecting the service rendered. Effective with dates of service October 1, 2003, the statewide maximum allowable reimbursement is 84.645% of the 2000 Resource Based Relative Value Scale (RBRVS) as specified by Medicare for Georgia Area 1 (Atlanta). All procedure codes recognized and adopted after the 2000 RBRVS are subject to the same level of reimbursement.

1002. Reimbursement Limitation

Reimbursement for Psychological and Therapy Services is limited to no more than twenty-four units per member, per calendar year. In those instances, in which a member is receiving services from more than one Psychologist, the basis for reimbursement up to the twenty-four-unit limitation will be the first correct claim received from any enrolled psychologist.

1003. Billing

1003.1. Medicaid Claims

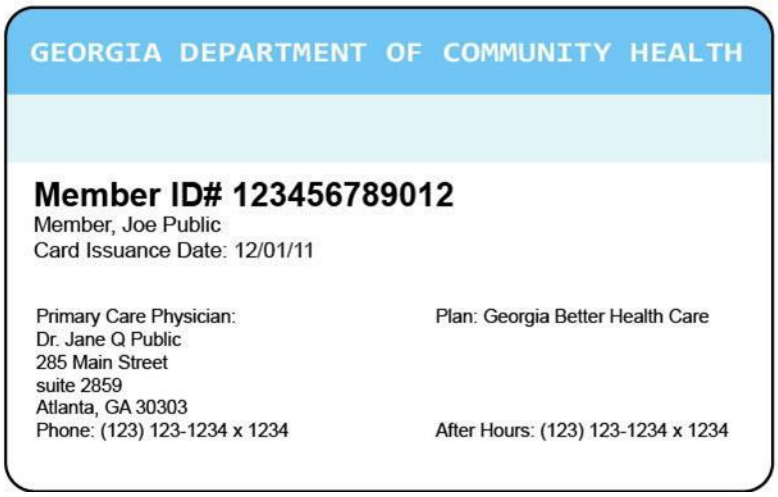
The appropriate claim for reimbursement of Psychological and Therapy Services is the CMS 1500 claim form. Please see the Billing Manual, Appendix I in Policy Manual Part I for detailed instructions on completing the claim form.

1003.2. Medicare/Medicaid

Please refer to Policy Manual Part I, Sections 301 and 302, and the Billing Manual for billing instructions for services rendered to members with dual eligibility for both Medicare and Medicaid. The Medicaid Secondary User Guide will also provide appropriate information for billing for dual eligible.

Appendix A
Medical Assistance Eligibility Certification

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



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

Appendix B
Psychological and Therapy Services Procedure Codes and Rates

Procedure Code	Maximum Allowable
90791	$128.24
96100	$62.11
96130	$100.88
96131	$76.71
96132	$113.32
96133	$86.45
96136	$40.59
96137	$37.51
90832	$53.22
90834	$68.44
90837	$111.16
90853	$28.92
96156	$84.57
96158	$57.70
96159	$20.15
96164	$8.55
96165	$3.97
96167	$61.98
96168	$21.98
98016	$13.45
Q3014	$20.52

Appendix C
Vaccines For Children (VFC) Program

A. General

This federal vaccine program provides free vaccines to be used for all children under nineteen (19) years old except those who have insurance that covers immunizations. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) created the funding for this program called Vaccines for Children (VFC). This program will simply expand upon the current Georgia Free Vaccine program.

The Georgia VFC program will supply vaccines for the following:

i. Children enrolled in Medicaid or qualified through a Medicaid waiver;
ii. Children who do not have health insurance;
iii. Children who are American Indian or Alaskan Native;
iv. Children who have health insurance, but vaccines are not a covered benefit; and
v. Children enrolled in PeachCare for Kids.

The State Department of Public Health will be responsible for enrolling physicians, physician's assistants, nurse practitioners and nurse midwives into the program and processing the vaccine orders.

All physicians, physician's assistants, nurse midwives and nurse practitioners who provide immunization services must enroll in the Vaccines for Children program and provide immunizations to Medicaid eligible children whose ages are birth through eighteen (18) years of age.

B. Enrollment

i. Providers who render immunizations to Medicaid children must be enrolled in the VFC program. The following are requirements for enrollment in the VFC program:

ii. Providers must complete the Provider Enrollment Form, the Provider Profile and Vaccine Order Form and return to the below address:

Georgia Immunization Program
P. O. Box 949
Atlanta, Georgia 30301-0949
(404) 657-5013 or 1-800-848-3868

iii. Providers in Group Practices need only complete one Enrollment Form. However, a copy of the license of each provider must be attached to the Enrollment Form. A Provider Profile must be completed for each location (separate office, clinic, etc.) where immunizations are given.

iv. Individual providers must attach a copy of their license to the enrollment form.

Questions regarding enrollment, vaccine orders and record keeping should be directed to the Georgia Immunization program.

For a complete list of procedure codes to bill for Immunizations (ages birth up to 19 years), Tuberculin Skin Tests and Blood Lead Tests, please refer to the EPSDT-Health Check Services program manual.

Bill only EPSDT-Health Check Program procedure codes on the same claim form. Bill other Medicaid program (i.e., Physician Services Program, etc.) procedure codes on a separate CMS-1500 Claim Form.

Appendix D

Procedure Codes Subject to the Site of Service Differential

(The list of procedure codes may not be all inclusive)

Cpt Codes
90791
96130
96131
96132
96133
96136
96137
90832
90834
90837
90853
96156
96158
96159
96164
96165
96167
96168

Appendix E
Copayments for Certain Services

A. General Copayment Information

The Division is implementing a tiered member co-payment scale as described in 42 CFR447.54 on all evaluation and management procedure codes (99202 - 99499) including the ophthalmological services procedure codes (92002 - 92014) used by physicians or physicians' assistants

The tiered copayment amounts are as follows:

State's payment for the service	Maximum copayment chargeable to recipient
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

The co-payment will be deducted from each evaluation and management procedure code billed unless the member is included in one of the exempted groups below.

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

1. Pregnant women
2. Nursing facility residents
3. Hospice care members
4. Members under 21 years of age
5. Women who have been screened for breast and cervical cancer under the Centers
6. Disease Control and Prevention breast and cervical cancer early detection
7. program established under title XV of the Public Health Service Act (42 U.S.C.
8. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42
9. U.S.C. 300n) and need treatment for breast or cervical cancer.) Categories of Service 245 and 800.

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

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

The provider may not deny services to any eligible Medicaid member because of the member's inability to pay the co-payment. The provider should check the Eligibility Certification (Medicaid card) each month in order to identify those individuals who may be responsible for the co-payment. The Eligibility Certification has been modified to include a co-payment column adjacent to the date-of-birth section. When "yes" appears in this column for a specified member, the member may be subject to the co-payment.

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

P	=	Pregnant
S	=	Nursing facility members
H	=	Hospice
E	=	Emergency services
FP	=	Family Planning

GAINWELL TECHNOLOGIES will automatically deduct the co-payment amount from the provider's payment for claims processed with dates of service July 1, 2005, and after. Do not deduct the copayment from your submitted charges. The application of the co-payment will be identified on the remittance advice. A new explanation of benefit (EOB) code will indicate payment has been reduced due to the application of co-payment.

Pharmacy Services

For copayments related to Pharmacy services, please refer to the Pharmacy manual which can be found on the GAMMIS web-portal at www.mmis.georgia.gov under the Provider Information, Provider Manuals tabs.

Appendix F
Gainwell Technologies Information

A. Member Information

Members should be instructed to call Gainwell for any member-related questions or concerns. Gainwell can be reached at 1-866-211-0950.

B. Provider Information

i. Providers should call Gainwell at 1-800-766-4456 for any provider issues or concerns and access the GABBY - Virtual Agent (formerly known as IVRS)

Please listen to the following prompts and select the appropriate option:

1. Member Eligibility and Service Limits
2. Claim Status
3. Payment Information
4. Provider Enrollment
5. Prior Authorization
6. Multi-Factor Authentication (MFA), Web-Portal Access
7. All Other Information

Pharmacy Benefits

Web portal

Nurse Aide

HIPPA 12

ii. For questions or concerns regarding the below topics, contact 1-877-261-8785:

1. Web Portal Password Resets
2. Provider Pin Activations
3. Electronic claim file submissions
4. Claim Rejects
5. Web Portal Navigation/Registration
6. Identifying and troubleshooting technical issues
7. Enrollment of trading partners

Appendix G
Statement of Participation

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

Written request for copies should be forwarded to:

GAINWELL TECHNOLOGIES

Provider Enrollment Unit

P. O. Box 88030
Atlanta, GA 30356

OR

Phone your request to:

1 (800) 766-4456

Choose option (#4)

Appendix H
National Provider Identifier (NPI) Requirements

A. NPI General Information

The National Provider Identifier (NPI) has been adopted by the U.S. Department of Health and Human Services to meet the HIPAA health care provider identification mandate. It is a 10-digit number assigned to health care providers. Once a provider has an NPI, it will not change regardless of job or location changes. It replaces all existing health care provider identifiers including numbers assigned by Medicare, Medicaid, Blue Cross, etc. on standard HIPAA transactions. It will be the number used to identify providers nationally

i. Who needs an NPI?

All Medicaid providers, both individuals and organizations, who are eligible to receive an NPI, are required to have an NPI. This includes the below:

1. All Medicaid healthcare providers and

2. All CMO healthcare providers.

The NPI will be required on electronic claims

Medicaid providers who are not eligible to receive an NPI will maintain their current Medicaid Provider ID. A table showing the types of Medicaid providers and whether they are required to get and use an NPI is included at the end of this Appendix.

ii. When do I need to use my (National Provider Identifier) NPI with Georgia Medicaid?
1. Applying to be a Medicaid Provider

2. On all electronic claim submissions including claims submitted via WINASAP.

iii. When do I need to use my Medicaid Provider Number?

You will need to use your Medicaid Provider Number in the following circumstances.

1. Paper claims submission (CMS 1500)

2. Resubmission of electronic claims on paper

3. Submission of web claims

4. IVR System inquiries

(a) Provider authentication

All claim inquiries

All other inquiries

5. Telephone inquiries

    (a) Provider authentication

        All claim inquiries

        All other inquiries

6. Prior authorizations

    (a) Requests

        Inquiries

7. Referrals

    (a) Request

        Inquiries

8. Medicaid forms

iv. When do I need both my NPI and my Medicaid Provider Number?

1. Adding a location to my Provider record
2. Changing my Provider information
3. Written inquiries and correspondence
4. E-mail and 'Contact Us' inquiries

Refer to the Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual for additional information about NPI requirements. The manual can be found on the GAMMIS web-portal at www.mmis.georgia.gov under the Provider Information, Provider Manuals tabs.

Appendix I
New 1500 CMS Claim Form

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/GAINWELL:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?)
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)." Removed the arrow and text in the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier." **FOR DCH/GAINWELL: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date)**.
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/GAINWELL:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/GAINWELL:** Remove the Health Check logic from field 19 and add it in **field 24H.**

Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. **(Do not bill ICD 10 code sets before October 1, 2015.)**
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. **FOR DCH/GAINWELL**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

Appendix J
General Information - Georgia Families, Georgia Families 360, Non-Emergency Medical Transportation

A. Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

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

ii. Georga Families 360 Overview:
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

iii. Non-Emergency Medical Transportation Overview:
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.asp