PART II

POLICIES AND PROCEDURES
for
DIALYSIS SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: October 1, 2025

TABLE OF CONTENTS

Policy Revision Record 3
Part II: Dialysis Services 4
Preface 4
Chapter 600: Special Conditions of Participation 5
601. Conditions of Participation 5
Chapter 700: Special Eligibility Conditions 6
701. Special Eligibility Conditions 6
Chapter 800: Prior Approval 7
801. Prior Approval 7
Chapter 900: Scope of Services 8
901. General 8
902. Coding of Claims 8
903. Service Limitations 12
904. Non-Covered Services 16
Chapter 1000: Basis For Reimbursement 18
1001. Reimbursement Methodology 18
Appendix A 19
Medical Assistance Eligibility Certification 19
Appendix B 20
Georgia Medicaid ESRD Enrollment Application 20
Appendix C 23
Claim Forms 23
Appendix D 24
Health Insurance Claim Form (CMS-1500) 24
Appendix E 25
UB-04 Claim Form 25
Appendix F 31
Renal Dialysis Setting Condition Codes 31
Appendix G 32
Tips for Submitting Medicare Crossover Claims 32
Appendix H 33
Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation (NEMT) 33
Appendix I 34
Dialysis Transportation - NEMT 34
Appendix J 35

National Correct Coding Initiative (NCCI) 35

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.)
10/1/2024	N/A	No changes were made for this quarter	N/A	N/A
07/01/2025	N/A	No changes were made for this quarter	N/A	N/A
04/01/2025	N/A	No changes were made for this quarter	N/A	N/A
01/01/2025		No changes were made for this quarter.	N/A	N/A
01/01/2025	N/A	No changes were made for this quarter.	N/A	N/A
10/1/2024	Appendix E, F, G	Deleted Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation (NEMT) Appendices	D	N/A
10/1/2024	Appendix H	Added comprehensive appendix which includes links to the websites providing information on Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation (NEMT) Appendices	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.

Part II: Dialysis Services
Preface

This manual contains basic information concerning the Dialysis Services Program and is intended for use by all participating providers and in conjunction with the Part I Policies and Procedures Manual for Medicaid and PeachCare for Kids. Part I of any DCH manual outlines the Statement of Participation for participating providers. Part II of any DCH manual is program specific and outlines the policies and procedures for that program as well as the terms and conditions for receipt of reimbursement.

We urge you and your office staff to familiarize yourself with the contents of Part I and Part II of the manual and refer to it when questions arise. Use of the manual will assist in the elimination of misunderstandings concerning program policies, coverage levels, eligibility, and billing procedures that can result in delays in payment, incorrect payment, or denial of payment.

Amendments to this manual will be necessary from time to time due to changes in federal and state laws and the Department of Community Health (DCH or the Department), Division of Medical Assistance (Division) policy. Manuals are updated and posted quarterly on the Gainwell Technologies (Gainwell) web portal at www.mmis.georgia.gov. Manuals will include any changes or amendments, if applicable, when such amendments are made. These postings shall constitute formal notification to providers of any changes or amendments. The amended or changed provisions will be effective on the date of the notice on the manual or as specified by the notice itself. All providers are responsible for complying with the amended manual provisions as of their effective dates.

Thank you for your interest and participation in Georgia's Medicaid/PeachCare for Kids program and the Dialysis Services Program. Your service is greatly appreciated.

Chapter 600: Special Conditions of Participation

601. Conditions of Participation

601.1. The Facility must be Medicare-certified to provide End Stage Renal Disease (ESRD) services.

601.2. Both hospital-based and non-hospital-based dialysis facilities must be enrolled in the Dialysis Services Program. The physician responsible for the provision of the professional component of dialysis services also must enroll in the Dialysis Services Program. ESRD dialysis services will not be reimbursed in the Hospital or Physician program of Medicaid.

601.3. The ESRD facility must furnish all necessary equipment, supplies and dialysis services.

601.4. Each facility must bill its usual and customary composite/treatment rate on the UB-04 claim form. The professional component must be billed under the physician's unique Dialysis Services Program provider number on the HCFA-1500 (CMS-1500) claim form.

601.5. The facility must notify the Division of any changes in the member's Medicare status or eligibility. The ESRD lock-in period will not be adjusted without such notification being made in writing.

601.6. Submit to the Provider Enrollment Unit a completed copy of the Disclosure of Ownership Form (CMS-1513) with the provider enrollment application.

601.7. For any provider billing outpatient laboratory procedures, agree to the rules regarding enrollment, Clinical Lab Improvement Act certification, reimbursement, and adhere to the policies in the Part II , Policies and Procedures for Laboratory Services and the Schedule of Maximum Allowable Payments for Clinical Laboratory and Anatomical Pathology Services.

Chapter 700: Special Eligibility Conditions

701. Special Eligibility Conditions

In addition to any eligibility conditions listed in Part I, Section 102, members receiving services under the Dialysis ESRD Program must have a diagnosis of chronic renal failure (end stage renal disease (ESRD). Coverage of eligible ESRD members is limited to:

701.1. Services provided by providers enrolled in the Dialysis Services Program;

701.2. Members enrolled in this program.

Chapter 800: Prior Approval

801. Prior Approval

The services covered in this Policy Manual do not require approval by the Division prior to the provision of such services. However, the Division may require prior approval of all, or certain procedures rendered in certain dialysis facilities based on the findings or recommendations of the Division, its authorized representatives or agents, the Secretary of the U.S. Department of Health and Human Services or the applicable State Examining Board. In such instances, the Division will serve written notice to the dialysis facility of this requirement and the grounds for such action.

Chapter 900: Scope of Services

901. General

Dialysis services include those services and procedures designed to promote and maintain the functioning of the kidney and related organs. Dialysis services are covered only when provided by an enrolled Dialysis Services provider.

902. Coding of Claims

All claims for dialysis services must be completed as instructed in Appendix D. Procedure codes are required on the CMS-1500 claim form and revenue codes with the procedure/HCPCS code are required on the UB-04 claim form. Appropriate diagnosis codes are required on each. Procedure codes and revenue codes assigned for the services are presented in Section 902.2 of this manual. Diagnosis codes are discussed in Section 902.1.

902.1. ICD-10-CM Diagnosis Coding

The diagnosis coding scheme accepted by the Division for diagnosis for dates of service on or before September 30, 2015 is the ICD-9-CM (International Classification of Diseases -9th Edition) and for dates of service October 1, 2015 and after is the ICD-10-CM (International Classification of Diseases – 10th Edition. Codes deleted from previous editions of the ICD-9 are not accepted by the Division. The ICD-9-CM coding scheme consists of three volumes. Only Volumes I and II are needed. Further, the special categories of codes which begin with alphabetic characters “E” (E800 - E999) and “M” (M800 M9970/1) are not accepted by the Division. The remaining special category of codes which begin with “V” are acceptable only if the “V” codes describe the primary diagnosis. The principal diagnosis for claims submitted through the dialysis program must be chronic renal failure (end stage renal disease ESRD). (Rev. 07/14/2014)

Copies of the ICD-10-CM codebook are available for purchase from the following organization:

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

ICD-10-CM codebooks are available for purchase from various organizations. There are a number of industry resources available for a fee.

902.2. Procedure and Revenue Codes

Only the Procedure and Revenue Codes listed in this section can be used to bill for dialysis services for Medicaid primary members. No other codes will be accepted. Please see Appendix D for specific billing instructions.

End Stage Renal Disease (ESRD) is defined as irreversible and permanent damage to the kidneys that requires either a regular course of dialysis treatment or kidney transplantation to maintain life.

902.3. Codes for Professional Services:

Code	Description
90951	End Stage Renal Disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to- face physician visits per month
90954	End Stage Renal Disease (ESRD) related services monthly, for patients two (2) - eleven (11) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to-face physician visits per month
- 90955	End Stage Renal Disease (ESRD) related services monthly, for patients two (2) -eleven (11) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with two (2) or three (3) face-to-face physician visits per month
90956	End Stage Renal Disease (ESRD) related services monthly, for patients two (2) - eleven (11) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with one (1) face-to-face physician visit per month
90957	End Stage Renal Disease (ESRD) related services monthly, for patients twelve (12) - nineteen (19) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to-face physician visits per month
90958	End Stage Renal Disease (ESRD) related services monthly, for patients twelve (12) - nineteen (19) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with two (2) -three (3) face-to-face physician visits per month.
90959	End Stage Renal Disease (ESRD) related services monthly, for patients twelve (12) - nineteen (19) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.
90960	End Stage Renal Disease (ESRD) related services monthly, for patients twenty (20) years of age and older, with four (4) or more face-to-face physician visits per month.
90961	End Stage Renal Disease (ESRD) related services monthly, for patients twenty (20) years of age and older, with two (2) - three (3) face-to-face physician visits per month.
90962	End Stage Renal Disease (ESRD) related services monthly, for patients twenty (20) years of age and older, with one (1) face-to-face physician visit per month.

902.4. Home Dialysis Patients:

Code	Description
90963	End Stage Renal Disease (ESRD) related services for home dialysis per full month, for patients younger than two (2) years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.
90964	End Stage Renal Disease (ESRD) related services for home dialysis per full month, for patients two (2) -eleven (11) years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.
90965	End Stage Renal Disease (ESRD) related services for home dialysis per full month; for patients twelve (12) - nineteen (19) years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.
90966	End Stage Renal Disease (ESRD) related services for home dialysis per full month, for patients twenty (20) years of age and older.

902.5. Codes for Professional Services (less than full month):

Code	Description
90967	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients younger than two (2) years of age
90968	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients two (2) - eleven (11) years of age
90969	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients twelve (12) - nineteen (19) years of age
90970	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients twenty (20) years of age and older.

902.6. Training Codes:

Code	Description
90989	Dialysis training, patient, including helper where applicable, any mode, completed course
90993	Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session

902.7. Facility Revenue Codes:

Code	Description
821	Hemodialysis/Composite/Treatment Rate
831	Peritoneal Dialysis/Composite/Treatment Rate
259	Injectable Drugs
634	Injectable Drugs
635	Injectable Drugs
636	Injectable Drugs

902.8. Facility Procedure Codes:

Code	Description
90999	Hemodialysis
90945	Home Dialysis

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

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

For the CMS-1500 claim form:
Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK, Referring = DN or Supervising = DQ).

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

For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the

provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

903. Service Limitations

The procedures in Section 902.2 are covered with the limitations described below. Documentation may be requested in prepayment or post-payment review, and lack of appropriate medical justification or documentation may be grounds for denial, reduction, or recoupment of reimbursement.

903.1. Services Included in the Facility Composite/Treatment Rate

Services included in the facility composite/treatment rate and professional monthly capitation payment are not separately reimbursable. The composite/treatment rate includes technical services, routine laboratory work, and cost of supplies and equipment as outlined in the sections below. All facility and professional charges are reimbursed at an all-inclusive rate for all modes of dialysis treatment. These services include but are not limited to:

903.1.1. IV fluids and supplies;

903.1.2. Drugs administered into dialysis delivery systems;

903.1.3. Oral medications;

903.1.4. Injections - including but not limited to: B-12, liver, steroids, antiarrythmics, heparin, protamics, mannitol, saline, pressor drugs, glucose, dextrose, antihistamines, antihypertensives, vitamins.

903.1.5. All hospital, emergency room, office or home visits and consults.

903.1.6. Specimen collection fee;

903.1.7. Blood Pressure Apparatus and Weight Scales;

903.1.8. Insertion or removal of catheters, shunt declotting;

903.1.9. ESRD services that are provided to dialysis patients by a non-Medicare certified facility; and

903.1.10. Laboratory tests listed in Section 903.2.

903.2. Laboratory Tests Included in Dialysis Composite/Treatment Rate

903.2.1. The procedures listed below are included in the facility's composite/treatment rate and are not separately reimbursable.

Procedure Code	Laboratory Test	Procedure Code	Laboratory Test
82040	Albumin, Serum	84295	Sodium, Serum

82042	Albumin, Urine	84300	Sodium, Urine
82247	Bilirubin, Total	84450	SGOT
82248	Bilirubin, Direct	84460	SGPT
82310	Calcium, Serum	84520	BUN
Procedure Code	Laboratory Test	Procedure Code	Laboratory Test
82340	Calcium, Urine		
82374	CO2 Combining Power	84550	Uric Acid, Blood
82435	Chloride, Blood	84560	Uric Acid, Blood
82436	Chloride, Urine	85014	Hct.
82540	Creatine, Blood	85018	Hgb.
82565	Creatinine, Blood		
82575	Creatinine Clearance	85025	CBC
82947	Glucose, Serum		
83615	LDH, Blood	85027	Hgm. with platelet count
83735	Mag., Serum Chemical	85041	RBC
84075	Alk. Phosphatase	85048	WBC
84100	Phosphorus (Phosphate), Serum	85610	Prothrombin Time
84132	Potassium, Serum		
85014	Hct		
84133	Potassium, Urine		
84105	Phosphorus (Phosphate), Urine		
84155	Total Protein, Serum		

903.2.2. The composite/treatment rate includes any other laboratory code(s) with similar descriptions and panels of laboratory tests (multiple test panels that contain routine lab tests).

903.3. Ancillary Services Rendered

The following procedures and services listed below in a, b, and c are recognized as medically necessary and are not included in the facility composite/treatment rate or physician professional monthly capitation payment (MCP).

903.3.1. Separately Billable Laboratory Tests for Dialysis Patients

Any laboratory tests not listed in Section 903.2 and not actually performed by the dialysis facility must be billed by the outside testing facility, e.g., independent laboratory or hospital laboratory.

The following are covered procedures that may be billed separately and are not included in the monthly composite/treatment rate:

903.3.1.1. Hepatitis B Surface Antigen (HBsAg) or testing for (sero-negative) patients (including those who have received Hepatitis B Vaccine and still have a negative response) is limited to one test procedure (87340) per

month;

903.3.1.2. Either Hepatitis B Surface Antibody or Hepatitis B Core Antibody testing is limited to one test procedure per year. Procedures included are: 86704, 86705, 86706, and 87350.Out of these procedure codes, only one will be reimbursed per calendar year.

903.3.1.3. Serum Aluminum - one every 3 months: 82108;

903.3.1.4. Serum Ferritin - one every 3 months: 82728;

903.3.1.5. If the procedures are performed at a frequency greater than that specified above, they are covered only if accompanied by medical documentation. For reimbursement of procedure codes performed outside of the frequency, the provider must submit a DMA-520A to Alliant Health Solutions (AHS) - Medical Review Unit via the Provider Workspace on the GAMMIS Web portal, www.mmis.georgia.gov, under the link Prior Authorization/Provider Workspace/Provider Inquiry Form. a copy of the remittance advice notice with the denied service, a completed CMS-1500 claim form, and documentation from the ordering provider of the medical necessity to support the need for the tests. This documentation must include information other than the physician's order and medical diagnosis of the member. The diagnosis code indicating ESRD alone is not sufficient. (Rev. 10/2018)

903.4. Separately Billable Medical Procedures for Dialysis Services

903.4.1. Bone Survey - one per year: 78300 - 78306;

903.4.2. Nerve Conduction Velocity test (NCV) - one every three months: 95907 - 95909.

903.4.3. Chest X-Ray - one every six months: 71045, 71046, 71048;

903.4.4. Bone Mineral density - one every 6 months: 77074, 77075. (rev. 01/2018)

903.5. Separately Billable Drugs for Dialysis Patients

The injectable drugs listed below are separately billable for dialysis patients. These drugs are contained in the Provider Administered Drug List (PADL) and may be billed by the Dialysis facilities. Details for billing are presented in Appendix D.

903.5.1. Antibiotics

903.5.2. Hematinic

903.5.3. Anabolic

903.5.4. Muscle relaxants

903.5.5. Analgesics

903.5.6. Sedatives

903.5.7. Tranquilizers

903.5.8. Billable covered oral medications must be obtained by the patient through the Medicaid Pharmacy Program and are subject to Pharmacy Program limitations.

903.6. Home Dialysis

The Social Security Administration does not require a delay period for home dialysis services; therefore, Medicare will reimburse from the initiation of services. As a result, Medicaid will not reimburse for home dialysis if an application submitted to Medicare is still pending or if the member is Medicare covered. If the patient is denied Medicare benefits, Medicaid will reimburse retroactively.

Home dialysis services for Medicaid-only patients will be reimbursed at the same facility and professional services rate paid for in-center dialysis services. See Section 903.1 for a list of services included in the reimbursement fee.

903.7. Professional Services

Professional services are defined as monthly supervision of medical care, dietetic services, social services and procedures directly related to ESRD. The rate of reimbursement is the same for all patients regardless of mode of treatment or location.

The Monthly Capitation Payment (MCP) for professional services cannot be billed in the same month as Professional Training codes (90989 - 90993). Care provided to patients in acute renal failure is not a part of this program and must be billed through the Medicaid Physician Program according to the Physician Policies and Procedures manual.

903.8. Dialysis Training

The Division will reimburse only one unit of service for hemodialysis (90989) training or peritoneal dialysis training during a lifetime. The monthly capitation payment will not be allowed for the month in which the training code is billed. The MCP is included in the training reimbursement for that month. The training is to be billed in the month of completion only.

Retraining for hemodialysis is limited to fifteen sessions per lifetime. Retraining for peritoneal dialysis may be billed under code 90993. It is also limited to fifteen sessions per lifetime. Each day of retraining will be reimbursed up to the current maximum allowable rate. Professional services (MCP) will be billed using the appropriate CPT-4 procedure code for per day and will be reimbursed up to the maximum allowable rate.

903.9. Kidney Transplant

Kidney transplant services are not covered in the Dialysis Services Program. They are covered under the Hospital and Physician Services Programs. Please see the appropriate policy manual for details.

903.10. Medicare Coverage

Medicare is the primary payor for ESRD with Medicaid as a secondary payor. Medicaid will reimburse as primary for the ninety (90) day waiting period required for Medicare eligibility (other than home dialysis) or if the individual has been denied Medicare coverage. In order for reimbursement to occur during the ninety (90) day waiting period, the facility must submit an ESRD Enrollment Application (DMA-615) to, P.O. 105200, Tucker, Georgia 30085-5200. Please refer to Appendix C for further instructions regarding completion of the ESRD Enrollment Application (DMA-615). Reimbursement will not be made after 90 days of treatment if a Medicare determination is still pending. Reimbursement made on behalf of members later determined to be retroactively eligible for Medicare will be recouped and both professional and technical fees must be billed to Medicare.

Please refer to Part I, Policies and Procedures for Medicaid/PeachCare for Kids for more details regarding reimbursement for Medicare co-insurance and deductible crossover claims.

903.11. Telemedicine

The Centers for Medicaid and Medicare Services (CMS) has added Dialysis Services to the list of services that can be provided under Telehealth. (Rev.04/2020)

903.11.1. The originating facility/site (Dialysis Facility) will bill with the revenue code and procedure codes listed below.

Revenue Code	Description	Procedure Code	Modifier
780	Telemedicine, General Classification	Q3014	GT

903.11.2. The distant site/physician providing the service via a telecommunications system will bill using Place of Service 02 to indicate Telehealth. For a list of the procedure codes used for Telemedicine services please refer to the Telemedicine Guidance manual on the GAMMIS web portal at www.mmis.georgia.gov.

903.11.3. The term “distant site” means the site where the physician or practitioner providing the professional service, is located at the time the service is provided via a telecommunications system.

903.11.4. Please refer to the Telemedicine Guidance manual for specific information regarding services, coverage, and limitations for Telemedicine Services. Paper copies of the manual may be obtained from the Division’s fiscal agent by contacting Gainwell Technologies at 1 (800) 766-4456.

904. Non-Covered Services

The services listed below are non-covered under this program. This list is representative of non-covered services and is not meant to be exhaustive.

904.1. Services not listed as separately billable in this manual. (Rev. 04/2024)

904.2. Experimental services or procedures or those which are not recognized by the profession, the Division, or the United States Public Health Service as universally accepted treatment. (Rev. 04/2016)

904.3. Services provided to members not enrolled in this program; and

904.4. Services provided to members enrolled in a CMO plan.

Chapter 1000: Basis For Reimbursement

1001. Reimbursement Methodology

The Division will pay the lower of the submitted charge or the statewide facility treatment rate or the statewide Monthly Capitation Payment for the services rendered. The treatment rate includes payment for the maintenance, supplies and equipment required to provide ESRD services to eligible Medicaid members. This rate is comprehensive and applies to all modes of in-facility and home dialysis services. The statewide monthly capitation includes payment for monthly supervision of medical care, dietetic services, social services and procedures directly related to ESRD provided to eligible Medicaid members. The rate of reimbursement is the same for all patients regardless of mode of treatment or location.

1001.1. Technical Component Billing

Reimbursement for the technical component will be made to the enrolled dialysis facility under the appropriate assigned provider number for the location where services were rendered. The facility must bill the Division for the technical services using the UB-04 claim form. Detailed instructions for the completion of the UB-04 are contained in Appendix D.

1001.2. Professional Component Billing

The professional component must be billed under the physician's unique dialysis provider number on the CMS-1500 Claim form. Detailed instructions for the completion of the CMS-1500 claim form are contained in Appendix D.

1001.3. Co-Payment

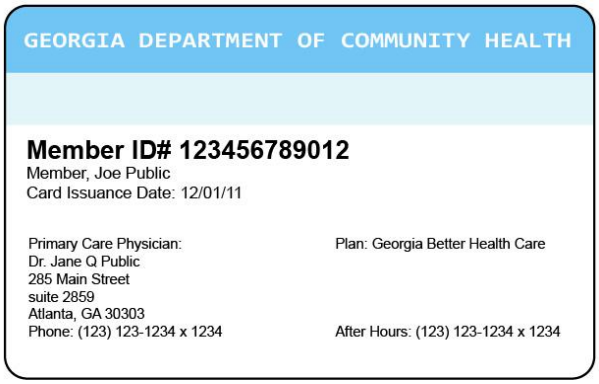
Patients receiving ESRD services are not subjected to co-payment.

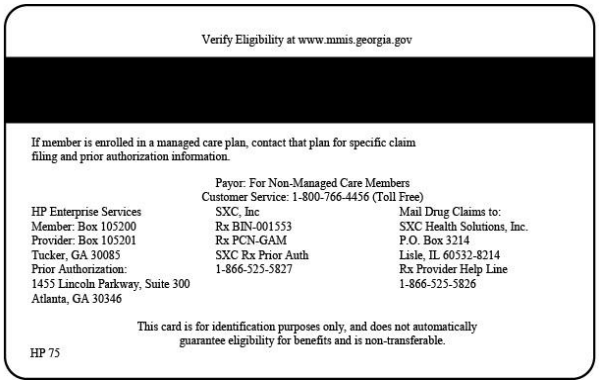
1001.4. CMO

The Division will not make direct reimbursement to a dialysis facility for members enrolled in a CMO plan.

Appendix A
Medical Assistance Eligibility Certification

A. Medical Assistance Eligibility Certification Card





Appendix B
Georgia Medicaid ESRD Enrollment Application

A. Georgia Medicaid ESRD Enrollment Application

STATE OF GEORGIA
DIVISION OF Medicaid
GEORGIA MEDICAID ESRD ENROLLMENT APPLICATION

PART I – PATIENT INFORMATION			
Name:	Date of Birth: / /	Social Security No.: ☐☐☐-☐☐-☐☐☐☐	
Address:	Medicaid ID NO.:	Medicare Eligible: Yes☐ No☐	
Medicare Application Submitted: Yes ☐ No ☐			
County:	Medicare No.:	Effective Date:	Medicare Denied: Yes ☐ No ☐
Reason for Denial			
DOCUMENTATION SHOWING MEDICARE DENIAL MUST BE ATTACHED TO THIS FORM			
PART II – TREATMENT INFORMATION - DIALYSIS			
Date of First Treatment:	Transplant Candidate: Yes ☐ No ☐	Place of Dialysis: Home ☐ Clinic ☐	
Name of Facility Transferred from:			
Mode of Treatment: HEMODIALYSIS ☐ PERITONEAL DIALYSIS ☐ SELF DIALYSIS ☐			
PART III – TO BE COMPLETE BY PATIENT			
I have elected to receive dialysis services provided by the facility shown on this application			
Patient Signature	Date		
PART IV – PROVIDER INFORMATION			
Clinic Name: Provider Number:			
Physician's Name:	Physician's Provider Number:		
Form Completed by:			
Name: Telephone No.:			

Mail this form to:
Gainwell Technologies
P.O. Box 105200
Tucker, GA. 30085-5200

DMA 615 Rev. (04/2021)

This section provides specific instructions for completing the Georgia Medicaid ESRD Enrollment Application (DMA-615 Rev. 02/21). A sample form is included for your reference.

i. Item 1 Member's Name
Enter the name exactly as listed on the Medicaid Eligibility Card (last name first).

ii. Item 2 Member's Date of Birth
Enter the date of birth as month, day and year (April 15, 1994, would be listed as 04/15/94).

iii. Item 3 Member's Social Security Number
Enter the Member's Social Security number exactly as it appears on the Social Security Card.

iv. Item 4 Member's Address
Enter the street number, street name, post office box, county, state and zip code.

v. Item 5 Member's Medicaid I.D. No.
Enter the Member I.D. Number exactly as it appears on the Medicaid Eligibility Card.

vi. Item 6 Medicare Eligibility
Enter "yes" if member is Medicare eligible.

vii. Item 7 Medicare Application Submitted
Enter the date that the Medicare application was mailed.

viii. Item 8 Medicare Number
Enter the Member's Medicare Number exactly as it appears on the Social Security Card.

ix. Item 9 Effective Date
Enter the effective date of the Member's Medicare coverage.

x. Item 10 Medicare Denied
Check appropriate block indicating "Yes or No".

xi. Item 11 Reason for Denial
Enter the reason for the Medicare denial.

xii. Item 12 Date of First Treatment
Enter the date that the member was first treated in the dialysis facility.

xiii. Item 13 Transplant Candidate
Check the appropriate box indicating "Yes or No".

xiv. Item 14 Place of Dialysis
Check the appropriate block indicating the place of dialysis.

xv. Item 15 Name of Facility Transferred From
Enter the name of the facility the member was transferred from.

xvi. Item 16 Mode of Treatment
Enter the appropriate mode of treatment.

xvii. Item 17 Clinic Name
Enter the facility providing treatment.

xviii. Item 18 Provider Number
Enter the facility's Medicaid provider number.

xix. Item 19 Physician's Name and Provider Number
Enter the primary treating physicians name and Medicaid provider number on the first line. Add any additional physician's names and Medicaid provider numbers that belong to the same physician group and rotate at this facility.

xx. Item 20 Form Completed By
Enter the name of the person completing this form.

xxi. Item 21 Telephone Number
Enter the telephone number (including Area Code) of the person completing the form.

xxii. Item 22 Title
Enter the title of the person completing the form.

xxiii. Item 23 Date
Enter the date the form is completed.

NOTE: Part III requires that the member sign the ESRD Enrollment Application. This form *must* be signed to be a valid application. "Signature On File" is *not* acceptable.

You *must* attach to the Enrollment Form a copy of the Medicare Application Form (HCFA/CMS 2728) *or* show proof of Medicare denial for coverage *or* attach a copy of Medicare eligibility card with effective dates.

You must have proof of Medicare denial to extend enrollment beyond 90 days.

You must notify the DMA of clinic transfer or change of physician.

Mail to: Gainwell Technologies P. O. BOX 105200 Tucker, GA 30085-5200

Appendix C
Claim Forms

A. Claim Forms

Claims must be filed on the required form with appropriate information in specific blocks for payment. Claim forms for dialysis services are:

i. Health Insurance Claim Form (CMS-1500) version dated 02/12

1. Claim (s) must be submitted within six (6) months from the month of service.

2. Claim (s) with third party resource (s) must be submitted within twelve (12) months from the month of service.

ii. Medicaid-Medicare Crossover (CMS –1500) version dated 02/12

1. A special crossover claim form is no longer required when billing Medicaid/Medicare crossover. Claims must be submitted in the same format as they are submitted to Medicare. This claim must have an Explanation of Medicare Benefits (EOMB) from Medicare for Medicaid payment.

iii. Claim (s) must be submitted within twelve (12) months from the month of service.

iv. National Uniform Billing Form (UB-04)

1. Claim (s) must be submitted within six (6) months from the month of service.

2. Claim (s) with third party resource (s) must be submitted within twelve (12) months from the month of service.

v. Medicaid-Medicare Crossover (UB-04)

A special crossover claim form is no longer required when billing Medicaid/Medicare crossover. Claims must be submitted in the same format as they are submitted to Medicare. This claim must have an Explanation of Medicare Benefits (EOMB) from Medicare for Medicaid payment.

1. Claim (s) must be submitted within twelve (12) months from the month of service.

Appendix D
Health Insurance Claim Form (CMS-1500)

A. Health Insurance Claim Form (CMS-1500)



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 TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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

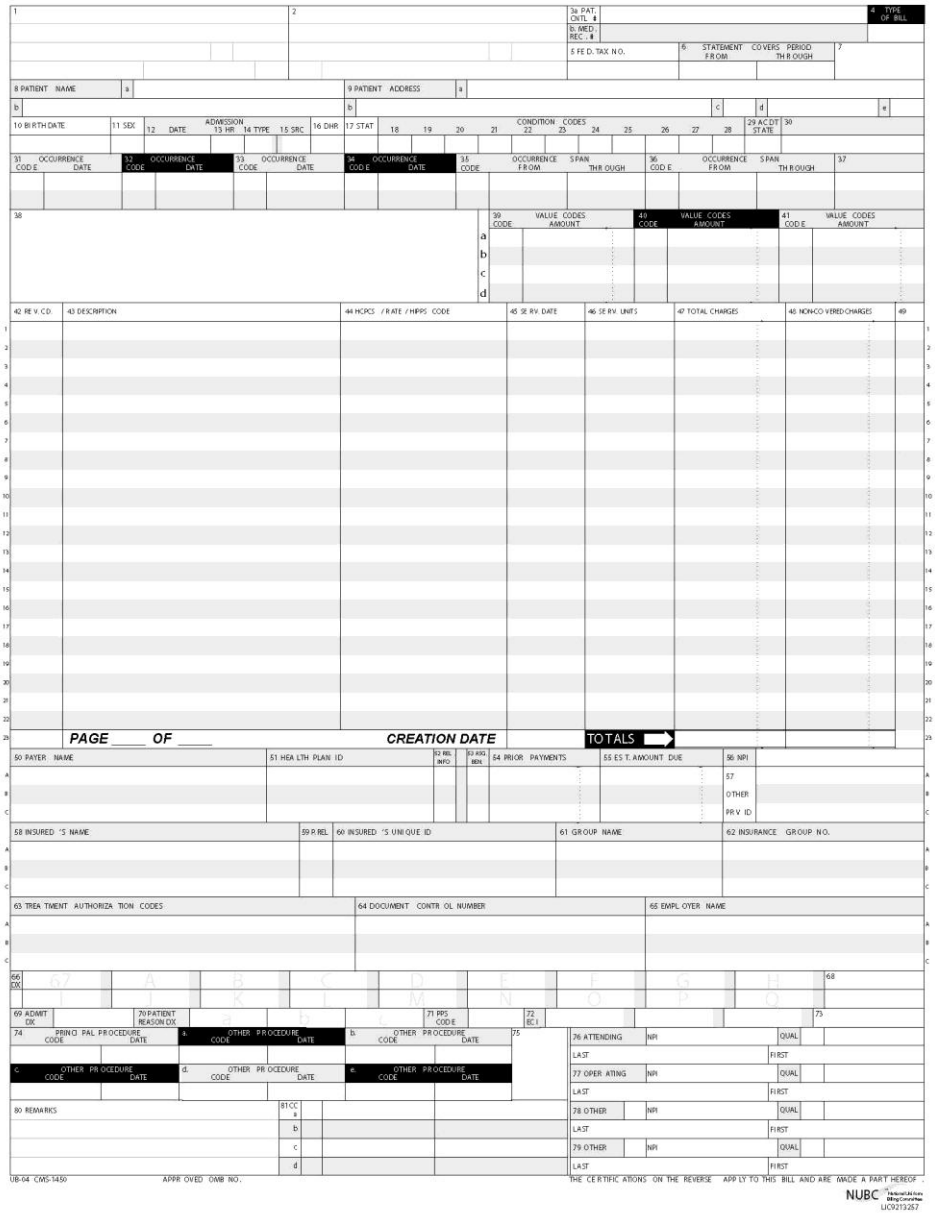
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Appendix E
UB-04 Claim Form

A. UB-04 Claim Form



Note: Form Locators (FL) is not required by Georgia DMA are not included in these instructions.

i. FL1 Provider Name, Mailing Address, and Telephone Number
Enter the name of the provider submitting the bill, the complete mailing address, and telephone number.

ii. FL 2 Pay-to Name, address, and Secondary Identification Fields Situational

iii. FL 3a Patient Control Number
Enter the patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual case records and posting of payment.

iv. FL 3b Medical Record Number

v. Enter the number assigned to the patient's medical/health record by the provider.

NOTE: The medical/health record number is typically used in auditing the history of Treatment and can expedite the processing of claims when medical records are required. It should not be submitted for the Patient Control Number (FL3), which is assigned by the provider to facilitate retrieval of the individual financial record.

vi. FL 4 Type of Bill
Should be 72X

vii. FL 5 Federal Tax Number

viii. FL 6 Statement Covers Period
Enter the beginning and ending service date(s) of the period included on this bill.

NOTE: Monthly Technical Capitation Billing
If you are billing for the full capitation fee, the dates of service will be the first day of the month and the last day of the month.
If the patient was not under your care for the full month, you must bill only for the portion of the month the patient was under your care.

ix. FL 8 Patient Name
Enter last name, first name, and middle initial of the patient. If the name on the Medicaid card is incorrect, the member or the member's representative should contact the local DFCS to have it corrected immediately.

x. FL 9 Patient Address
Enter the full mailing address including street number and name or post office box number or RFD, city name: state name; zip code.

xi. FL 10 Patient Birthdate
Enter date of birth exactly as it appears on the Medicaid card. An unknown birthdate is not acceptable. If the date on the Medicaid card is incorrect, the member or the member's representative should contact the DFACS to have it corrected immediately.

xii. FL 11 Patient Sex
Enter the sex of the patient as "M" for male or "F" for female. If the sex on the Medicaid card is incorrect, the member or the member's representative should contact the DFCS to have it

corrected immediately.

xiii. FL 18 - Condition Codes
Thru 28 The condition codes for dialysis services must be 71 through 76.

xiv. FL 42 Revenue Code
Enter the appropriate Revenue Code. Refer to the Uniform Billing Manual for a listing of revenue codes.

xv. The last revenue code on each UB-04 should be 001 for the total submitted charges.

xvi. FL 43 Revenue Description
Enter a narrative description of the related revenue categories included on this bill. Abbreviations may be used. (Rev. 10/2015)

NOTE: When billing injectable drugs on a UB04, the 11 digit NDC (National Drug Code) for the actual administered drug must be billed in Field Locator 43. Enter the 2 digit qualifier "N4" as a prefix to the 11 digit NDC number. Example: N455513028310. The associated code must be entered into Field Locator 44.

For Medicaid-Medicare Crossover Claims: When billing injectable drugs on a UB04, the 11-digit NDC (National Drug Code) for the actual administered drug must be billed along with revenue code 636, 634, or 635. Enter the 2-digit qualifier "N4" as a prefix to the 11 digit NDC number. Example: N455513028310. The associated code must be entered into Field Locator 44.

NOTE: Currently, Venofer® NDC- 11s are marketed under two separate and specific labeler codes. The terms and license agreements, approved by the Federal Trade Commission, limits their marketing use to specific indications and distributors. Reimbursement for end stage renal dialysis use will require free-standing dialysis entities to submit the accurate and appropriate NDC code. The Department reserves the right to recoup all monies reimbursed for inaccurate and inappropriately submitted NDC codes.

xvii. FL 44 CPT/HCPCS/Rates
Enter the CPT/HCFA Common Procedure Coding System (HCPCS) code to describe ancillary services.

NOTE: All claims billing for hemodialysis sessions must report a Healthcare Common Procedure Code (HCPCS) code of 90999 (unlisted dialysis procedure, inpatient or outpatient) when billing revenue code 821. (Rev. 10/2015)

All claims billing for home dialysis sessions must report a Healthcare Common Procedure Code of 90945 (dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) with single physician evaluation) when billing revenue code 831.

NOTE: When billing using an electronic format (EDI, Web) the appropriate CPT/HCPCS code for the actual administered drug must be entered in FL 44. The NDC code for the actual administered drug must be billed in the field specified for the NDC. This applies to Medicaid primary and Medicaid-Medicare Crossover claims.

xviii. FL.45 Service Date
Enter the actual date the service was provided if a span of dates is billed, the actual date the service was provided must be entered adjacent to the appropriate revenue code (s).

NOTE: When billing for drugs given on multiple dates, please bill a separate line for each date of service and the appropriate amount of units.

NOTE: Effective April 1, 2007, Dialysis Facilities will be required to line-item bill. All ESRD claims with dates of service on or after April 1, 2007, are required to bill all services with line-item date of service detail, excluding epoetin alfa (EPO).

xix. Effective April 1, 2011, Dialysis Facilities will be required to line item bill all services with line-item date of service detail.

FL 46 Units of Service
Enter the units of service or number of days associated with Revenue Codes in FL42

xx. FL 47 Total Charges (by Revenue Category)
Enter the total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period. Only charges relating to the covered eligibility dates should be included in the total charges. The figures in this field add up to a total which is reported in this FL using revenue code 001.

NOTE: Lines A, B, and C are used for FL 50 through 66 to indicate primary (A), secondary (B) and tertiary (c) payers. For example: If Medicaid is the primary payer listed on line A of FL 50, Medicaid information must be listed on line A through FL 66.

The "PAGE ____ OF ____" and CREATION DATE on line 23 should be reported on all pages of the UB-04.

xxi. FL 50 Payer
A, B, C Enter payer name and carrier code of any liable third-party payer other than Medicare. (*Carrier codes are in the Third-Party Insurance Carrier listing). A reasonable effort must be made to collect all benefits from other third-party coverage. Federal regulations require that Medicaid be the payer of last resort. (See Chapter 300 of the Policies and Procedures Manual applicable to all Medicaid providers.)

When a liable third-party carrier is identified on the card, the provider must bill the third party.

xxii. FL 51 Health Plan ID
A, B, C
Report the national health plan identifier when one is established; otherwise report the "number" Medicare has assigned.

xxiii. FL 54 Prior Payments
A, B, C Enter the amount that the dialysis facility has received toward payment of this bill from the carrier.

xxiv. FL 56 National Provider ID (NPI)

xxv. FL 57 Other Provider ID (primary, secondary, and/or tertiary)
Report other provider identifiers as assigned by a health plan (as indicated in

FL50 lines 1-3) prior to May 23, 2007

xxvi. FL 58 Insured's Name
A, B, C Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the Medicaid card. If the name on the Medicaid card is incorrect, the member or the member's representative should contact the local DFCS to have it corrected immediately.

xxvii. FL 60 Certification/SSN/HIC/ID No.
A, B, C Enter the Medicaid Member Client Number exactly as it appears on the Medicaid card.

xxviii. FL 61 Insured Group Name
A, B, C Enter the name of the group or plan through which the insurance is provided to the insured. Medicaid requires the primary payer information on the primary payer line when Medicaid is secondary.

xxix. FL 62 Insurance Group Numbers
A, B, C Enter the identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.

xxx. FL 63 Treatment Authorization Code (Precertification)
A, B, C A number or other indicator which designates that the treatment covered by this bill has been authorized by the DMA. Enter the twelve (12) digit authorization number as required for inpatient hospital admissions and selected outpatient procedures, if applicable.

xxxi. FL 64 Document Control Number (DCN)
The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.

xxxii. FL 65 Employer Name
A, B, C Enter employer name that might or does provide health care coverage for the individual in FL 58.

xxxiii. FL 66 Diagnosis and Procedure code qualifier (ICD Version Indicator)
The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The qualifier 9 indicates Ninth Revision and the qualifier 10 indicates Tenth Revision.

xxxiv. FL 67 Principle Diagnosis Code
Enter the ICD-9-CM code for the principal diagnosis for dates of service on or before September 1, 2015. Enter the ICD-10-CM code for the principal diagnosis for dates of service on or after October 1, 2015.

Codes prefixed in 'E' or 'M' are not accepted by the Department. A limited number of 'V' codes are accepted.

(The principle diagnosis for dialysis claims must be chronic renal failure (end stage renal disease ESRD).

xxxv. FL 67A- Other Diagnosis Codes
Thru 67Q Enter the ICD-9-CM diagnosis codes for dates of service on or before September 30, 2015, and the ICD-10-CM diagnosis codes for dates of service on or after October 1, 2015, corresponding to additional conditions that co-exist at the time of admission/service, or develop subsequently, and which have an effect on the treatment received or the length of stay.

Codes prefixed in ‘E’ or ‘M’ are not accepted by the Department. A limited number of ‘V’ codes are accepted.

xxxvi. FL 69 Admitting Diagnosis
Enter the ICD-9-CM diagnosis code for dates of service on or before September 30, 2015, and ICD-10-CM diagnosis code for dates of service on or after October 1, 2015, provided at the time of admission/service as stated by the physician.

xxxvii. FL 76 Attending Provider Name and Identifiers (including NPI)
Enter the NPI /QUAL/ID and name of the physician attending the patient. This is the physician primarily responsible for the care of the patient.

Appendix F
Renal Dialysis Setting Condition Codes

A. Renal Dialysis Setting Condition Codes

i. 71 Full Care in Unit - Code indicates the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.

ii. 72 Self-Care in Unit - Code indicates the billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.

iii. 73 Self-Care Training - Code indicates the billing is for special dialysis services where a patient and his helper (if necessary) were learning to perform dialysis.

iv. 74 Home - Code indicates the billing is for a patient who received dialysis services at home, but where code 75 below does not apply.

v. 75 Home – 100% Reimbursement - Code indicates the billing is for a patient who received dialysis services at home, using a dialysis machine that was purchased by Medicare under the 100 percent program.

vi. 76 Back-up in Facility Dialysis - Code indicates the billing is for a home dialysis patient who received back up.

Appendix G
Tips for Submitting Medicare Crossover Claims

A. Tips for submitting Medicare Crossover Claims – UB-04

i. Enter valid data in all required fields on the claim form as if billing a Medicare Primary claim.

ii. In field 50, enter name of all payers in this order:

iii. Primary Payer

iv. Secondary Payer

v. Tertiary Payer

vi. In field 51, enter the provider number used to bill each payer, see above for order.

vii. In field 54, enter the amounts actually paid by each payer prior to billing Medicaid.

viii. In field 55, enter the amount that you estimate is due from Medicaid. That amount should equal any patient liability listed on the RA/EOB.

ix. In fields 58-66, enter valid data as it relates to each payer as listed in field 50.

x. Attach the Medicare EOB to the claim form.

NOTE: Please refer to the Medicaid Secondary Claims User Guide for additional information regarding submission of secondary claims (Rev. 10/2015):

https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/Medicaid%20Secondary%20Claims%20User%20Guide_July%2020240621135524.pdf

Appendix H
Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation (NEMT)

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

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

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

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

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

Appendix I
Dialysis Transportation - NEMT

A. Dialysis Transportation

Non-Emergency Medical Transportation services are defined as medically necessary transportation for eligible Medicaid members (and escort, if required) who have no other means of transportation available to any Medicaid-reimbursable service for the purposes of receiving treatment, medical evaluation, obtaining prescription drugs or medical equipment**. It is the responsibility of NEMT providers to provide transportation only.**

i. NEMT Driver and/or Attendant Responsibilities:

ii. NEMT drivers and attendants are not required to assist the members beyond the scope of NEMT policy guidelines.

iii. NEMT drivers and/or attendants are not medical personnel and do not provide any direct medical services to the members at the dialysis facility.

iv. NEMT drivers and/or attendants are only responsible for transporting members within the NEMT guidelines which include:

1. Safely transporting the members to and from their designated locations.

2. Adhering to NEMT policies and procedures.

3. No driver and/or attendant shall touch any passenger except as appropriate and necessary to assist the passenger into or out of the vehicle, into a seat on the vehicle and to secure the seatbelt, or as necessary to render first aid or assistance in case of an emergency.

4. Transporting the members to and from their designated locations with the appropriate mobility as described below:

(a) Ambulatory – Curb to Curb (Member can walk to and from the vehicle without assistance). If a member with ambulatory mobility needs special assistance, the member's escort or facility staff is responsible for providing the member with the needed assistance upon arrival.

(b) Wheelchair – Door to Door (No lift assistance provided for member to the dialysis chair by the NEMT provider)

(c) Stretcher – Bed to bed/treatment chair. The facility must have a bed/treatment chair ready for the Member to offload immediately upon arrival. A letter of medical necessity must be included with all stretcher mobility standing order requests.

v. Dialysis Facility Responsibilities:

1. Upon arrival at the dialysis facility, the dialysis health care team assumes responsibility for the member's care.

2. This includes weighing the member, transferring the member to the dialysis chair, and any other duties outside of the scope of NEMT services.

Appendix J
National Correct Coding Initiative (NCCI)

A. National Correct Coding Initiative (NCCI)

The Centers for Medicare and Medicaid Services (CMS) has directed all State Medicaid agencies to implement the National Correct Coding Initiative (NCCI) as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010.

Georgia Medicaid uses NCCI standard payment methodologies. NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUEs) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

For additional questions regarding the NCCI or MUE regulations, please see the CMS website: http://www.cms.gov/.