PART I

POLICIES AND PROCEDURES
for
PART 1 POLICIES AND PROCEDURES FOR MEDICAID PEACHCARE FOR KIDS

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: July 1, 2026

TABLE OF CONTENTS

Policy Revision Record
from 2025 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
7/1/2026	105.3	Fee changed from $709.00 to $750.00	M	
4/1/2026	NA	No changes	NA	
12/23/2025	105.9	Change in Enrollment Information	M	
12/23/2025	105.11	Voluntary Termination	M	
10/1/2025	105.2	Took out 2nd paragraph	D	
10/1/2025	105.13	Added a paragraph	A	
6/12/2025	508.1	Provided email option to submit appeals of adverse actions.	A	
4/28/2025	401.1.1.4	Behavioral Health providers with an audit score below 70% per Part II, Policies and Procedures for Community Behavioral Health Rehabilitation Services, Appendix E, Audit Protocol	D	
4/28/2025	401.1.1.5.5 (note underneath)	Modified - Providers must bill the greater of 10% of normal billing volume or a minimum of 40 claims for dates of service that occurred while on PPR to be considered for removal.	M	
03/19/2025	204.1	The policy was updated by removing DXC and changing to Gainwell.	M	
03/19/2025	105.3	New Fee Amount $709.00	M	
03/19/2025	Definitions	Authorized Representative	A	

[1] The revisions outlined in this Table are from 2025 to current. For revisions prior to 2024, please see prior versions of the policy.

Preface

This manual contains basic information concerning Georgia's Medicaid/PeachCare for Kids program and is intended for use by all participating providers. This manual along with the statement of participation, any applicable letter of agreement, and program specific manual encompasses the terms and conditions for doing business as a Medicaid Provider in Georgia.

We urge you to familiarize yourself with the contents of this manual. This manual will assist you with understanding the coverage levels, eligibility, and billing procedures to prevent delays in payment, incorrect payment, or denial of payment of claims. This manual is your initial resource to use when questions arise concerning operating as a Georgia Medicaid Provider.

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 (the Department), Division of Medicaid's (Division) policies and procedures. When such amendments are made, they will be posted at www.mmis.georgia.gov, which shall constitute formal notice to providers. The amended provisions will be effective on the date of the notice or as specified by the notice itself, and all providers are responsible for complying with the amended manual provisions as of their effective dates.

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

Statement of Ethics

On January 1, 2008, the Department of Community Health has embraced a mission to improve the health of all Georgians through health benefits, systems development, and education. In accomplishing this mission, DCH providers must work diligently and conscientiously to support the goals of improving health care delivery and health outcomes of the members we serve. Providers should empower health care consumers to make the best decisions about their health and health care coverage and ensure the stability and continued availability of health care programs for the future. Ultimately, the mission and goals of the organization hinge on each provider's commitment to strong business and personal ethics. This Statement of Ethics requires that each provider:

Promote fairness, equality, and impartiality in providing services to members.

Safeguard and protect the privacy and confidentiality of members' health information, in keeping with the public trust and mandates of law.

Treat members with respect, compassion, and dignity.

Demonstrate diligence, competence, and integrity in the rendering of services.

Commit to the fulfillment of the organizational mission, goals, and objectives.

Comply with currently accepted standards of medical practice, ethics, and applicable laws or regulations.

Engage in carrying out DCH's mission in a professional manner.

Foster an environment that motivates DCH employees and vendors to comply with the Statement of Ethics.

The Department of Community Health expects all of its providers of Medicaid/PeachCare for Kids services, Care Management Organizations, vendors, contractors, and subcontractors (where allowed) to abide by the same requirements and guidelines of ethical standards as set forth for its employees.

Definitions

As used in this policy manual, unless the context indicates otherwise, the term:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Act means the Medicaid program as defined in Title XIX of the Social Security Act.

Administrative Review means the formal reconsideration, as a result of the proper and timely submission of a provider or member's request, by an Office or Unit of the Division which has proposed an adverse action.

Adverse action (provider) means an instance in which the Division (a) denies or reduces the amount of reimbursement claimed by a provider, (b) recovers funds previously paid to a provider, other than through lawsuit, (c) sets or changes a provider's reimbursement rate, (d) withholds reimbursement from a provider, (e) denies payment for future admissions to a nursing facility, except as provided elsewhere in the Medicaid policies and procedures pertaining to nursing facilities, or (f) suspends, terminates, or refuses to enroll, re-enroll, or reinstate a provider or prospective provider. An adverse action may occur due to the provider's failure to submit a corrective action plan. If the provider fails to submit a corrective action plan as required, the Division may seek to recoup money from the provider.

Adverse action (member) means any instance in which an applicant for medical assistance whose application is denied or is not acted upon with reasonable promptness and any recipient of medical assistance aggrieved by the action or inaction of the Department of Community Health as to any medical or remedial care or service which such recipient alleges should be reimbursed under the terms of the state plan which was in effect on the date on which such care or service was rendered or is sought to be rendered.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Applicant (individual) means an individual who has submitted a written application to the Division seeking Medicaid eligibility. The application may be submitted by a representative or a person legally responsible for the individual.

Authorized Representative is an individual or entity with official permission to act on behalf of another person or organization, whether by appointment, legal authority, or designation.

Background Screenings means the utilization and search of state and federal databases (including but not limited to the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS) state criminal history records, the records of any proceeding in the State that may contain disqualifying information, federal criminal history records, and fingerprint checks. This also includes pre and post enrollment, unscheduled, and unannounced site visits. The Division may also conduct license verifications across state lines, to ensure that a provider is in fact licensed and that the provider's license has not expired and that there are no current limitations on the provider's license.

Banner Message means the electronic message that accompanies a Remittance Advice and informs providers of upcoming changes in Medicaid/PeachCare for Kids policies and the date on which they become effective. Banner Messages will also be postedatwww.mmis.georgia.gov.

Claim means a bill for services, a line item of service, or all services for one recipient within a bill

Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

CMS means the Centers for Medicare & Medicaid Services, Department of Health and Human Services.

Conviction means that a judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether there is a post-trial motion or an appeal pending, or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed; a Federal, State or local court has made a finding of guilt against an individual or entity; a Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or an individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

Coordination of Benefits means the processes and procedures used by insurers to determine which payer has primary responsibility for payment of claims when more than one policy/plan is in effect for the same individual at the same time. For Georgia Medicaid/PeachCare for Kids, it is the sum of all policies and procedures related to claims payment for members with any other coverage or legally liable resource.

Co-payments means, in general, a set amount or cost share required by managed care plans to be collected from the patient at the time of service. Medicaid/PeachCare for Kids co-payments are nominal payments that members are required to pay to the provider in addition to what Georgia Medicaid/PeachCare for Kids pays to the provider for the services rendered.

Correct or ameliorate means to improve or maintain the health for a member under the age of 21 in the best condition possible, compensate for a health problem, prevent it from worsening, prevent the development of additional health problems, or improve or maintain overall health of a member under the age of 21, even if treatment or services will not cure the member's overall health.

Covered Service means an item of medical or remedial care or service, including dispensation of equipment and drugs, for which reimbursement is allowed through the Georgia Medical Assistance Programs.

Credentialing means the formal review of qualifications and other relevant information, including the background and legitimacy assessment, of a provider who has applied to participate in the State's Medicaid/PeachCare for Kids program and/or Georgia Families and Georgia Families 360°, the latter as part of a contracted CMO's plan network.

Credentialing Committee means a committee comprised of nine voting members who are responsible for reviewing each complete application as well as the Primary Source Verification results, verification of state and federal databases, and any applicable site visits, criminal background checks, fingerprinting and Medicare's Provider Enrollment Chain Ownership System queries in order to issue a decision approving or denying an applicant's credentialing status.

Credentialing Verification Organization (CVO) means an entity that is approved by the National Committee for Quality Assurance (NCQA) to determine the qualifications and ascribed privileges of providers to render specific health care services.

Credible Allegation of Fraud means an allegation which has been verified by the Department, from any source, including but not limited to fraud hotline complaints, claims data mining, and/or patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability, and the Department has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

Criminal Background Check means a state and/or national fingerprint-based background check.

Critical Access Hospital means a hospital that meets the requirements of the federal Centers for Medicare and Medicaid Services to be designated as a Critical Access Hospital and is recognized by the Department of Community Health as a Critical Access Hospital for purposes of Medicaid.

Days, except as otherwise noted, refer to calendar days. "Working day" or "business day" means a day on which the Division is officially open to conduct its affairs.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Division means the Division of Medicaid.

Early and Periodic Screening, Diagnostic, and Treatment Services refers to the screening services, vision services, dental services, hearing services and such other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan. These services are applicable to members under the age of 21.

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

Electronic Funds Transfer (EFT) means the direct deposit of Medicaid/PeachCare for Kids claims payments into a provider's bank account. Providers will receive a Remittance Advice showing the status of claims submitted. The provider must complete the EFT Provider Agreement, and the EFT information forms as a condition of participation.

Entity shall include, but not be limited to, a corporation, limited liability company, partnership, business, provider organization, or professional association.

Enterprise Level: a mass reprocessing request that involves the Department with a fiscal or changed policy/pricing impact or as a result of a federal or state mandate resulting in a volume of identified claims (as directed by the Medicaid Chief). The Enterprise approval is provided by the Georgia Medicaid Chief.

Exclusion means that items and services furnished, ordered or prescribed by a specified individual or entity will not be reimbursed under Medicare, Medicaid and all other Federal health care programs until the individual or entity is reinstated by the OIG.

Fiscal Agent means a contractor that processes or pays vendor claims on behalf of the Division.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the

deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Georgia Health Partnership (GHP) is the third-party administrator for Medicaid and PeachCare for Kids.

Group of Practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Hearing means a proceeding before an Administrative Law Judge in which parties affected by an action, or an intended action of the Division shall be allowed to present testimony, documentary evidence and explanation as to why such action should or should not be taken.

High Categorical Risk means categories of service that pose a significant risk of fraud, waste, and abuse to the Medicaid program. These include Rev. 07/12 community mental health centers, prospective (newly enrolled) home health agencies and prospective (newly enrolled) suppliers of durable medical equipment, including orthotic and prosthetic supplies (facilities only). (Rev. 10/2015)

Hospital precertification means approval of all inpatient hospital admissions (except routine deliveries) and selected services performed in an outpatient hospital or ambulatory surgical center setting at least one (1) week prior to the planned admission or procedure. Emergency admissions, emergent surgical procedures and hospital transfers must be certified within thirty (30) calendar days of admission.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Inpatient means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who, (a) receives room, board and professional services in the institution for a twenty-four (24) hour period or longer, or (b) is expected by the institution to receive room, board and professional services in the institution for a twenty-four (24) hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for twenty-four (24) hours.

License means the whole or part of any agency permit, certificate, approval, registration, charter, or similar form of permission required by law.

Limited Categorical Risk means categories of service that pose a minor risk of fraud, waste, and abuse to the Medicaid program. These include physician or non-physician practitioners (including advanced nurse practitioners, occupational therapist, speech/ language pathologist, audiologist and dieticians) and medical groups or clinics, ambulatory surgical centers, end- stage renal disease facilities, federally qualified health centers, hospitals, including critical access hospitals, rural health clinics, skilled nursing facilities, and pharmacies.

Manage Care Entity means a managed care organization.

Managing Employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-today operations of an institution, organization or agency, either under contract or through some other arrangement.

Medicaid Provider ID-The Medicaid Provider ID is the number assigned to a Medicaid/PeachCare for Kids provider when upon enrollment in the Medicaid/PeachCare for Kids program. Medicaid Provider ID is required for the paper claims submission on both the CMS-1500 and UB04 (in addition to the NPI), web-based

transactions, Medicaid forms, and for all other Medicaid activities.

Medicaid Secondary means that the provider is billing Medicaid as the "payer of last resort", acknowledging that any and all other insurance benefits have been pursued for payment prior to billing Medicaid/PeachCare for Kids.

Medically necessary, medical necessity or medically necessary and appropriate means medical services or equipment based upon generally accepted medical practices in light of conditions at the time of treatment which is (a) appropriate and consistent with the diagnosis of the treating physician and the omission of which could adversely affect the eligible member's medical condition, (b) compatible with the standards of acceptable medical practice in the United States, (c) provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms, (d) not provided solely for the convenience of the member or the convenience of the health care provider or hospital, (e) not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage, and (f) there must be no other effective and more conservative or substantially less costly treatment, service and setting available.

Member means an individual who has been determined eligible for Medicaid or PeachCare for Kids.

Moderate Categorical Risk means categories of service that pose a moderate risk of fraud, waste, and abuse to the Medicaid program. These include ambulance service providers, hospice organizations, independent care waiver program, independent clinical laboratories, physical therapists, revalidating home health agencies, and revalidating durable medical equipment providers.

National Provider Identifier (NPI) is a 10-digit number used as a health care provider identifier. This number has no intelligence. Once this number is assigned it remains with the provider for life and is used as the sole provider identifier on standard electronic transactions such as claims and eligibility inquiries. Medicaid will also require the NPI to be submitted on the UB04 when the form is implemented.

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

Outlier means a case that has either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same diagnosis related group (DRG).

Outpatient means a facility-based patient of an organized medical facility, or distinct part of that facility, who is expected by the facility to receive and who does receive professional services for less than a twenty-four (24) hour period regardless of the hour of admission, whether or not the patient remains in the facility past midnight.

Outpatient Services, means any non-inpatient, community-based service including both medical and associated

supportive services, such as, but not limited to diagnostic, therapeutic, laboratory, restorative, rehabilitative, educational, social, or residential. Outpatient services are not time-bound.

Outpatient Observation Care means a member is seen at the hospital for no more than 48 hours for a provider to determine if a hospital admission is necessary.

Overpayment means a payment to a provider that is: fora service for which reimbursement is not available under the State Plan or other policy of the Division; in excess of the amount allowed under the State Plan or other policy of the Division for that service, including but not limited to, costs or payments determined to be inappropriate through the application of currently accepted standards of auditing or accounting; for a covered service for which any coordination of benefits (COB) payment also has been received by the provider when the sum of payments is greater than the Medicaid/PeachCare for Kids maximum allowable amount; for a service not actually rendered by that provider; for a service which is determined by the Division or its authorized agent to be medically unnecessary; rendered by a provider who failed to comply with all conditions of participation related to the service(s) for which a claim was paid; for a claim submitted by a data processing agent for whom a Provider/Billing Agent Agreement was not filed at the time of submission; submitted via electronic media billing in violation of the Provider Agreement for Electronic Data Interchange Processing for claims submission; submitted via electronic media billing in violation of the Provider Agreement for Electronic Data Interchange Processing for claims submission; and, for a service that does not comply with all requirements, terms and conditions for reimbursement detailed in the Division's Policies and Procedures manuals.

Overutilization means the provision of health care services that exceed the amount, duration, scope, or frequency that is reasonable and necessary under currently accepted standards of medical practice for the treatment of a particular physical or mental health condition.

Owner (Ownership Interest) means a person or corporation with an or control interest that: Has an ownership interest totaling 5 percent or more in a disclosing entity; Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; Has a combination of direct and indirect ownership interests equal to5percent or more in a disclosing entity; Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; Isan officer or director of a disclosing entity that is organized as a corporation; or Is a partner in a disclosing entity that is organized as a partnership.

Patient Liability means the amount a member is required to contribute (pay) for Medicaid –eligible services in order to maintain his/her Medicaid eligibility. Patient Liability is determined by the Department of Human Services, Division of Family and Children Services. The amount is calculated based on a formula that considers the individual's available resources, such as income and assets. Patient Liability is based on a member's stay in a medical institution such as a long-term care facility, an intermediate care facility for individuals with disabilities, and home and community-based waiver services.

Peer Review means review by health care practitioners of services ordered or furnished by other **practitioners** in the same professional field.

Practitioner means a physician or other individual licensed under State law to practice his or her profession.

Primary Source Verification (PSV) means the process of validating an applicant's credentials from the original issuing entity, or primary source that conferred the credentialing element, in order to identify the legal authority of an applicant to practice as well as relevant training and experience. (01/2016)

Prior approval means approval of certain services or procedures performed by a specified provider or group of providers prior to the time they are rendered. (01/2016)

Provider means any individual or entity furnishing Medicaid services pursuant to a Statement of Participation (provider agreement) with the Division.

Re-credentialing means the process for screening providers every three (3) years to update credentialing information and ensure that the provider is eligible for participation in the Medicaid/PeachCare for Kids program and/or a contracted CMO's plan network. This term is used interchangeably with revalidation.

Reject/Rejected means that the provider's enrollment application or claim was not processed due to incomplete information, or that additional information or corrected information was not received from the provider in a timely manner.

Satisfactory Fitness Determination means a written determination that an individual subject to the fingerprinting requirements of Section 105.13(C) was found to have no disqualifying crimes pursuant to Section 404(j).

Secure Electronic Signature means an electronic or digital signature or symbol, which is created, transmitted, received, or stored by electronic means which (1) requires the application of a security procedure; (2) capable of verification/authentication; (3) adopted by a party with the intent to be bound or to authenticate a record; (4) signed under penalty of perjury; (5) unique to the person using it; (6) under the sole control of the person using it; and (7) linked to data in such a manner that if the data is changed the electronic signature is invalidated.

State means the state of Georgia, unless otherwise noted.

State Plan means a comprehensive written commitment, submitted by the Division, pursuant to section 1902(a) of the Social Security Act, to administer and supervise the administration of the Medicaid program.

Subcontractor means an individual, agency, or organization to which a disclosing entity has contracted or delegated in part or in whole its management functions or responsibilities of providing medical care to its patients; or an individual, its **patients**; or an individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under its contract with the Department. Not all Georgia Medicaid programs allow subcontracting. Providers must comply with part II Policies and Procedures for program specific rules related to subcontracting.

Suspension means a situation where a provider (including any individual with an ownership or controlling interest, an agent or managing employee) is barred from participation in the Georgia Medicaid/PeachCare for Kids program for a defined period of time not to exceed one year.

Termination means a situation where a provider (including any individual with an ownership or controlling interest, an agent, or managing employee) is barred from participation in the Georgia Medicaid/PeachCare for Kids program for a period of time not less than one year.

Third Party means any individual or entity or program that is or may be liable to pay all or part of the expenses for medical care furnished to a member. (See Coordination of Benefits).

Third Party Administrator means the organization under contract with the Department of Community Health for the processing of claims, provider enrollment, provider and member inquiry support, processing of prior authorization and precertification requests, issuance of member identification cards, and other related functions.

Unsatisfactory Fitness Determination means a written determination that an individual subject to the fingerprinting requirements of Section 105.13(C) was found to have disqualifying crimes pursuant to Section 404(j). An unsatisfactory fitness determination may also be issued if the individual subject to fingerprinting does not submit documentation requested by the Department which is required to make such determination.

Utilization Review means a review of services ordered or furnished by providers conducted by the Program Integrity Section of the Office of the Inspector General that safeguards against unnecessary or inappropriate use of Medicaid/PeachCare for Kids services and excess payments, assesses the quality of those services, and ensures the provision of all services in accordance with the applicable policies and procedures of the Medicaid/PeachCare for Kids program, state and federal law, rules and regulations.

101. Program Administration

The Georgia Medical Assistance Program (Medicaid) is authorized by the provisions of Title XIX of the Social Security Act. The PeachCare for Kids Program (PeachCare) is authorized by Title XXI of the Social Security Act and legislation passed during the1998 session of the Georgia Assembly. Together, Medicaid/PeachCare for Kids provides medical assistance to certain individuals with low income and resources. (Rev. 04/2020)

The Department of Community Health (DCH) is managed by a nine-member board appointed by the Governor, and the Division of Medical Assistance (the Division) within DCH, administers Medicaid/PeachCare for Kids. (O.C.G.A. §§31-5A-1 et seq.). Service delivery is accomplished through a variety of relationships with private and public entities and reimbursement is coordinated through DCH's third party administrator.

102. Severability Clause

In the event any provision or portion of any provision of this Manual conflicts with state law, federal law, or federal regulations, or is otherwise held invalid, the other provisions of this Manual and the remaining portions of said provision will not be affected thereby and will continue in full force and effect.

103. Policy Language Interpretation

The Provider and the Department agree that in the event of a disagreement regarding, arising out of, or related to policy language interpretation, the Department's interpretation of its policy language in dispute shall control and govern. The Department's interpretation of the contract language in dispute shall not be subject to appeal under any circumstance.

104. General Reimbursement Principles

The Division pays enrolled providers within numerous reimbursable categories for covered services furnished to eligible members. The numerous reimbursable categories are listed in Appendix A and the covered services and reimbursement guidelines associated with each category are discussed separately in Part II.

104.1. Provider Discretion

As it relates to this specific subsection (104.1) only, the term "Provider" shall only refer to those providers enrolled as individual practitioners. Providers enrolled as entities including, but not limited to, hospitals, nursing homes, personal support providers, skilled nursing agencies, pharmacies and durable medical equipment providers are not afforded the benefit of this subsection.

104.1.1. It is within a provider's discretion to accept a patient as a Medicaid or

PeachCare for Kids member (Medicaid as primary or secondary payer). By accepting a patient as a Medicaid or PeachCare for Kids member, the provider:

104.1.1.1. Agrees to accept, as payment in full, the amount paid by the Division for all covered services under the Medicaid/PeachCare for Kids program with the exception of authorized co-payments and payments from liable third parties.

104.1.1.2. Is prohibited from picking and choosing specific procedures for which the provider will accept Medicaid/PeachCare for Kids, whereby the Medicaid or PeachCare for Kids member would be required to pay for one type of covered service and Medicaid/PeachCare for Kids to pay for another service if applicable.

104.1.1.3. Agrees to treat members at any of the multiple locations that may be serviced by that provider.

104.1.2. The Division will deem a patient to have been accepted as a Medicaid or PeachCare for Kids member if the patient was eligible for Medicaid/PeachCare for Kids on the date of service and:

104.1.2.1. The provider represents or demonstrates to the patient that the provider will treat the patient as a Medicaid or PeachCare for Kids member,

104.1.2.2. The provider bills the Division for services rendered

104.1.3. In the event that a provider does not accept a patient as a Medicaid/ PeachCare for Kids member, the provider may accept the patient as private pay (patient would be either financially responsible for the entire medical bill or the difference between the bill and what other accepted insurance covers) only after first disclosing the names of two (2) other known providers which would likely accept the patient as a Medicaid or PeachCare for Kids member for the same services. **Likewise, a provider that is not enrolled with a care management organization (CMO) may accept a member enrolled with a CMO only after providing the member with the contact information for the member's selected CMO and disclosing that the service in question is covered by the CMO**. The patient must agree, in writing, to have the service provided with full knowledge of the patient's personal financial responsibility to the provider.

104.1.4. A provider may, upon accepting a patient as a Medicaid/PeachCare for Kids member, charge the member for non-covered services. In order to charge the member for non-covered services, the provider must disclose the following in writing:

104.1.4.1. That the service to be rendered is not covered by

Medicaid.

104.1.4.2. Whether there are procedures or treatments covered by the Department that are available to the member in lieu of the noncovered procedure or treatment. If there are covered procedures or treatments available to the member, the member must indicate on the disclosure form his or her willingness to accept the noncovered service.

104.1.4.3. The member shall sign a statement evidencing his or her knowledge of said disclosures. The statement should also include the cost of the non- covered service and an assurance that there are no other covered services available to the member. In addition, the disclosure statement must contain the payment arrangements. If the member will be subject to collection action upon failure to make the required payment, the terms of said action must be included in the disclosure document. A copy of the disclosure form must be kept in the member's treatment record. Failure to comply with these procedures will subject the provider to sanctions, up to and including termination from the Medicaid/PeachCare for Kids Program.

104.2. Prudent Buyer

It is the Division's goal to make quality health care services available to all eligible members. To maximize allocated funds, the Division has employed the concept of the "Prudent Buyer." Briefly stated, if two different plans of treatment will meet the need of the member, the less expensive treatment should be employed, all other conditions being equal.

104.3. Payer of Last Resort

Medicaid/PeachCare for Kids providers must attempt to pursue any other health benefit resources prior to filing a claim. If a third party or primary insurance plan does not pay at or in excess of the applicable Medicaid/ PeachCare reimbursement level, a provider may submit a claim and will be paid the applicable reimbursement minus any reimbursement received from all other resources.

Providers are obligated to notify the Division if other insurance exists for a member. This information may be provided by calling the third-party administrator or by faxing or mailing the completed COB Notification form to the third-party administrator. You may also use the "Contact Us" feature of the third-party administrator's website after logging in as an authenticated user and clicking on the "Contact Us" tab.

104.4. Collection Agencies

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

105. Provider Enrollment-Medicaid Fee for Service

In order to receive reimbursement through the Medicaid/PeachCare for Kids program, a provider must be enrolled with the Division in an appropriate service category.

105.1. Enrollment Process

Providers must submit an online application through the third-party administrator's website at www.mmis.georgia.gov. Approval is contingent upon verification of a provider's compliance with all provider enrollment requirements.

Photocopies of enrollment forms are acceptable; however, all forms (unless otherwise indicated) must have original signatures. The Division's receipt and approval of the application package signed by the provider is a condition that must precede each provider's enrollment. Approval is contingent upon verification of a provider's compliance with all provider enrollment requirements and may include a site audit of the provider's place of business. (Rev. 10/2018)

105.1.1. The Division does not enroll group practices in the fee for service program. Each Provider must enroll at each location where services are provided to Medicaid/PeachCare for Kids members.

105.1.2. The effective date of enrollment will be the first day of the month in which the application was received or the date of licensure or certification, whichever is later. However, this policy does not supersede effective date requirements in Part II manuals for each category of service.

105.1.3. Providers located within 50 miles of the Georgia border who routinely treat Georgia Medicaid/PeachCare for Kids members may enroll with in-state status. However, this policy does not supersede mileage or location requirements in Part II manuals for each category of service.

105.1.4. All health care providers eligible for a National Provider Identifier (NPI) must submit a copy of their NPI confirmation letter or e-mail from the National Provider and Plan Enumeration System (NPPES) when applying for participation in any Medicaid program.

105.1.5. OPR only physicians or non-physician practitioners will follow the same enrollment process as described in this section; however, they will only be required to submit the following:

Enrollment Application
Medical or other Professional
License DEA Registration, if applicable
Statement of Participation (paper application only)

105.2. Application Status

A provider will be notified of the Division's decision to accept or reject an application for enrollment by its third-party administrator.

105.2.1. If the application is approved, the provider will receive a Georgia Medicaid/PeachCare for Kids Approval Notice. This notice includes a summary of the information contained in the provider file including the effective date of enrollment. The Division will make no reimbursement for services rendered prior to the effective date of enrollment.

105.2.2. If the application is denied, the applicant will receive notification from the Division explaining the reason(s) for the denial and the applicant's right to appeal.

105.2.3. The Division reserves the right to reject an application as incomplete and request additional information for clarification or completion of an enrollment application. Requested documentation must be received at the Division within ten (10) days from the date of the request unless other arrangements have been made with the Division.

105.2.4. Applications that have been started in the Medical Management Information System (MMIS), but not submitted, and remain incomplete for more than ten (10) days from the date started will be rejected. The applicant will be required to start the application process anew and submit the application with all supporting documentation.

105.3. Application Fee

To help defray the costs associated with the background screening process, and reduce fraud, waste, and abuse, federal regulations require that certain prospective (new), re-enrolling, or re-credentialing providers pay an application fee prior to executing the Statement of Participation or provider agreement. The following are exempt from the application fee:

105.3.1. Individual physicians or non-physician practitioners

105.3.2. Providers who are enrolled in either of the following:

105.3.2.1. Title XVIII of the Act.

105.3.2.2. Another State's title XIX or XXI plan

105.3.3. Providers that have paid the application fee to:

105.3.3.1. A Medicare contractor; or

105.3.3.2. Another State

Pursuant to the Federal Register for calendar year 2020 the application fee of $750.00 is due from all institutional providers initially enrolling in the Medicaid program or the Children's Health Insurance Program (CHIP), revalidating their Medicaid or CHIP enrollment; or adding a new Medicaid practice location. The fee is required with any enrollment application submitted on or after January 1, 2021, through December 31, 2021. The Division does not have the discretion to change the amount of the fee. (Rev. 1/1/24)

The Division may reject an enrollment application from a newly enrolling provider that is not accompanied by the application fee or by a Request for Hardship Waiver Application Fee. (Rev. 01/2014)

A request for a hardship exception/waiver of the application fee shall be made at the time of submission of a Medicaid/PeachCare for Kids enrollment, re-enrollment or re-credentialing application. The Request for Hardship Waiver of Application Fee form can be found at https://www.mmis.ga.gov. The Request for Hardship Waiver Application Fee shall describe the hardship and why the hardship justifies a waiver of the application fee. (Rev. 01/2014, Rev. 04/2014, Rev. 01/2016)

Upon receipt of the Request for Hardship Waiver Application Fee, the Division shall forward the waiver application to CMS for review. CMS shall approve or deny the Request for Hardship Waiver Application Fee within 60 days of receipt. If the request for a hardship exception or waiver is denied by the CMS, the provider will have thirty (30) days from the date of the denial to submit the application fee. A provider may not appeal the denial of a hardship exception or waiver. (Rev. 04/2014)

The Division will not process an enrollment application that is accompanied by a request for a hardship exception or waiver until the CMS has made a decision to approve or disapprove the hardship exception request.

Within thirty (30) days from the date of submission of an application, the Division may reject an enrollment application from a prospective (new), re-credentialing or re-enrolling institutional provider that is not accompanied by the application fee or the Request for Hardship Waiver of Application Fee requesting a hardship exception or waiver of the application fee. The Division shall suspend or terminate any current provider who fails to pay the application fee for the revalidation or enrollment. (Rev. 04/2014)

The application fee is non-refundable unless:

105.3.4. The application fee is submitted along with a request for hardship exception/waiver which is approved by CMS;

105.3.5. An application is rejected prior to initiation of the screening process;

105.3.6. The application is subsequently denied as a result of the imposition of a temporary moratorium.

The following institutional providers are subject to the application fee at initial enrollment, re-enrollment and re-credentialing; (Rev. 09/2023)

105.3.7. Independent Laboratories

105.3.8. Pharmacies

105.3.9. Durable Medical Equipment

105.3.10. Orthotics and prosthetics (Facility)

105.3.11. EMS, Ground

105.3.12. EMS, Air

105.3.13. Community Mental Health

105.3.14. Federally Qualified Health Centers

105.3.15. Hospital Based Rural Health Clinics

105.3.16. Freestanding Rural Health Clinics

105.3.17. Georgia Pediatric Program-In-Home Skilled Nursing

105.3.18. TCM Adults AIDS (Facility)

105.3.19. At Risk Incarceration (Facility)

105.3.20. Inpatient/Outpatient Hospital

105.3.21. Swing Bed

105.3.22. Skilled Care Nursing Facility

105.3.23. Skilled Care Nursing Facility/Outpatient

105.3.24. Nursing Facility

105.3.25. ICF/MR

105.3.26. Home Health Agencies

105.3.27. Family Planning Clinic

105.3.28. Ambulatory Surgical Center

105.3.29. Hospice

105.3.30. Dialysis (Technical)

105.3.31. Mobile X-Ray Units

Institutional providers who are enrolled in more than one category of service that are subject to the application fee shall only be required to pay the fee for one category of service provided they are located at the same service location address. (07/2015)

105.4. Taxpayer Identification Information

Medicaid/PeachCare for Kids taxpayer identification information (Federal Employer Identification and/or Social Security Numbers) must be identical to the information that the provider submits to the Internal Revenue Service (IRS). As a requirement for enrollment, all providers must submit confirmation from the IRS of the payee's taxpayer identification number. Failure to submit correct tax identification information to the Division will result in tax withholding of thirty-one percent (31%) of each payment from the Division. The withholding amount will be transferred to the IRS and can only be refunded by that agency.

105.5. Retroactive Enrollment

Upon written request, the Division may grant up to an additional six (6) months retroactive enrollment to eligible providers. Any period of retroactive enrollment must be requested in writing within sixty (60) days of the notification of the original enrollment date listed on the Georgia Medicaid/PeachCare for Kids Approval Notice.

Ordering, Prescribing, and Referring practitioners shall follow the same retroactive enrollment process as described above; however, an enrollment application must be received by the Division's third-party administrator within 60 days of the date of service for services rendered to the member by the Fee-for-Service provider.

Emergency Room providers will be retroactively enrolled in accordance with this policy, provided that the enrollment is requested within three (3) months of their start date.

Retroactive enrollment will be considered on an individual basis and will be approved only for situations that appear to be beyond the provider's control.

Retroactive enrollment is not applicable to rejected applications that have been resubmitted for reconsideration. The effective date is the first day of the month in which the resubmitted application is received. The Department considers the following situations within the control of the provider:

105.5.1. Change in or absence of office management or billing personnel

105.5.2. Change in office procedures such as the computerization of claims processing

105.5.3. Lack of coordination between billing staff and providers in obtaining signatures or other authorizations

105.5.4. Delay in obtaining necessary forms because of provider or provider staff

105.5.5. Loss of claims in transit to the Third-Party Administrator or Division

105.6. Additional or New Specialties for Individual Practitioners

In those instances, wherein an enrolled individual practitioner subsequently adds a new category of service or specialty to an existing provider number, the effective date of the added/new category of service or specialty will be the first day of the month in which the request is received by the Division.

105.7. Statement of Participation Renewal

The Division will exercise its option to renew the Statement of Participation of each provider enrolled as of May 1 of each state fiscal year (July 1 -June30) unless one of the following occurs or has occurred:

105.7.1. The provider voluntarily terminates enrollment.

105.7.2. The Division terminates the provider's enrollment.

105.7.3. Correspondence from the Division to the provider has been returned at least three times as undeliverable.

105.7.4. The Division has no record of receiving a claim from the provider during a twelve (12) month period.

105.7.5. The provider has violated one or more provisions of Section 404. Should the Division exercise its option to renew the Statement of Participation, each provider is subject to the provisions of the most recent version of the Statement of Participation.

105.8. Inactive Providers

Providers must inform the Division immediately when they leave any provider location at which they have been enrolled.

Any provider who has not submitted a claim for a twelve (12) month period will be considered inactive. The Division will suspend inactive provider numbers and the provider whose provider number is suspended under this provision must request re-instatement in writing. If the provider number remains inactive for a period of sixteen (16) months, the number will be terminated, and the provider must apply for reenrollment.
The Division will notify the provider prior to termination for inactivity.

Retroactive enrollment will not be granted for provider numbers that have been terminated due to inactivity. The effective date will be the first day of the month in which the resubmitted application is received.

105.9. Change in Enrollment Information

Should the information submitted during enrollment (e.g., office location, change of an address, the payee, etc.) change, the provider must report those changes within ten (10) days of the change by submitting the request to include but not limited to the third-party administrator's website at www.mmis.georgia.gov. Notice of a change of information is

not accomplished by simply including the updated information on claims submitted for payment. These claims will be processed, and payment will be made to the payee on file. Checks returned to the Division by the Post Office will be voided.

A provider or provider group who has moved their practice from one location to another location and the Tax ID remains the same, may use the Change of Information form to update their service locations address. A copy of their IRS Form W-9 must be submitted with the completed Change of Information form. If the change in enrollment information was completed in error, providers will have (30) thirty days to reverse the change.

A provider who leaves one location and goes to work at another location must submit an Additional Location application. Section 105.1(A) of the Part I Policy and Procedures manual requires that each provider be enrolled at each location where services are provided to Medicaid/PeachCare for Kids members. (Rev 09/2023)

105.10. Change of Ownership or Legal Status

The successor provider must submit a new enrollment application and supporting documentation to become effective at the time of the change of ownership. A change of ownership includes, but is not limited to, a dissolution, incorporation, re-incorporation, reorganization, change of ownership of assets, merger, or joint venture whereby the provider either becomes a different legal entity or is replaced in the program by another provider.

Any person or entity that is a Medicaid/PeachCare for Kids provider, and any person or entity that replaces a provider, shall be deemed to have accepted joint and several liability, along with its predecessor, for any overpayment and/or provider fee sought to be recovered by the Division after the effective date of the successor provider's enrollment, regardless of the successor's enrollment status or lack of affiliation with its predecessor at the time the overpayment was made. An entity shall be deemed to have replaced a provider if it:

105.10.1. effectively became a different legal entity through incorporation, re-incorporation, merger, joint venture, dissolution, creation of a partnership, or reorganization; took over more than fifty percent (50%) of the predecessor's assets, Medicaid/PeachCare for Kids clients, or Medicaid/PeachCare for Kids billings, or 3) has substituted for the predecessor in the program, as evidenced by all attendant circumstances. Reimbursement for services rendered prior to the effective date of enrollment of a successor provider (including any adjustments for underpayments made by the Division) shall be made to the provider of record at the time the payment is made or to that provider's payee as properly designated on the appropriate form(s) required by the Division. Any dispute or conflict, legal or otherwise, arising between the currently enrolled provider and the predecessor provider concerning either apportionment of liability for any overpayment previously made by the Division or the right to additional reimbursement for any underpayments previously made by the Division shall be the sole responsibility of such parties and shall not include the Division. The new owner, applying for enrollment may not request a change of the predecessor's provider

number without the express consent of the Chief of the Division of Medical Assistance.

105.10.2. To allow for continuity of care and timely filing of claims, the successor shall submit claims using the predecessor's provider number while the Change of Ownership enrollment application is being processed. Failure to submit claims in a timely manner pursuant to Chapter 200 of this Part may result in denial of claims. Until the Change of Ownership is completed, claims will be processed, and payment will be made to the predecessor's payee number.

105.11. Voluntary Termination

An enrolled provider, other than a nursing facility, may voluntarily terminate participation in the program by giving ten (10) days written notice to the Provider Enrollment Unit of such election. A provider may also submit a request to terminate enrollment on the web to include but not limited to the third-party administrator's website at www.mmis.georgia.gov. A nursing facility provider may voluntarily terminate participation in the program by giving thirty (30) days written notice to the Provider Enrollment Unit and residents of such election. Voluntary termination subsequent to the Division's issuance of notice of proposed adverse action may result in the Division's retention of reimbursement until the resolution of the matter that caused the Division to issue a Notice of Adverse Action.

105.12. Termination

105.12.1. Termination by Provider. Unless otherwise authorized by the Department or by law, Provider shall give ten (10) days prior written notice to the Department of voluntary termination.

105.12.2. Termination under Other Programs. The Department may terminate and take other action against Provider under the Medicaid program when adverse action is taken against Provider under any other plan or program, including, but not limited to, exclusions from or licensure restrictions or conditions by other federal or state authorities, plans or programs. The Department shall issue written notice of termination to Provider to be effective on the date indicated therein. The Department also may notify other state and federal authorities, plans or programs of Provider's enrollment status in the Medicaid program, including other plans or programs within the Department. Termination under the Medicaid program may result in Provider's termination under other federal and state plans or programs.

105.12.3. Termination for Unavailability of Funds. Notwithstanding any other provision hereof, in the event that funds are no longer appropriated for the Department, Division of Medical Assistance by the General Assembly of the State of Georgia or from the Congress of the United States of America, or in the event that the sum of all obligations of the Department incurred pursuant to the Medicaid program equals or exceeds the balance of such sources available to the Department for "Medical Assistance Benefits" for the fiscal year in which this Statement

of Participation is effective less one hundred dollars ($100.00), then this Statement of Participation shall terminate immediately without further obligation to or by the Department. The certification by the Commissioner of the Department of the occurrence of either of the events stated above shall be conclusive. The Department will attempt to provide Provider with ten (10) days' notice of the possible occurrence of events described in this provision.

105.12.4. Failure to submit information: The Division shall terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods.

105.12.5. Convictions: The Division shall terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years, unless the Division determines that termination of enrollment is not in the best interests of the Medicaid program and the Division documents that determination in writing.

105.12.6. The Division shall terminate the enrollment of any provider that is terminated on or after January 1, 2011, under title XVIII of the Act or under the Medicaid program or CHIP of any other State.

105.12.7. The Division shall terminate the provider's enrollment if the provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, unless the Division determines that termination is not in the best interests of the Medicaid program and the Division documents the determination in writing.

105.12.8. Failure to submit fingerprints: The Division shall terminate the enrollment of a provider if the provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner determined by the Division within thirty (30) days of a CMS or a Division request, unless the Division determines that the termination is not in the best interests of the Medicaid program and the Division documents that determination in writing.

105.12.9. Failure to Permit Access to Provider Locations: The Division shall terminate the enrollment of a provider if the provider fails to permit access to any and all provider locations for any site visit unless the Division determines that termination is not in the best interest of the Medicaid program and the Division documents the determination in writing.

105.12.10. The Department shall terminate a provider's enrollment in the categorical risk providers; however, the Division reserves the right to conduct site visits for any category of service. The purpose of the site

visit is to verify that the information submitted to the Division is accurate and to determine compliance with Federal and State enrollment requirements. Based on the results of the site visit, providers may be denied enrollment, suspended or terminated from the Medicaid/PeachCare for Kids program for any of the following, but not limited to:

105.12.10.1. Current provider or applicant's service location is not operational;

105.12.10.2. Current provider or applicant's service location is not physically located at the address identified in the enrollment application;

If the service location is closed, inoperable, or at a different location other than the address provided in the application at the time of the initial site visit, the Division will conduct a second unannounced site visit. Enrollment will be denied, suspended, or terminated if the service location is closed, inoperable, or at a different location other than the address provided in the application at the time of the second unannounced site visit.

Medicaid/PeachCare for Kids program if the provider does not revalidate their enrollment within 60 days of being placed on suspension for failure to revalidate their enrollment.

105.12.11. The Division may terminate a provider's enrollment if CMS or the Division:

105.12.11.1. Determines that the provider has falsified any information provided on the application; or

105.12.11.2. Cannot verify the identity of any provider applicant.

105.12.12. In the course of the re-credentialing process, the Division shall terminate enrollment of an existing provider, at all service locations, in which a provider is denied enrollment by the Credentialing Committee.

105.12.13. Medicare revocation: The Division shall terminate the enrollment of any provider whose Medicare billing privileges have been revoked by CMS or their contractor.

105.13. Reinstatement of Provider Enrollment

In those instances, wherein a provider's enrollment has been terminated (deactivated) or suspended, before the provider can be reinstated (reactivated) the Division must re-screen the provider and require payment of applicable application fees.

When a providers file has been suspended for an expired license/certification and/or permit, once the updated license/certification and/or permit has been submitted to the Department, the enrollment file will be reactivated to reflect the original effective date and not the date the file was suspended.

105.14. Background Screenings

The Division reserves the right to request that all enrolled providers and applicants submit to random background screenings. Background screenings consist of criminal history checks as defined in the Definitions section of this manual and site visits. Failure to submit to requested criminal history and screening checks shall result in adverse actions including termination from the Georgia Medicaid program. The Division and/or its agent will conduct criminal history and screening checks of all new and re-enrolling providers. The screening will consist of checks of various databases as defined in the Definitions section of this manual.

105.14.1. Site visits- The Division and/or its agent shall conduct unscheduled, unannounced site visits at any or all of the provider's service locations prior to enrollment, post-enrollment, re-enrollment, revalidation, or during any period of time in which the provider is enrolled. Site visits will be conducted for providers who are designated as "moderate" or "high"

105.14.2. Federal Database Checks: The Division will confirm the identity and determine the exclusion status of providers and any person with an ownership or controlling interest or who is an agent or managing employee of the provider through routine checks of Federal databases. This includes but is not limited to checks of the Department of Health and Human Services, Office of the Inspector General's (OIG) Exclusion List, Social Security Administration's Death Master File, Medicare Exclusion Database, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS). Federal database checks will also be conducted for providers who re-enroll and for revalidation of enrollment.

105.14.3. Criminal Background Checks: As a condition of enrollment, an owner whose category of service is considered high risk will be required to submit to fingerprinting at the time of enrollment, re-enrollment, recredentialing, or any period of time during which the provider is enrolled in the form and manner as determined by the Division. Should the background screening indicate that an owner has received an unsatisfactory fitness determination due to a disqualifying crime pursuant to Section 404(j) the Department may deny enrollment or terminate the provider from the Georgia Medicaid program.

105.15. Re-credentialing in the Medicaid Program as a Provider

The Division shall revalidate the enrollment of all providers regardless of provider type at least every three years. As part of the re-credentialing process, the agency will conduct all credentialing activities, including background screening, federal database checks, site visits, and criminal records checks. The Division shall suspend or terminate the enrollment of any provider who fails to submit a re-credentialing application or does not cooperate with the credentialing process.

The Department shall suspend any current provider who fails to submit a re-credentialing application within 60 days of the date of their re- credentialing notice. The Department shall terminate any current provider who fails to submit a re-credentialing application within 60 days after being placed on suspension.

Any current provider who submits a re-credentialing application shall have 60 days from the date of submission to complete the enrollment process. The Department shall terminate any current provider who fails to complete the enrollment process within the 60-day requirement.

105.16. Disclosure by Medicaid providers and fiscal agents: Information on ownership, control, and persons convicted of crimes.

Pursuant to federal regulations, the Division is required to obtain certain information from disclosing entities, fiscal agents, and managed care entities. Accordingly, in addition to the requirements outlined in the Code of Federal Regulations, disclosing entities, fiscal agents, and managed care entities must disclose the following information:

105.16.1. The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include primary business addresses, every business location, and P.O. Box addresses.

105.16.2. Date of birth and Social Security Number (in the case of an individual).

105.16.3. Tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity), or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

105.16.4. Information which indicates whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

105.16.5. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

105.16.6. The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

105.16.7. The identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or title XX since the inception of the program.

105.16.8. Failure to provide the requested information will result in a denial of federal final participation. Additionally, the Division may refuse to enter into or may terminate a provider agreement or contract if it determines that the provider, fiscal agent, or managed care entity did not fully and accurately make any disclosure as required under this section and the Code of Federal Regulations.

105.17. Disclosures must be provided to the Division at the following times:

105.17.1. Disclosures from providers or disclosing entities

105.17.1.1. Upon submission and execution of the Division's provider enrollment application and the Statement of Participation,

105.17.1.2. Upon request of the Division;

105.17.1.3. Within 35 days after any change in ownership of the disclosing entity.

105.17.2. Disclosures from fiscal agents

105.17.2.1. Upon request of the Division;

105.17.2.2. Upon submission of a proposal during the Division's procurement process;

105.17.2.3. Execution, renewal, or extension of a contract with the Division;

105.17.2.4. Within 35 days after any change in ownership with of the managed care entity.

105.18. Temporary Moratoria

105.18.1. Upon request from CMS, the Division shall impose temporary moratoria on enrollment of new providers or provider types identified by CMS as posing an increased risk to the Medicaid program.

105.18.2. The Division is not required to impose such a moratorium if it determines that imposition of a temporary moratorium would adversely affect

105.18.2.1. If the Division makes such a determination, it shall notify CMS writing.

105.18.2.2. The Division may impose temporary moratoria on

enrollment of new providers or impose numerical caps or other limits that they identify as having a significant potential for fraud, waste, or abuse and that CMS has identified as being at high risk for fraud, waste, or abuse.

105.18.2.3. Before implementing the moratoria, caps, or other limits, the Division must determine that its action would not adversely impact members' access to medical assistance.

105.18.3. The Division shall notify CMS in writing in the event they seek to impose such moratoria, including all details of the moratoria; and obtain CMS's concurrence with imposition of the moratoria.

105.18.3.1. The Division must impose the moratorium for an initial period of six (6) months.

105.18.3.2. If the Division determines that it is necessary, they may extend the moratorium in six (6) months increments.

105.18.3.3. For each occurrence the Division must document in writing the necessity for extending the moratorium.

106. General Conditions of Participation

As general conditions of participation, all enrolled providers must:

106.1. Be fully licensed without restriction and certified under all applicable state and federal laws to perform the services in the applicable category of service, maintain current (non-delinquent) licenses and certifications required for the provision of such services, and inform the Division in writing immediately upon the expiration, suspension, probation, limitation or revocation of any such license or certification. Medical residents may enroll as prescribing physicians using their Residency Training Permit (RTP) only for the purpose of prescribing outpatient prescription medications.

106.1.1. A restriction shall be defined as:

106.1.1.1. A suspension of any license for any period;

106.1.1.2. A license revocation;

106.1.1.3. A limit or restriction on any license which bars the provider from performing any applicable category of service;

106.1.2. As licensure relates to the operation of personal care homes that meet a business need for the Department, an initial provisional license without restriction issued as part of the application process fora license to operate a personal care home shall not be considered a restriction.

106.1.3. Ensure that all licensed professional personnel providing services to members through a provider's number are fully licensed without restriction as defined in §106(A)(1). All licensed professional personnel must meet all standards for full licensure in their respective field.

106.2. Comply with all State and Federal laws and regulations related to furnishing Medicaid/PeachCare for Kids services.

106.3. Provide services in compliance with Title VI of the Civil Rights Act of 1964 as amended which provides that no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

106.4. Provide services in compliance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. Section 504 provide that no otherwise qualified handicapped individual shall solely by reason of his or her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

106.5. Not contact, provide gratuities or advertise "free" services to Medicaid or PeachCare for Kids members for the purpose of soliciting members' requests for services. Any activity such as obtaining a list of Medicaid or PeachCare for Kids members or canvassing neighborhoods for direct contact with Medicaid or PeachCare for Kids members is prohibited. Any offer or payment of remuneration, whether direct, indirect, overt, covert, in cash or in kind, in return for the referral of a Medicaid or PeachCare for Kids member is also prohibited. It is not the intent of this provision to interfere with the normal pattern of quality medical care that results in follow-up treatment. Direct contact of patients for follow-up visits is not considered solicitation, nor is an acknowledgment that the provider accepts Medicaid/PeachCare for Kids patients.

106.6. Allow Medicaid or PeachCare for Kids members the opportunity to choose freely among available enrolled providers. It is not the intent of this provision to preclude referrals to other enrolled providers when medically necessary.

106.7. Not engage in any act or omission that constitutes or results in over utilization of services.

106.8. Not intentionally or negligently damage or endanger the health, safety, or welfare of any Medicaid or PeachCare for Kids member.

106.9. Not bill the Division for an amount greater than the lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date of service or accepted from other third-party payers.

106.10. Neither bill the Division for any services not performed or delivered in accordance with all applicable policies, nor submit false or inaccurate information to the Division relating to provider costs, claims, or assigned certification numbers for services rendered.

106.11. Bill the Division for only those covered services that are medically necessary and within accepted professional standards of practice.

106.12. Accept responsibility for every claim submitted to the Division that bears the provider's name or Medicaid/PeachCare for Kids provider number. Submission of a claim by a provider or his agent, acceptance of a Remittance Advice, or acceptance of claim payment constitutes verification that the services were performed by that provider (or under his direct supervision, if allowed by the Division) and that the provider authorized submission of the claim for reimbursement. Remittance Advices shall be deemed accepted if the provider does not notify the Division or its third-party administrator to the contrary in writing within ninety (90) days after their issuance. Payments shall be deemed accepted when cashed, negotiated, or deposited, including those payments deposited electronically.

106.13. Refund any overpayments to the Division within required timeframes.

106.14. Accept the Division's payment as payment-in-full for covered services to patients accepted as Medicaid or PeachCare for Kids members. In most cases, this does not prohibit the provider from receiving reimbursement for covered services from liable third parties or other insurance plan. See Section 303.5 for special rules that apply to tort cases.

106.15. Deduct all payments for covered services received from third parties or other insurance plans from the amount billed to the Division for covered service(s) rendered and notify the Division regarding the existence of any other insurance or third-party resource unless billing for managed care co-payment.

106.16. Agree not to seek or accept any payment whatsoever for covered services from the member or other interested party when the member was accepted as a Medicaid or PeachCare for Kids member. However, they are required to pay a co-payment for some services received. Further, no deposit may be required from the member or other interested party pending receipt of Division payment.

106.17. Not seek reimbursement from the member or other interested party from claims submitted to the Division for which payments subsequently are denied, reduced, recouped, or refunded due to the provider's failure to comply with Divisional policies and procedures (e.g., timely submission of claims, incorrect billing, determination that services were not medically necessary, etc.) or due to the provider's receipt of payment from a third party.

106.18. Maintain such written records for Medicaid/PeachCare for Kids members as necessary to disclose fully the extent of services provided and the medical necessity for the provision of such services, for a minimum of six (6) years after the date of service. Active and recently active records must be maintained at the approved service location for review for a minimum of (2) two years after the last date of service. Providers should ensure that a photocopy of the member's record is forwarded to a member's new provider during a change of ownership, voluntary or involuntary termination, transfer of a member to a new provider or any other action that requires the review of member records to determine course of treatment. Member records must, at a minimum, reflect the date of service, member name and medical history, the service provided, the diagnosis and the prescribed drugs or treatment ordered, and the original (not stamped)

signature of the treating provider. The Department will accept secure electronic signatures as defined in the Definitions section of this Manual. Please refer to Part II for more stringent documentation and secure electronic signature requirements applicable to different categories of service.

106.19. Comply in a timely fashion with all requests for records, information, and documentation made by the Division, its authorized representatives and agents, and the Secretary of the U.S. Department of Health and Human Services, related to services provided under the Medicaid/PeachCare for Kids Program. Records, information, and documentation requested during onsite visits must be made available within two (2) hours of the request to be considered timely. Records requested by mail must be made available within 14 days of the date of the request letter to be considered timely. Records not received in a timely fashion may be subject to recoupment for the services which are the subject of the audit. No fee can be charged to the Division by the provider for records, information and/or documentation requested by the Division, its agents or the Department of Health and Human Services. When a provider or authorized billing entity utilizes Electronic Health Records (EHR), the provider or authorized billing entity is required to authorize the release of EHR to the Department, Medicaid Fraud Control Unit, or law enforcement agencies within the required time frame. Failure to comply with this requirement can result in adverse action including but not limited to suspension or termination of the provider and/or authorized billing entity. A copy of the authorization shall be required at enrollment/revalidation, or at the time a provider contracts with an EHR company, whichever event occurs first.

106.20. Make available for on-site audits by the Division or its agents all records related to services for which claims are submitted to the Division (including private-pay invoices, other insurance remittance advices, denial letters and explanation of benefits for members with other insurance). (Refer to time guidelines stated in Part I, Section 106

106.21. Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Division or its agents. No fee can be charged to the Division by the provider for records, information and/or documentation requested by the Division, its agents or the Department of Health and Human Services.

106.22. Adhere to all the applicable policies and procedures of the Department.

106.23. Not have been terminated from or refused enrollment by the Division in the Medical Assistance Program within one year prior to the date of application, or within a period otherwise specified by the Division.

106.24. Not employ or contract with a person, provider, owner, managing employee, partnership, or corporation previously terminated or suspended from the Program, barred from enrollment, previously or currently placed on the Department of Health and Human Services, Office of the Inspector General's sanction or exclusions lists, General Service Administration's Excluded Parties List System (EPLS), the Social Security Administration's Death Master File or a person, owner, managing employee, partnership, or corporation that has ever been convicted of any offense as described in §404(J) of this Manual. Medicaid payments cannot be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services knew or should have known of the

exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. (42 CFR Section 1001.19019(b)). The exclusion includes administrators, billing agents, accountants, claims processors or utilization reviewers that are related to and reimbursed, directly or indirectly by a Medicaid program. Providers can search by individual names or entity names on the HHS- OIG, EPLS, and the Social Security Administration's Death Master File websites. Providers are required to search the HHS-OIG and EPLS websites monthly to capture exclusions and reinstatements that have occurred since the last search. Providers are required to report to the Department of Community Health Provider Enrollment Section immediately any exclusion information discovered among employees or contractors.

106.25. The Provider, owner, and managing employee cannot appear on the Department of Health and Human Services, Office of the Inspector General's (OIG) Exclusion List, General Service Administration's Excluded Parties List System (EPLS), and the Social Security Administration's Death Master File. Providers required to have a NPI number must appear on the National Plan and Provider Enumeration System (NPPES).

106.26. Provide services in compliance with the Age Discrimination Act of 1975 as regulated by 45 CFR, Part 91 which provides that "no person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

106.27. Furnish to the Division and to the Secretary of the U.S. Department of Health and Human Services, within thirty-five (35) days of the date of a request, full and complete information about the ownership of any subcontractor with whom the provider had business transactions totaling more than Twenty-Five Thousand Dollars ($25,000) during the twelve (12) month period ending on the date of the request, and any significant business transactions between the provider and wholly-owned supplier, or between the provider and any subcontractor, during the six (6) year period ending on the date of the request.

106.28. Disclose fully and accurately to the Division, prior to execution or renewal of a Statement of Participation or upon written request by the Division, the identity of any person who has ownership or controlling interest in the provider organization or is an agent or managing employee of the provider and their criminal history, if any.

106.29. Furnish services to a member regardless of a third party's potential liability for payment for the service.

106.30. Not bill or otherwise seek reimbursement from the member or other interested party for missed appointments, claims preparation, completion of forms, telephone consultations, after hours surcharges, reading or interpreting reports, supplying supporting documentation to the Division or its Third-party administrator, or forwarding copies of a patient's medical records one time to other providers when requested by the patient or the patient's chosen provider. If a patient requests a provider to forward medical records more than one time, the provider may charge the patient a reasonable cost for making the copies, not to exceed ten dollars ($10.00).

106.31. Refund to the Division any prescription drug rebates obtained by the provider for prescription drugs furnished to members.

106.32. Maintain current contracts with other State agencies if said contracts are necessary to continue operations.

106.33. Not alter patient records, even in an effort to correct an error. All errors shall be corrected according to currently accepted standards of medical practice (corrections shall evidence the error, the correction, the initials of the corrector and the date of the correction). Failure to comply with medical records requirements will subject providers to recoupment of payment. See §405.

106.34. Register your National Provider Identifier with the Department prior to May 23, 2007.

106.35. Be responsible for the integrity and accuracy of its representations and the Division may reasonably rely upon the representations and certifications made by the Provider, without first making an independent investigation or verification.

106.36. Be responsible for the integrity and accuracy of its audit reports, summaries, analyses, certifications, reviews, and work products and the Division may reasonably rely upon any audit report, summary, analysis, certification, review, or work product that the provider produces in accordance with its duties under its Statement of Participation, without first making an independent investigation or verification.

106.37. Not employ, contract, or partner with any person employed with the Department or with any person employed by a subcontractor or vendor of the Department.

106.38. Comply with the Privacy Rule and the Security Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as set forth in federal regulations at 45 C.F.R. Parts 160 and 164, and maintain administrative, physical and technical safeguards of protected health information.

106.39. Consent to criminal background checks including fingerprinting.

106.40. Not intentionally or knowingly order, refer, or prescribe and item and/or service that allows a false or fraudulent claim to be presented for payment by Medicaid.

106.41. Re-credential their enrollment as required by Section 105.14.

106.42. Be approved by the Credentialing Committee for initial credentialing, enrollment, re-enrollment or re-credentialing.

106.42.1. Compliance with 42 U.S.C. §1396(a) (68)

As further terms and conditions of participation, and in compliance with 42 U.S.C. §1396(a)(68), all entities that receive annual Medicaid payments of at least $5 million shall, as a condition of receiving such payments, establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in 42 U.S.C.§1396(a)(68)(A).

The entity must provide copies of its written policies to its employees (including management), and to any of its contractors and agents that perform billing or coding functions for the entity, or that furnish or authorize the furnishing of Medicaid health care items or services on behalf of the entity, or that are involved in monitoring of health care provided by the entity.

The entity's written policies and procedures must contain detailed information about the Federal laws identified in Section 6032(A) and about Georgia's laws imposing civil or criminal penalties for false claims and statements, and about whistleblower protections under such laws as found in the State False Medicaid Claims Act, Article 7B of Chapter 4 of Title 49 of the Official Code of Georgia.

The entity's written policies and procedures must also contain detailed information regarding its own policies and procedures to detect and prevent fraud, waste and abuse in Federal health care programs, including the Medicare and Medicaid Programs. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents.

The entity's written policies and procedures must be included in any employee handbook maintained by the entity. The entity need not create an employee handbook if one already exists.

Affected entities shall execute an Attestation of Compliance (Appendix K) that will be maintained with the Department. Affected entities are those that meet the $5,000,000 annual threshold as measured from October 1 through September 30 of the previous Federal fiscal year.

As further explanation, please note the following:

106.42.1.1. An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for- profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

106.42.1.2. An "employee" includes any officer or employee of the entity.

106.42.1.3. A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services,

performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

106.42.1.4. If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

106.42.1.5. A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

NOTE: Initial Attestations are due on July 15, 2008. Subsequent yearly submissions are due December 31.

106.43. Georgia Tamper-Resistant Prescription Pad Program

106.43.1. As further terms and condition of participation, the Georgia Medicaid Fee- For-Service (FFS) Outpatient Pharmacy Program in accordance with Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, and in an attempt to combat fraud and abuse, will require prescribers to use tamper- resistant prescription pads for any new prescription with fill dates on and after April 1, 2008. This requirement applies to hard copy prescription orders for any drug, device or product covered through the Medicaid FFS outpatient pharmacy program whether legend or over-the counter. Prescribers should review their Part II, Policies and Procedures manuals for any additional requirements.

106.43.2. Effective April 1, 2008, a prescription pad must contain at least one of the following three characteristics:

Required tamper-resistant characteristics include one or more industry-recognized features designed to:	**Examples include but are not limited to:**
Prevent unauthorized copying of a completed or blank prescription form	High security watermark on reverse side of blank Thermochromic ink technology Copied prescription blanks show the word "Copy," "Illegal," or "Void."

Prevent erasure or modification of information written on the prescription by the prescriber	Tamper-resistant background ink shows erasures or attempts to change written information
Prevent the use of counterfeit prescription forms	Duplicate or triplicate blanks

106.43.3. Beginning April 1, 2008, any pharmacist receiving a hard copy prescription not written on a tamper-resistant prescription blank for a Medicaid recipient subject to this rule must verify the prescription order with the prescriber's office by handwriting on the face of the original prescription the name of the person contacted at the prescriber's office, the date verified, the initials or name of the pharmacist or licensed pharmacy intern who verified the prescription, and the word "Verified."

106.43.4. In circumstances of other insurance coverage in addition to Medicaid, tamper-resistant prescription pads are required regardless of whether Medicaid FFS the primary or subsequent payer is.

106.43.5. A prescription order written on a tamper-resistant prescription blank does not automatically make the prescription order compliant or valid. The pharmacist must exercise professional judgment and take appropriate measures necessary to ensure the validity and integrity of any prescription received. As always, the pharmacist must comply with all Medicaid Policies, as well as all laws and regulations applicable to the practice of pharmacy.

106.43.6. Effective for dates of service on and after October 1, 2008, all prescription pads utilized for Medicaid FFS member prescriptions must comply with all three of the characteristics in the table above.

106.43.7. A prescriber's or pharmacy's routine failure (as determined by the Division) to comply with the requirements of this term and condition of participation will subject it to sanctions up to and including termination from the Medicaid/PeachCare for Kids programs.

107. Member Eligibility

The Division establishes eligibility criteria for Medicaid/PeachCare for Kids benefits based upon federal regulations. Eligibility criteria for major coverage groups are identified in Appendix B.

107.1. Verification of Eligibility

It is the responsibility of the provider to verify Medicaid/PeachCare for Kids eligibility on each date of service.

Though members will be issued Medicaid/PeachCare for Kids identification cards (See Appendix C) which should be presented, providers must verify eligibility by contacting the Provider Contact Center at (770) 325-9600 or 1-800-766-4456 or by conducting a member eligibility verification on the third-party administrator's website at

www.mmis.georgia.gov. Providers may request verification either individually or in batch by submitting a HIPAA-compliant transaction, or by submitting a written request for eligibility verification to:

GAINWELL TECHNOLOGIES
P.O. Box 105200
Tucker, Georgia 30085-5200

Written requests for eligibility verification must include the patient's full name, social security number if available, Medicaid/PeachCare for Kids number if available, home address, date of birth, gender, and date of service for which verification is sought.

Providers may also submit electronic requests for eligibility verification through their clearinghouse to the third-party administrator's EDI gateway. More information about this submission may be obtained by contacting the EDI Unit at: 1-800-987-6715 or www.mmis.georgia.gov.

Providers may also confirm a member's Primary Care Provider through the Provider Contact Center, the third-party administrator's website (www.mmis.georgia.gov) or eligibility vendors who provide access to eligibility information through the magnetic swipe and readers on the member identification cards.

Providers are barred from accepting Medicaid members if the Provider is not willing to accept a member who has been issued a temporary Medicaid card.

Please Note: That the Division does not guarantee payment unless the patient is actually eligible and Federal Financial participation is available.

107.2. Verification of Eligibility for Disproportionate Share Hospitals

The Division facilitates Medicaid/PeachCare for Kids eligibility verification for the benefit of hospitals that serve a disproportionate share of low-income patients. The disproportionate share hospital (DSH) may access this verification service as provided in this policy. In order to enable DSH providers to efficiently access the extensive data necessary for this verification, the Division provides data access only through appropriately qualified contractors. The selection of contractors who will be authorized to provide the data will be based upon considerations that include whether:

107.2.1. The proposed service is consistent with the relevant goals and objectives of the Medicaid/PeachCare for Kids program.

107.2.2. The disproportionate share hospitals in the proposed market to be served have a need for the service.

107.2.3. Existing alternative access to the necessary eligibility verification by the DSH providers to be served is not cost efficient for those providers.

107.2.4. The service is reasonably financially and physically accessible to the DSH providers.

107.2.5. The proposed service fosters overall improvement in the system of

reimbursement for health care services without a loss of quality of care.

107.2.6. The contractors are bound by the terms of a contract with DCH for eligibility verification services and by applicable laws and regulations, particularly those provisions governing confidentiality and privacy of information.

Providers may also submit electronic eligibility verification requests on the web through the department's third-party administrator's website at www.mmis.georgia.gov. Batch eligibility requests can be submitted through the web in a HIPAA-compliant format. For more information, providers may contact the third-party administrator's EDI gateway at 1800-987-6715.

107.3. Presumptive Pregnancy Eligibility

Women who are granted presumptive eligibility shall be entitled to receive medical assistance as described in accordance with the DCH Provider Manuals when such assistance is provided pursuant to the following conditions:

107.3.1. Services must be provided on an ambulatory basis;

107.3.2. Services must be related to the pregnancy; and

107.3.3. Services must not be provided for the purposes of terminating the pregnancy or preventing future pregnancies

Women eligible under Presumptive Pregnancy eligibility criteria shall not have access to non-ambulatory care including but not limited to inpatient care, institutional care, and long-term home health care. Providers submitting claims for women eligible under a presumptive pregnancy category of aid are attesting the ambulatory service billed is medically necessary and related to the pregnancy.

108. Premium Payment and Continued Coverage

Some Medicaid/PeachCare for Kids services require members to pay premiums. Unless stated to the contrary in Part II, premiums are due and payable on the first day of the month preceding the month of coverage (i.e. April 1st for May coverage). Late payment of premiums could result in a break in coverage. Premium amounts for different programs and the effect of their untimely payment are described in Appendix D.

109. Limitations on Member Services

The Division has developed certain service limitations in an attempt to deter members' over-utilization of services (e.g., office visits, prescriptions, examinations, etc.). Please refer to Part II for limitation information applicable to different categories of service. Inquires related to a member's utilization history should be directed to the Provider Contact Center by dialing 1-800-766-4456. Data provided will be for informational purposes only and should not be regarded as official records upon which reimbursement relies. The Division is not responsible for the payment of services exceeding any monthly, annual, or other period limitation.

109.1. Member Lock-In

Federal regulations provide that the Division may place restrictions on the provider or providers from which a member can receive items or services if the Division has determined that the member has utilized such items or services at a frequency or amount not medically necessary as determined in accordance with utilization guidelines established by the Division. Members determined to be abusing the Medicaid Pharmacy Benefit shall be placed in Pharmacy Lock-In status for an initial period not to exceed twenty-four (24) months. At the conclusion of the lock-in period, the member's usage will be reevaluated to determine whether or not restriction(s) should continue. The Division will select the single physician or pharmacy to provide services to the locked-in Member. The provider chosen will be geographically situated to give reasonable access to the Member.

109.1.1. A Lock-in does not apply to emergency services or if a specialized provider is medically necessary.

109.1.2. The selected physician and pharmacy will be contacted by the Division. The selected physician and/or pharmacy may decline participation if they so desire.

109.1.3. Claims submitted for a lock-in member by providers other than those selected will be denied.

At the conclusion of the lock-in period, the member's usage will be reevaluated to determine whether or not restriction(s) should continue.

While in Lock-In Status, the member will be restricted to one pharmacy to obtain their Medicaid prescriptions; other pharmacies will not be paid if they fill Medicaid prescriptions prescribed for the member. If the member is also locked into one provider/provider group only prescriptions prescribed by the designated provider will be reimbursed. The Point-of-Sale system will alert pharmacies of any lock-in restrictions placed on an individual member during on-line/real-time adjudication. Pharmacy Lock-In will be under the purview of the Division's Program Integrity Unit who shall determine the need for lock- in according to established utilization criteria. Please review Part II Policies and Procedures for Pharmacy Services manual section 606.1.

110. Paperless Initiatives

Georgia Medicaid launched a paperless initiative that began September 1, 2014, and implement it over a 10-month period in 2015. Provider notifications were published to alert-to-alert enrolled providers of the transition.

The Paperless Initiative enhance providers' experiences for online-only provider enrollment, electronic submission of claims filing for all claim types and provider types (no paper submissions will be accepted on or after May 1, 2015, except for Out-of-State claims for providers, filing appeals, and disbursement of payments to providers. The types of claims submitted electronically and/or via the web portal are the DMA520 Form (Provider Inquiry); Medicare and Medicare Advantage Claims; Institutional claims; and Inpatient Part B only claims. Any claims submitted on paper after

May 1, 2015, will be returned to the provider with a letter stating that the claims must be submitted electronically.

GA Medicaid is updated its manual and paper processes to expedite the handling of Georgia Medicaid claims through a 24/7 depository for all claims, electronic remittance advices (no mailed copies), to allow more timely filing of claims and appeals for easy access and follow-up, as well as increase efficiency and reduce administrative burden and overhead cost for our providers, improve cash flow, diminish the downtime of mail delivery, and a quicker and more secure transmission of payments through an Electronic Fund Transfer (EFT) process.

110.1. Post Office Boxes

There are some Gainwell Technologies PO boxes that will remain open and not closed under the Paperless Initiative. The following Post Office boxes are to be used for the specific mailed documents to Gainwell Technologies in Tucker, GA 30085.

Gainwell Technologies PO boxes will remain open and not be closed under the Paperless Initiative. The following Post Office boxes are to be used for the specific mailed documents:

110.1.1. PO Box 105200 – Member and Provider Correspondence

110.1.2. PO Box 105208 – Retroactive Eligibility Claims, Out of State Claims (Over 50 miles beyond the GA border), and Outlier Documentation

110.1.3. PO Box 105209 – Miscellaneous Non-Claim documents and Business Reply mail such as returned EOMBS and MSQs

ALL paper claims, appeals, certain forms, prior authorization/pre-certifications, provider enrollment documents are to be submitted as instructed (electronic or faxed). The Georgia Medicaid Information Management System (GAMMIS) secure web portal is found at www.mmis.georgia.gov.

On or after May 1, 2015, no paper or hard copy claims or paper appeals or prior authorization requests beyond GA Medicaid's policy deadlines will be accepted in GAMMIS. Only OUT OF STATE providers and facilities enrolled in GA MEDICAID located beyond 50 miles of the state border can submit paper or hard copy claims, paper appeals or prior authorizations via the listed PO Boxes above.

Chapter 200: Submission and Resubmission of Claims

201. General

This chapter describes the process for submitting claims for Medicaid/PeachCare for Kids reimbursement.

202. Medicaid/PeachCare for Kids Claims

Medicaid/PeachCare for Kids claims may be filed by hard copy, electronically through the Division's Electronic Data Interchange (EDI), or individually or in batch files through the third-party administrator's website at www.mmis.georgia.gov. In order to submit claims through EDI, a provider must first execute the Division's Provider Agreement for EDI. For information regarding this agreement and other requirements of EDI claim submission please contact:

Gainwell Technologies
ATTN: Electronic Data Interchange Enrollment Unit
P.O. Box 105201 Tucker, GA 30085-5201
1-877-261-8785 (toll free) or 770-325-9590(local)
www.mmis.georgia.gov

202.1. Submission of Claims by Terminated/Suspended Providers or those appearing on the DHHS OIG exclusion list

The Division will no longer reimburse claims for initial and refill prescriptions for drugs and services issued by physicians on the OIG Exclusion List or providers/physicians terminated/suspended from the Georgia Medicaid Program. The license numbers of these physicians/providers will be blocked by the Division's PBM, and payment will be denied for any prescription filled or refilled utilizing these numbers.

PLEASE NOTE: Physicians holding valid and active Georgia license numbers from the Composite Board of Medical Examiners may appear on this list.

202.2. Use of the National Provider Identifier (NPI) &Provider Medicaid ID

202.2.1. The provider's NPI is the required identifier on the following EDI and PES electronic transactions PES electronic transactions:

202.2.1.1. Claims

202.2.1.2. Claims Inquiry/Claims Status

202.2.1.3. Eligibility Status

202.2.2. The Provider Medicaid ID assigned at the time of enrollment is the required identifier on all Web transactions.

202.2.3. The Provider Medicaid ID assigned at the time of enrollment must be used as the provider identifier on the American Dental Association Claim Form.

202.2.4. The Provider Medicaid ID and the National Provider Identifier both must be submitted as provider identifiers on the UB04.

202.2.5. The Provider Medicaid ID assigned at the time of enrollment must be used as the provider identifier on the CMS 1500 (Rev. 04/2014)

203. Timely Submission of Medicaid/PeachCare for Kids Claims

203.1. Submission of Claims

203.1.1. Upon completion of services, providers are required to take all reasonable measures to determine the liabilities of third parties to pay for Medicaid/PeachCare for Kids covered services, and if third party liability is established, to bill the third party and exhaust appeal rights before filing a Medicaid/PeachCare for Kids claim. See Section 303 for exceptions to this requirement.

203.1.2. If third party liability is not established, providers should file the original claims as outlined in the program-specific billing manual, copies of which are available through the respective Provider Inquiry Unit.

203.1.3. Failure to file a claim so that it is received within six (6) months after the month in which service was rendered and/or failure to obtain prior approval or precertification when required will result in the denial of the claim. See Section 202.2 for exceptions to this requirement. The purpose of prior authorization or precertification is to monitor and control utilization of those medical procedures, supplies and services that are most susceptible to over-utilization and abuse. Obtaining prior approval or precertification does not guarantee payment of a claim. All requests for prior approval or precertification should be addressed to the appropriate staff or organization indicated in Part II of the manual.

203.1.4. Claims will be denied under Section 202.1(c) regardless of:

203.1.4.1. Change in or absence of office management or billing personnel,

203.1.4.1.1. Change in office procedures such as the computerization of claims processing,

203.1.4.1.2. Lack of coordination between billing staff and providers in obtaining signatures or other authorizations

203.1.4.1.3. Delay in obtaining necessary claims

forms because of provider or provider staff

203.1.4.2. Loss of claims in transit to the Third-party administrator or Division,

203.1.4.3. Billing claims under the wrong provider number, and

203.1.4.3.1. A provider's unawareness of a patient's Medicaid/PeachCare for Kids eligibility unless the determination of the patient's eligibility was pending on the date of service (in which case the provider must submit a completed Pending Eligibility Affidavit attached hereto as Appendix G). It is the responsibility of a provider to verify the eligibility of a Medicaid or PeachCare for Kids member on each date of service. In the event that a provider fails to submit a claim or request prior approval in a timely fashion because of unawareness of a patient's Medicaid/PeachCare for Kids eligibility, even if that unawareness was caused by action or inaction on the part of the patient, the settlement of associated claims for services is between that provider and that patient as the Division will not bear financial responsibility.

203.2. The submission of claims with dates of service after a member's date of death are prohibited and will be denied

203.3. Exceptions to Section 202.1(c)

The categories identified in this section are considered extenuating or have been determined by the Commissioner of DCH, as authorized by O.C.G.A. §49-4-145, to constitute conditions beyond the control of providers. Claims which fall into a category identified herein will not be denied if received more than six (6) months after the month in which service was rendered or lack of timely prior approval or precertification, but still must be medically necessary and meet the requirements specific to each category, despite any failure on the part of the Medicaid or PeachCare for Kids member, to be approved.

203.3.1. Catastrophic Event: An extraordinary circumstance (e.g. fire, flood, vandalism, etc.) has caused the destruction of records. Claims in this category must be received, along with a letter detailing the events and dates of occurrence, within twelve (12) months from the month of service at the following address:

Department of Community Health Division of Medicaid
Attn: Division Director
East Tower, 19th Floor,
2 MLK, Jr Dr., SE.
Atlanta, GA 30334

203.3.2. Claims originally filed timely with a third-party carrier, but were recouped, denied or paid insufficiently, must be billed to Medicaid three (3) months of the date of the recoupment letter, denial or payment, but never more than twelve (12) months from the month of service.

Claims filed timely with a third-party carrier, but did not generate a response from the carrier despite all reasonable actions taken, may be filed with Medicaid using the COB Notification Form attachment, DMA-410, indicating no response was received.

When billing a hard copy or paper claim, claims in this category must be received, along with

203.3.2.1. a copy of the third-party denial notice,

203.3.2.2. a copy of the third-party payment record, or

203.3.2.3. a completed COB Notification Form signed and dated by the provider or provider's representative. The signature date on the form must be within 12 months of the date of service.

When filing claims electronically through the third-party administrator's website, the provider must access all "Other Insurance Information and Additional Detail" screens necessary to advise the Division of the primary insurance final adjudication determination. Please refer to Section 7, Appendix H, Billing Manual, for details of billing Medicaid as Secondary. Parties may file claims electronically using any other EDI format (PES or a clearinghouse), but if the other insurance denies the claim or pays a $0.00, the claim will suspend for thirty (30) days to allow sufficient time to submit, by fax or mail, a copy of the appropriate denial documentation or COB Notification form.

203.3.3. Retroactive Eligibility: An individual is not a Medicaid or PeachCare for Kids member on the date of service, the individual later applies for Medicaid/PeachCare for Kids and is determined to be eligible not only for the current month, but also for the month in which service was rendered.

If a provider, who has already rendered service, learns that the patient subsequently qualified for Medicaid/PeachCare for Kids eligibility for the dates that service was rendered, the provider may:

203.3.3.1. Continue to bill the patient as private pay because the patient had not been accepted as a Medicaid or PeachCare for Kids member on the date of service, or

203.3.4. Accept the patient as a Medicaid or PeachCare for Kids member after the fact and bill the Division for the dates of service accordingly. Claims in this category must be received by the Division within six (6) months after the date in which the determination of retroactive eligibility was made at the address used for regular claims submission. This policy may not apply to services that require a Prior Authorization (PA). Please review the applicable Part II Manual for specific information regarding retroactive prior authorizations.

203.3.5. Medicare/Medicaid Crossover Claims: Claims on eligible Medicaid members that were originally timely filed with Medicare, allowed by Medicare, and submitted to Medicaid by Medicare or provider for potential payment of coinsurance and deductible amounts.

Claims in this category must be received within twelve (12) months from the month of service.

203.3.6. Medicare Denials: Claims on eligible Medicaid members that were originally timely filed with Medicare but were denied by Medicare.

Claims in this category are not crossover claims. When filed on paper they must be received, along with 1) Medicare Remittance Advice (RA), 2) letter of denial from either the Social Security Administration or fiscal intermediary, 3) Social Security Administration 1600, or 4) Work- In-Progress (WIP), within three (3) months of the month in which Medicare denied payment at the address used for regular claims submission.

For claims in this category that are filed electronically using the third-party administrator's website, the provider must complete all required data fields in the "Other Insurance Information and Additional Detail" screens. If billing using EDI (PES or other clearinghouse vendor), your claim will automatically pend for 30 days to allow sufficient time for the provider to fax or mail in a copy of the Medicare RA denial or other appropriate denial documentation. The document must include the associated Medicaid Transaction Control Number (TCN) in the upper right-hand corner. An indication that the Medicare patient is enrolled in a Health Maintenance Organization (HMO) is not an example of a valid denial and associated claims must be submitted to the HMO.

204. Remittance Advice

Medicaid/PeachCare for Kids and Medicaid/Medicare crossover claims which are paid, denied, adjusted, or placed in-process by the Division will be listed on the Remittance Advice. The information contained on the Remittance Advice is intended to assist the provider in reconciling Medicaid/PeachCare for Kids accounts and to assist the Division in guarding against false or erroneous billings. Remittance Advices will be provided to providers through the mail, the provider's Message Center on the third party administrator's website, www.mmis.georgia.gov, or the Bulletin Board System (BBS). Remittance Advices provided electronically will be in a HIPAA-compliant format. The Remittance Advice will contain one or more of the following sections, depending on the claims filed by the provider and the action(s) taken by the Division on those claims.

204.1. Paid Claims

The Remittance Advice will list each claim paid, the date of service, the amount paid for each service on the claim, and the total amount paid for each claim. Some paid claims may have lines disallowed. These disallowed lines actually are denied charges and may be resubmitted. The reason for the disallowance is listed to the left of the line that was disallowed. Note that same claims in paid status may have paid zero dollars.

204.2. Pending Claims

This Remittance Advice section will indicate those claims that require further research, evaluation, or other action by the Division before they can be paid or denied. As long as a claim is pending, it is not necessary for a provider to submit a duplicate claim. The Pending Claims section will reflect only those claims that have entered the Division's computer system. Claims that have been received by the Division but are still being prepared for computer entry will not be shown. It is the responsibility of the provider to ensure that each and every claim is received by the Division within applicable deadlines for submission and resubmission. If a claim does not appear as pending, or if a claim ceases to appear on the pending report and the provider is not aware of its payment or denial, the provider bears the responsibility for inquiring about the claim's status and taking appropriate action.

204.3. Denied Claims

The Remittance Advice will indicate the adjustment reason code(s) and remark code(s) that indicate why a particular claim, or service could not be paid. The denial of a claim constitutes the termination of the transaction between the Division and the provider for the services billed. Any reconsideration for payment must be initiated by the provider through a new claim. If the provider does not intend to resubmit the claim, the charges for the services should be written off any accounts receivable records maintained by the provider since no further action will be taken by the Division.

204.4. Adjustments

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

204.5. Financial Transactions

The Remittance Advice will indicate refund adjustments, recoupments subtracted from the amount payable, voluntary refunds by the provider, and lump sum payouts.

204.6. Banner Messages

A Banner Message is a means to inform providers of upcoming changes in Medicaid/PeachCare for Kids policy of which they should be aware. Banner Messages will be posted on the third-party administrator's website at www.mmis.georgia.gov. The Division considers Banner Messages formal notice to providers of changes occurring in Medicaid/PeachCare for Kids.

205. Timely Resubmission of Medicaid/PeachCare for Kids Claims

It is the provider's responsibility to monitor the status of submitted claims. Providers are instructed to check their Remittance Advices before submitting repeat requests for payment. Claims should be resubmitted to the Division only if they meet one or more of the following criteria:

205.1. The claim does not appear as paid, denied, or in-process after thirty (30) days from the date of original submission to the Division. Claims in this category must be received by the Division within six (6) months from the month in which service was rendered.

205.2. The claim has appeared as pending on a Remittance Advice and subsequently fails to appear on a Remittance Advice as paid, denied, or pending. Claims in this category must be received by the Division within six (6) months from the month in which service was rendered.

205.3. The claim has been denied due to erroneous or missing information. Claims in this category must be received within six (6) months from the month in which service was rendered or within three (3) months of the month in which the denial occurred, whichever is later. Denied claims must be resubmitted with corrected information on the third-party administrator's website at www.mmis.georgia.gov. When resubmitting a denied claim more than six (6) months after the month of service, it is necessary to attach a copy of the Remittance Advice with the denial to demonstrate that the original claim had been timely submitted.

Claims may be edited and resubmitted through the third-party administrator's website at www.mmis.georgia.gov.

Photocopies of claim forms may not be used and will be returned by the Division without further processing. Any claim denied for failure to be submitted or resubmitted timely will not be reprocessed.

206. Adjustments Related to a DCH initiated Mass Reprocessing

A DCH initiated Mass Reprocessing is defined only as a Mass Reprocessing that impacts the DCH enterprise level (not the DCH operational level), is initiated by DCH on the DCH Mass Reprocessing Request Form, which is subsequently sent from DCH to GAINWELLC, and is approved by the Medicaid Chief, Medicaid Chief's designee, or DCH Commissioner.

GAINWELLC will identify all the provider claims that are adversely impacted by the DCH enterprise level mass adjustment. The providers will be granted 30 days from the date of the adjustment to resubmit the impacted claim. The adverse impact must be a direct result of the mass adjustment. Only line items on the claim directly involved in the DCH initiated mass adjustment may be adjusted in the defined 30-day window.
Failure to adjust the claim within the 30-day time period during the DCH enterprise mass reprocessing is not grounds for Administrative Review. Adjusting line items on the claim outside those directly involved in the DCH enterprise level-initiated mass adjustment shall be considered fraudulent and result in claim denial and may be subject to recoupment.

Only line items on claims adversely impacted by a DCH initiated mass adjustment shall be considered upon request for administrative review pursuant to Georgia Medicaid Part 1 Policies and Procedures for Medicaid/ PeachCare for Kids, Chapter 500.

206.1. Adjustment Requests

If the amount reimbursed by the Division to an enrolled provider is not correct, a positive or negative adjustment may be necessary. Following are the procedures related to positive and negative adjustments.

206.1.1. Positive Adjustments

When a provider can substantiate that additional reimbursement is appropriate, the provider may adjust and resubmit a claim. To adjust or void a claim, with a secure log in, go through the third-party administrator's website at www.mmis.georgia.gov.

All documentation must be received within three (3) months from the month of payment. The adjustment request must include sufficient documentation to identify each claim. Incomplete requests will be returned without further action. Documentation includes but is not limited to:

206.1.1.1. COB's explanation of benefits (EOB)

206.1.1.2. Explanation of Medicare benefits (EOMB)

206.1.1.3. Medicaid Remittance Advice (RA)

If a positive adjustment is warranted, the Division will make additional reimbursement upon processing of the request. If an adjustment is not warranted, the provider will be notified via Remittance Advice or written correspondence from the Division.

206.1.2. Negative Adjustments

When a provider believes a negative adjustment is appropriate, the provider may adjust and resubmit a claim. This may be done through the third-party administrator's web site at www.mmis.georgia.gov.

This will result in a deduction from future reimbursement. A provider may also mail a check for the appropriate amount along with a copy of the paid Remittance Advice to:

New lockbox address, effective 5/1/2020

Benefits Recovery Section
Division of Medical Assistance
PO Box 734660
Dallas, TX 75373-4660

The Department does not accept checks with limited endorsements. Providers submitting checks with limited endorsement language waive such endorsement when rendering payment to the Department. There is no timeliness limitation for processing negative adjustments.

206.1.3. Reordering Claim Forms

To reorder CMS-1500 or UB-92 claim forms please contact: U.S. Government Printing Office at (202) 512-1800

To reorder the American Dental Association 1999, Version 2000 Claim Form for dental services, please call: 1-800-947-4746

206.1.4. Inquiries Regarding Claims and Policies and Procedures

Claim status inquiries that require submitted documentation may be conducted through the third-party administrator's website at www.mmis.georgia.gov. Submit under the link "Prior Authorization/Provider Workspace/Provider Inquiry Form (DMA-520A)". Provider correspondence or written inquiries that require review should be directed to:

GAINWELL TECHNOLOGIES
P.O. Box 105200
Tucker, Georgia 30085-5200 (Statewide)
1-800-766-4456

207. Emergency Medical Assistance for Immigrants

Immigrants, including undocumented immigrants, who, except for their immigration status, would be eligible for Medicaid, are potentially eligible for Emergency Medical Assistance. This includes persons who are aged, blind, disabled, pregnant women, children, or parents of dependent children who meet eligibility criteria. Services rendered to Emergency Medical Assistance (EMA) recipients are limited to emergency care only. As described in the Federal Regulations 1903 (v) of the Social Security Act and the Code of Federal Regulation 42 CFR §440.255, emergency services are those that are:

207.1. Medically necessary, and

207.2. Result from the sudden onset of a health condition with acute symptoms, and

207.3. In the absence of immediate medical attention, are reasonably likely to result in at least one of the following:

207.3.1. placing the individual's health in serious jeopardy, or

207.3.2. serious impairment to bodily functions, or

207.3.3. serious dysfunction of any bodily organ or part.

208. Submission of EMA Claims

208.1. A physician must verify that the service has been rendered. The physician verifies emergency medical services by completing DMA Form 526, "Physician's Statement for Emergency Medical Assistance". The signature on the DMA Form 526 should be the original signature of the Physician or a medically trained employee of the Physician designated to act on his behalf. DMA Forms 526 using the Physician's stamped signature are not acceptable. The form must be submitted to the County Department of Family and Children Services or out stationed Medicaid Worker as part of the Medicaid eligibility determination.

208.2. With certain exceptions, all claims for services provided to individuals eligible under the Emergency Medical Assistance Program will be reviewed by Alliant on a case-by-case basis. The exceptions are as follows:

208.2.1. Labor and Delivery Services Only (Prenatal and Postpartum Care is not covered)

208.2.2. Dialysis Services

208.3. Provider claims must be submitted electronically via the web portal. Claims must include documentation that supports the emergent nature of the services provided. Records should be submitted in distinct sections and in chronological order beginning with the admit date through the date of discharge. Only the following should be submitted to GMCF for review:

208.3.1. History and Physical

208.3.2. Admission Notes

208.3.3. Discharge Summary

208.3.4. Operative Report, if applicable

208.3.5. Physician Progress Notes

208.3.6. Deliveries or C-section claims only: L&D report or C-Section Opreport.

208.3.7. Anesthesia claims only: Anesthesia report and L&D or C Section Op reports.

208.4. Providers (as defined in §104.1) who routinely do not submit EMA claims for review and possible payment by the Department should attempt to provide some notice of such policy to the potential EMA member. The Department strongly encourages providers to negotiate payment plans that assist these members with payment of these services.

208.5. If the Department determines that the EMA claim contains both emergent and non-emergent services, payment will only be rendered for emergency services. Providers will be informed of the need to submit additional documentation to facilitate the rendering of such payment. Failure to submit the required documentation within 30 days of the date of the split decision notice will result in the denial of the entire claim.

208.6. If the Department determines that services rendered were nonemergent, providers may bill EMA members for those services. The Department strongly encourages providers to negotiate payment plans that assist these members with payment of these services.

208.7. Denial of EMA claims are subject to the administrative appeal processes outlined in Chapter 500.

208.8. EMA claim denials that result from a provider's failure to submit these claims according to this subsection are subject to the provisions of §106(Q).

209. National Correct Coding Initiative (NCCI) Methodologies by GA Medicaid

Effective October 1, 2010, the Centers for Medicare & Medicaid Services (CMS) incorporated NCCI methodologies into the state Medicaid programs pursuant to the requirements of Section 6507, Mandatory State Use of National Correct Coding Initiative (NCCI), of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Recovery Act of 2010 (P.L. 111-152), together referred to
as the Affordable Care Act, which amended section 1903(r) of the Social Security Act. NCCI is a CMS program, and CMS makes the final determinations.

CMS identified six NCCI methodologies for compliance by state Medicaid programs:

209.1. National Correct Coding Initiative (NCCI)Procedure-to-Procedure (PTP) edits for practitioner and ambulatory surgical center (ASC)claims.

209.2. NCCI PTP edits for outpatient hospital services including emergency department, observation care, and outpatient hospital laboratory services.

209.3. Medically Unlikely Edit (MUE) units of service (UOS) edits for practitioner and ASC services.

209.4. MUE UOS edits for outpatient hospital services including emergency department, observation care, and outpatient hospital laboratory services.

209.5. MUE UOS edits for durable medical equipment (DME) billed by providers.

209.6. NCCIPTP edits for durable medical equipment (added by CMS in October2012).

210. General Background

The NCCI PTP edits and MUEs are utilized by state Medicaid agencies or fiscal agents to adjudicate provider claims for practitioner services, ambulatory surgical center services, outpatient hospital services, durable medical equipment, prosthetics, orthotics, and supplies. NCCI edits are not applied to facility claims for inpatient services. The Medicaid NCCI PTP edits and MUEs are applied to services performed by the same provider for the same beneficiary on the same date of service. Medicaid PTP edits are applied to all services with the same date of service whether the services are submitted on the same or different claims. The Medicare and Medicaid NCCI programs undergo continuous refinement with revised edit tables published quarterly. Medicaid MUEs are applied separately to each line of a claim.

211. Georgia Medicaid applies the following billing requirements for submitting claims for reimbursement:

Procedure codes that are denied by NCCI procedure-to-procedure edits are considered non-covered by Medicaid as they are included in the payment for the base equipment or most comprehensive procedure or service when provided to the member on the same date of service. It is against the department's policy for any provider to resubmit claims for denied procedure codes on a different date of service in an attempt to avoid the NCCI/MUE edits. If this is discovered at any time by the department all items paid on another date of service will be recouped and the provider reported to the Office of Inspector General's Program Integrity Unit.

212. Billable Services

212.1. All items or services that are approved with a prior authorization for reimbursement but is denied by the NCCI/MUE edits at the time of the claim submission will not be separately reimbursed as they are included in the claim payment for the primary or greater procedure code (column 1). The items or services must be billed on the same date of service they are actually provided.

212.2. The date of service that the procedure is rendered/delivered is the date of service on the claim.

212.3. ALL Base procedures along with ANY related services, options, or accessories are to be billed with the date of service they are rendered or delivered.

NOTE for DME: Replacement parts are the only items that may be reported on a date of service that is not the same as the delivery date of the base equipment.

Chapter 300: Coordination of Benefits and Third-Party Liability

301. General

This chapter describes how benefits should be coordinated when a member is also covered by other public or private health plan and the means by which the Division reviews providers.

302. Coordination of Benefits

302.1. Medicare Traditional and Medicare Advantage Plans

Medicare, the federal health insurance program for the aged and disabled, covers certain hospital (Part A), medical (Part B) and as of January 1, 2006, drug coverage (Part D) for eligible beneficiaries. Medicare beneficiaries may choose to enroll in the traditional Fee-For-Service (FFS) plan or a Medicare Advantage Plan (MAP). Medicaid/PeachCare for Kids (Title XIX specifically) provides payment for Medicare Part B monthly premiums, deductibles, coinsurance, HMO co-payments, and certain noncovered charges, subjected to certain limitations. When a Medicaid member is also covered by Medicare, the following conditions must be met in order for Medicaid benefits to be paid:

302.1.1. The Medicare provider must be enrolled with Georgia Medicaid. A provider may choose to enroll in Medicaid to receive only Medicaid Secondary payments for services by indicating "Medicare Only" on the enrollment application. In addition, the provider's Medicare number must be associated with only one Medicaid location.

302.1.2. The provider must bill Medicare or the Medicare Advantage Plan for all services performed on a member before billing Medicaid.

302.1.3. The provider must accept assignment of Medicare benefits unless:

302.1.3.1. The member is not eligible for Medicaid on the date of service but is determined retroactively eligible for the month of service,

302.1.3.2. the provider fails to accept assignment through an administrative or clerical error,

302.1.3.3. the fiscal intermediary erroneously processes an assigned claim as non-assigned,

302.1.4. If any of these assignment conditions exist and the provider chooses to submit a claim for Medicaid Secondary payment, the provider must:

302.1.4.1. complete the appropriate claim form (CMS 1500 version 02/12) or UB04,

302.1.4.2. attach a copy of the Medicare RA with a letter containing the reason of non-assignment and certifying the provider has not accepted nor will accept payment from the patient in any amounts in excess of the Medicaid allowed amount. The provider may also state this information on a DMA-460 form

Claims submitted to the Medicare Carriers or Fiscal Intermediaries will be forwarded to the Division's third-party administrator by automatic transfer via the Coordination of Benefits Contractor (COBC). When automatic crossover of claims occurs, providers do not have to submit a Medicaid Secondary claim to the Division. Medicare identifies claims selected for automatic crossover from eligibility files that Medicaid forwards to the COBC on a monthly basis. The provider's Medicare number must be on file with the Division and associated with only one Medicaid location in order for automatic transfer of claims to occur.

If the Medicare RA indicates a HIPAA Remark Code “MA07” then the claim has been forwarded to Medicaid for adjudication. If the claim is not processed by the Division's within forty-five (45) days from receipt of Medicare payment, a claim may be submitted directly to the Division's third-party administrator electronically. Claims will not crossover automatically if the following conditions exist:

302.1.4.3. The Medicare provider number is not on file with the Division or is not associated with an active Medicaid provider number;

302.1.4.4. The Medicare provider number is associated with more than one Medicaid location.

302.1.4.5. Member was not listed on the eligibility file sent to Medicare for the month the claims were processed;

302.1.4.6. Provider did not include the beneficiary’s Medicaid ID number when billing Medicare;

302.1.4.7. Provider did not correctly indicate Medicaid as the secondary payer;

302.1.4.8. Member is enrolled in a Medicare Advantage Plan.

NOTE: When billing either Medicare FFS or Medicare Advantage Plan, you must bill Medicaid in the same manner in which you submitted the bill to Medicare.

302.2. Claims for Medicare Advantage Plan payments

For beneficiaries enrolled in a Medicare Advantage Plan, providers must file an electronic crossover claim directly to Medicaid because these claims do not automatically crossover. Since the EOMB of a Medicare Advantage plan is similar to a

health plan's EOB the provider must write "Attachment 06" on the EOMB. Therefore, the claim will process as a crossover. Instead of an EOMB the provider may submit a DMA-460 form.

302.3. Medicare Non-Covered Services

Certain services that are not covered by Medicare may be covered by Medicaid for dually eligible members. If this is applicable, then you must refer to the manual specific to your category of service. You must follow the guidelines for submitting the claim as primary to Medicaid for covered services and any pre-certification or prior authorization requirements.

This does not apply to Qualified Medicare Beneficiaries (QMB's) whose benefits are limited to the Medicare premiums and payment toward the Medicare deductible and coinsurance (cost share). Therefore, if Medicare does not cover the service, there is no cost share available.

302.4. Inaccurate Medicare Payments Adjustments

Providers cannot request from Medicaid an adjustment to a claim that Medicare may have incorrectly processed and crossed over to Medicaid. To appeal the amount paid for services to a dually eligible member, providers should notify the appropriate Medicare fiscal intermediary.

If the payments are made to an incorrect provider or are above the amount due, the provider must return the erroneous checks or issue refunds to Medicare and to Medicaid for their respective shares. Any erroneous Medicaid payments or refunds due the Division should be made payable to the Department of Community Health and forwarded to:

New Lockbox address, effective 5/1/2020

State of Georgia
Georgia Department of Community Health
PO Box 734666
Dallas, TX 75373-4666

See Medicaid Secondary Claims User Guide, Chapter 3, for information on Medicare adjustments.

302.5. Medicare Coverage Limitation

With respect to Qualified Medicare Beneficiaries (QMB) and dually eligible members, Medicaid payments are based on Medicaid payment calculations for the specific category of service less any amounts paid by Medicare but only up to the sum of the Medicare deductible and coinsurance. Although Medicaid does not pay the difference between Medicare's allowed charge and the provider's submitted charge, providers are not allowed to seek the difference from the member.

303. Coordination of Benefits/Third Party Liability

As a general rule Medicaid/PeachCare for Kids is the "payer of last resort", meaning other available third-party resources must be exhausted before Medicaid/PeachCare for Kids pays for the medical care of a member. A "third party" is any individual, entity, or program that is or may be liable to pay all or part of the expenses for medical care furnished to a member. Examples of a liable third party include but are not limited to 1) government sponsored plans, 2) commercial insurance companies either through employment-related or privately purchased health insurance, 3) casualty-related coverage available as a result of an accidental injury, 1) groups, 5) unions, 6) parties to adoption agreements, or 7) State Workers' Compensation Board.

303.1. Exceptions

In accordance with Federal regulations Section 53102(a)(1) of the Bipartisan Budget Act of 2018, requires a state to cost avoid for prenatal services and to collect information on third party liability. Providers will use standard coordination of benefits for pre-natal service claims. The State will reject (suspend) but not deny the claim for third party. If the provider, submits one bill for all prenatal and labor and delivery services, the entire bundled claim will be cost avoided.

A provider is not required to exhaust other health plan benefits with respect to claims for preventive and pediatric services including health check (also known as EPSDT).

The Division may pay the full amount allowed for the service and seek reimbursement from any liable third party/primary insurance plan up to the limit of liability. However, a provider may choose to bill the primary health plan prior to billing Medicaid/PeachCare for Kids in the above exception.

The Division may pay the full amount allowed for the service and seek reimbursement from any liable third party/primary insurance plan up to the limit of liability. However, a provider may choose to bill the primary health plan prior to billing Medicaid/PeachCare for Kids Secondary in any of these situations.

Additionally, in those instances where the liability of a third party cannot be currently established or is not available to pay the individual's medical expense within applicable time frames, the Division will reimburse the provider for covered services in accordance with standard reimbursement procedures and the timely submission and resubmission guidelines.

In a casualty (tort) situation, once the provider has billed Medicaid/ PeachCare for Kids for accident-related medical services, (s) he cannot reimburse the Division and then seek reimbursement from the liable third party in excess of the Medicaid/PeachCare for Kids reimbursement amount. See Section 303.5.

303.2. Identification of Other Insurance/Health Plan

The enrolled provider must make reasonable efforts to collect funds from any insurance/benefit plan primary to Medicaid. Reasonable efforts include, but are not limited to:

303.2.1. Questioning the member to identify any other insurance or health plan.

303.2.2. Filing a claim with the appropriate primary health plan(s) prior to filing with Medicaid/PeachCare for Kids.

303.2.3. Indicating on the Medicaid/PeachCare for Kids claim form the identity of the other insurers and the amount of their payment(s).

The third-party administrator's website, www.mmis.georgia.gov, includes the TPL Listings, Alphabetical and Numerical, which are updated monthly. Where applicable, claims should be submitted to the appropriate insurance carrier or health plan prior to being submitted to Medicaid/PeachCare for Kids. Hard copies of the TPL Listings are available through the Georgia Health Partnership at www.mmis.georgia.gov.

303.3. COB reimbursement with Other Insurance/ Health Plan

Unless billing for a commercial insurance co-payment, any items or services for which another health plan reimburses an amount equal to or greater than Medicaid/PeachCare for Kids maximum allowable amount, there will be no payments made by Medicaid/PeachCare for Kids.

Supplemental or partial payment may be made by Medicaid/PeachCare for Kids when another health plan pays less than the Medicaid/PeachCare for Kids maximum allowable amount. However, the sum of the Medicaid/PeachCare for Kids and the other health plan payments cannot exceed the Medicaid/PeachCare for Kids maximum allowable payment.

Georgia Medicaid/PeachCare for Kids will process the claim as primary for the maximum allowable amount when covered Medicaid services are not covered by the primary insurance or health plan. Regardless of whether or not the primary plan has made any payment toward a service, when billing the secondary claim to Medicaid, you must follow the Medicaid policies and procedures for that particular Category of Service, including adherence to all policies/guidelines for pre- certification and pre-authorizations of services.

When the primary health plan has in-network and out-of-network providers and the member has chosen to seek care from an 'out-of-network' provider for a service that is fully covered by an 'in-network' provider, Georgia Department of Community Health will not pay this claim as primary, and no re-imbursement will be processed to the provider for those services.

Georgia Department of Community Health will not reimburse the provider submitted charges denied by the primary plan because of the provider's failure to follow the primary plan's rules, guidelines or polices.

Note if the member has more than one (1) health care plan, policy and procedures must be followed for all plans before the claim is considered for payment by Georgia Medicaid.

When a member fails to cooperate with an insurance carrier/health plan in providing requested additional insurance information, the provider must contact the member and encourage cooperation. If the member continues to refuse to cooperate, the provider must notify the Division by completing electronically Section III-COB Information update of the DMA 410 EBTPL form. (Appendix R). To provide this information, upload a scanned image of the member's insurance card for COB updates by logging into the GAMMIS Web Portal at www.mmis.georgia.gov perform an eligibility request for the member in question, select the new "Member Transactions" button and follow the instructions provided on the member transactions page.

Please note that Provides will need to continue using the paper format of the DMA 410-Form for Section I: Co-Payment Notification and Section II: COB Non-Coverage Affidavit.

Filing (electronically) the COB information and a timely claim along with the appropriate attachments constitutes notification to the Division. See the Medicaid Secondary Claims User Guide for details on completing the DMA- 410 Form.

If at a later date the provider receives payment from the insurance carrier or health plan for the services, a refund must be made to the Department. See Appendix H, Billing Manual, and Section 10.3 for refund information.

303.4. Other Insurance/ Health Plan Coverage

It is a member's responsibility to be aware of the physician's, pharmacies, hospitals, and other providers who participate in his or her managed care plan. When a member's claim is denied by the managed care plan because the member had failed to comply with the rules, policies, and procedures of the plan, the member and not the Division is responsible for associated payment. Providers should make members aware of their current status with the managed care plan

However, services denied by a primary care plan as "non-covered" are reimbursable up to the Medicaid/PeachCare for Kids maximum allowable amount. Non-covered services include, but are not limited to the following situations:

303.4.1. Plan does not provide the same service, in the same setting, as required by the Medicaid Waiver programs.

303.4.2. Plan does not cover a service or diagnosis, whether the patient is in network or out-of-network.

303.4.3. Plan does not provide appropriate services (e.g., only provides adult therapies for pediatric clients).

303.4.4. Plan annual or lifetime service limitations have been exhausted.

A Provider participating in a managed care plan in which his or her Medicaid/PeachCare for Kids patient is also enrolled may submit a claim to the Division for reimbursement of the required managed care copayment. See Medicaid Secondary Claims User Guide.

303.5. Tort/Casualty (Personal Injury) Liability

In certain situations, the cause of a member's medical condition may invoke a third party's legal liability. These situations might include but is not limited to injuries resulting from an automobile accident, injuries suffered on-the-job, medical malpractice, or "slip and fall" injuries.

In such situations and pursuant to O.C.G.A §49-4-148, DCH is subrogated or substituted for the member or his/her representative's right to recovery against the person or entity legally liable for the injury and subsequent treatment of the member (i.e., the Department has the right to recover any Medicaid payments from settlement awards).

When a provider learns that a third party might be responsible for reimbursement associated with a Medicaid/PeachCare for Kids member's medical costs, the provider must choose between billing Medicaid and billing the third party or third-party carrier. Providers are prohibited from:

303.5.1. Filing claims with Medicaid and subsequently billing the third-party carrier (or the member) for the same service, even if the provider refunds Medicaid; and

303.5.2. Billing Medicaid, the third-party carrier, or member for the difference between the amounts Medicaid has paid and the amount the provider charged.

In the event that a provider is aware that a member's condition was the result of an accident at the time of submission of associated claims, a Coordination of Benefits/Third Party Liability Accident Information Form (DMA-312), should be submitted online via the web portal. To access the online DMA-312 form, you must log into the Georgia Medicaid Management Information System (GAMMIS), web portal at www.mmis.georgia.govusing your username and password. The online DMA-312 form is located under the TPL.

If a provider chooses not to initially bill Medicaid, the provider may submit a DMA-312 "Coordination of Benefits/Third Party Liability Accident Information Online Form" within six months of the date of service to request an extension within the timely filing limits, if necessary, in order to pursue the liable third party. By completing and submitting the online DMA- 312 form, an extension of 12 months may be granted if the submitted form is approved. This is in lieu of the normal timely filing limitations as described in Section 202.2 of this manual.

If a provider chooses to complete the DMA-312 form, the provider must:

303.5.3. Complete the online form and submit it to the Department. (On the DMA-312 form, check the box or field "Request Claim Filing Extension and attach a copy of claim)

303.5.4. Submit the DMA-312 form and a copy of the claim to the address listed on the form.

The DMA-312 form will be reviewed and either stamped "APPROVED," DENIED or returned to the provider for additional information (RFAI) if form is incomplete.

If the DMA-312 form is approved the provider must print and maintain an approved copy and submit it with the Medicaid claim(s) when or if the provider decides to cancel the lien and bill for Medicaid's payment.

NOTE: The approved DMA-312 form is considered an "EB-COB/TPL." Due to the new online process an "EB-COB/TPL" stamp is no longer needed, and an approval letter will generate online via GAMMIS web portal www.mmis.georgia.gov.

If the DMA-312 form is returned to a provider for additional information, the provider must complete the unanswered questions on the form and resubmit to DCH online via the web portal. Approval of the DMA-312 form grants the requesting provider an additional twelve (12) months in which to file their Medicaid claim. This extension will not exceed twenty-four (24) months from the month of service for tort related claims.

The provider may also use the DMA-312 form to inform the Department of the potential tort related claim. (On the DMA-312 form – check the box or field "For information only")

Checking the "For information only" box indicates that a provider is not requesting an extension but is notifying the Department that there is a potential casualty recovery case. The provider may later submit the tort related claim to Medicaid in accordance with all billing guidelines.

In the event that a provider is aware that a member's condition was the result of an accident, at the time of submission of the associated claims, a Coordination of Benefits/Third Party Liability Accident Information Form (DMA-312) should be submitted. A DMA-312 must also be submitted when a request is made for a copy of the bill.

Once the hospital claim is billed to the Department, the provider must release their hospital lien since the Department, and not the provider, has the right to seek reimbursement from the liable third parties.

If a provider elects not to bill Medicaid initially and subsequently receives a liability payment less than the Medicaid allowable amount for the claims, the provider may bill Medicaid for the balance between the liability payment amount and Medicaid allowable amount.

Providers may not keep any liability payment in excess of Medicaid's payment. Should the Department discover that a provider has attempted to receive payment from both a third party, or third party carrier after having received reimbursement from Medicaid/PeachCare for Kids, the Department will recoup their reimbursement, regardless of whether the provider ultimately received any payment from that liable third party.

For additional requirements, see Part II, Policies and Procedures for Hospital Services, Part II, Policies and Procedures for Nursing Facility Services and/or O.C.GA. §44-14-470.

303.6. Filing a Medicaid/PeachCare for Kids Claim Involving another Insurer's Payment

A provider may use any available claims billing process used for any Medicaid/PeachCare for Kids claim when filing a Medicaid/PeachCare for Kids Secondary claim. See the Medicaid Secondary Claims User Guide for specific instructions.

303.7. Refund Requirements When Medicaid/PeachCare for Kids and Other Insurance Payments are Received

Payment for any item or service is made on the condition that a refund will be made to the Division if the provider receives payment for the same item or service from a third party. No provider refund is allowed in a casualty (tort) situation, unless the refund was unsolicited. The amount of the refund shall be the lesser of a) the amount received from all other insurers for that service, or b) the amount of the Medicaid/PeachCare for Kids payment. Other insurance payments and the Medicaid/PeachCare for Kids payment cannot be added together to satisfy the total billed amount for the service(s). The refund must be made in accordance with Section 303.8.

303.8. Credit Balance Reporting

All Medicaid/PeachCare for Kids providers are required to review their records for any outstanding credit balances on a quarterly basis. Hospitals and nursing facilities are required to submit these quarterly reports even if a zero ($0.00) credit balance exists. All other providers should complete this form only when reporting an outstanding credit balance. The report must be sent no later than thirty (30) days following the end of each calendar quarter (September 30, December 31, March 31, and June 30). Providers will not receive quarterly notices or reminders but are expected to comply within required timeframes.

The Medicaid/PeachCare for Kids Credit Balance Form, DMA-710, is for the purpose of monitoring and recovering "credit balances" owed to the Medicaid/ PeachCare for Kids program. Credit balances arise from overpayments made to providers. Those credit balances related to payments from another insurance and Medicaid/PeachCare for Kids must be reported on a separate form from other types of credit balances.

For the purpose of completing the Medicaid/PeachCare for Kids Credit Balance Report, a Medicaid/PeachCare for Kids Credit Balance is the amount determined to be refundable to the Division. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit". However, credit balances include money due the Division, regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period and then transfers the account or writes it off to a holding account, this does not relieve the provider of its liability to the Division. The provider is responsible for identifying and repaying all monies owed. When any other medical benefit plan pays for a service also paid by Medicaid/PeachCare for Kids, the provider must refund to the Division the lesser of the two payments.

The Medicaid/PeachCare for Kids Credit Balance Report requires specific information on each credit balance on a claim-by-claim basis. A sample DMA-710 form and

instructions for completion are located in Appendix E and atwww.mmis.georgia.gov.

A check for any applicable refund should be made payable to the Georgia Department of Community Health and sent along with the completed Medicaid/PeachCare for Kids Credit Balance Report:

Credit Balance Reporting
State of Georgia
Department of Community Health
Third Party Liability Unit
PO Box 734666
Dallas, TX 75373-4666

Failure to submit a Medicaid/PeachCare for Kids Credit Balance Report could result in the withholding of Medicaid/PeachCare for Kids payments until the report is received. The provider could also be subjected to a complete on-site audit and/or assessed additional monetary penalties.

303.9. Release of Information to Other Parties

Whenever a copy of an itemized statement of medical services for a Medicaid or PeachCare for Kids member is released from the provider for the purpose(s) of obtaining insurance or other third-party benefits, including requests from patients, insurance agents or agencies, attorneys at law, subpoenas of records for court, etc., the following actions are required by the provider:

303.9.1. Prior to releasing the document, affix directly to the itemized statement the notification that a claim for these Medicaid/PeachCare for Kids services has been submitted to the Division. This notification shall be in bold letters (typewritten, handwritten, or rubber stamped) across the body of the itemized statement in such a way as to be immediately obvious to anyone viewing the document.

303.9.2. Upon releasing such information, formal notification, attached to a copy of the claim previously submitted, must be sent to:

Casualty Recoveries
Coordination of Benefits Unit
Department of Community
Health Division of Medicaid
P.O. Box 1984
Atlanta, Georgia 30301-1984

This notification must include the name and address of the party to whom the statement was released, the intended use of the statement, and the name and address of any attorney or law firm known to be involved in any legal suit or pending court action involved in the services.

Chapter 400: Utilization Review, Office of the Inspector General, And Adverse Actions

401. General

This chapter describes the method the Division uses to conduct utilization reviews and the role of the Program Integrity Unit of the Office of the Inspector General. Further, this chapter describes some of the types of adverse actions the Division is authorized to take and the grounds for taking such actions.

401.1. Prepayment Review

401.1.1. Prepayment review (PPR) is the review of a provider's medical documentation prior to payment of a claim. The Department makes the decision to place agencies on prepayment review because of, but not limited to:

401.1.1.1. Violation of Medicaid policy or Conditions of Participation;

401.1.1.2. Inappropriate or aberrant billing practices;

401.1.1.3. Credible allegations of fraud;

The Office of Inspector General Program Integrity Unit (OIG-PI) will evaluate decisions for PPR on a case-by-case basis. OIG-PI will exercise discretion when determining if specific CPT codes, or all CPT codes will be placed on PPR. OIG-PI will place providers on PPR for the same CPT codes across the enterprise to ensure consistency of the review.

OIG-PI will notify the provider that a determination has been made to place the provider on PPR by providing a written notification within 30 calendar days of the start date. At a minimum, the notification will include documentation upload requirements, contact information, and CPT codes being reviewed. In certain instances, it may be necessary to implement PPR immediately. In those cases, providers will be notified subsequent to the action.

401.1.2. OIG-PI or its representative reviews the provider's documentation to determine whether the claim is appropriate for Medicaid payment based on criteria including, but not limited to, provider documentation which establishes that:

401.1.2.1. Services were provided according to OIG-PI policy requirements;

401.1.2.2. Billed services were medically necessary, appropriate, and not in excess of the member's need;

401.1.2.3. Members were Medicaid-eligible on the date the services were provided;

401.1.2.4. Prior authorization was obtained if required by policy;

401.1.2.5. Providers and their staff were qualified as required by Medicaid policy; and

401.1.2.6. Providers possessed an active Medicaid provider number, licenses, and certifications at the time the services were provided to the Medicaid member(s).

401.1.3. Providers may not appeal the OIG-PI decision to place the provider on Prepayment review. Prepayment review and the removal of a provider from Electronic Data Interchange (EDI) are not considered adverse actions. Providers may appeal the denial of any claim, reduction of reimbursement or the withholding of reimbursement, which occurred during the PPR process.

401.1.4. OIG-PI will review CMO monthly report and conduct a billing risk assessment, within 30 days, to determine if OIG-PI and other CMO payers should take similar action for claims billed to the Fee for Service (FFS) program and/or other CMOs for the same CPT codes. OIG-PI will also notify other CMOs by sending written notification if it is determined that OIG-PI or another CMO has placed a provider on PPR.

OIG-PI will notify the CMO when a provider is placed on PPR by providing a written notification.

OIG-PI will provide a monthly report to the provider regarding the outcome of reviewed Fee for Service claims.

401.1.5. Removal from Prepayment Review:

Providers must bill timely and accurate claims during the prepayment review period. Providers who demonstrate a continued pattern of not billing timely and accurately during the prepayment review period may be terminated from the Medicaid/PeachCare for Kids® program pursuant to § 404 (D). A provider may appeal their termination from Fee-for-service by requesting a hearing from the Commissioner of the Department of Community Health within ten (10) days of the date of the initial decision issued by the Department regarding termination in Medicaid/PeachCare for Kids programs. The request for hearing must include:

401.1.5.1. A copy of the Notice of Termination from Medicaid/PeachCare for Kids;

401.1.5.2. A clear expression by the provider or authorized representative that he/she wishes to present his/her case to an Administrative Law Judge or designated Hearing Officer;

401.1.5.3. Identification of the action being appealed and all issues that will be addressed at the hearing;

401.1.5.4. A specific statement of why the provider believes the Department's decision is wrong; and

401.1.5.5. A statement of the relief sought.

Providers must bill the greater of 10% of normal billing volume (that was prior to being placed on PPR) for dates of service that occurred while on PPR to be considered for removal. The aggregate of claims reviewed must meet an 85% pass rate to be considered for removal. (Rev. 04/2025)

Providers who have an error rate of less than 15% (based on claim line items) for a period of at least three months will be considered for removal after they have fulfilled the requirements for all CPT codes under review. Providers will be notified in writing of the effective end day of review.

OIG-PI will notify the CMOs when a provider is removed from PPR by providing a written notification.

401.1.6. Post Payment Review:

Providers who have been released from Prepayment Review will be subject to a post-review of claims billed, six (6) to 12 months from release. Providers will be notified by OIG-PI or its representative of the claims being reviewed, the documentation needed for the post review, and the due date of the requested documents.

If the provider does not comply with the request for documentation within the given timeframe, the provider will be placed back on PPR until OIG-PI determines it is no longer necessary.

If the Post Payment Review determines the provider has an error rate of more than 15%, the provider may be placed back on PPR or be considered for termination from the Medicaid/PeachCare for Kids® program pursuant to § 404 (D). A provider may appeal their termination by following the provisions outlined in Chapter 500 of this manual.

401.1.7. Termination of Medicaid ID of providers on PPR

OIG-PI may terminate the provider agreement because of, but not limited to:

401.1.7.1. Provider/Provider group has been on PPR for 16 months and there has been no billing activity during this time;

401.1.7.2. Documentation consistently fails to support services billed or medical records were not provided to support claims billed to Medicaid;

401.1.7.3. Provider/Provider group currently on PPR may be terminated when entering a guilty plea or when a jury

returns a guilty verdict in a federal or state prosecution involving healthcare fraud.

402. Utilization Review

Federal regulations require that the Division perform a comprehensive review of services billed to and paid for by the Medicaid/PeachCare for Kids program. Selected provider and member reviews are performed by the Program Integrity (PI) Section of the Division or its agent.

Provider reviews usually include analysis of selected medical records, departmental reports, films, x-rays, and other documentation needed to assess services billed to Medicaid/PeachCare for Kids. Review information is obtained by requesting specified medical documentation from the provider's place of business and/or performing an on- site visit. An on-site visit may be necessary in addition to receiving specified medical documentation.

The Division's procedures for reviewing providers may involve the use of sampling. If sampling is used, the Division, or its agents, will utilize a generally accepted, statistically valid sampling methodology for selecting the sample of claims to be reviewed. Overpayments identified by the Division may be calculated through the use of extrapolation techniques based on such sampling. Providers may rebut the Division's findings of overpayments through such sampling and extrapolation techniques by presenting evidence to establish that the sample used by the Division is invalid or by conducting an audit of 100% of the claims for which overpayments were identified.

402.1. Identification

Providers whose services are reviewed by the Division, or its agents are identified through multiple primary sources including, but not limited to:

402.1.1. Exceptions from a computer-generated statistical profile in which each provider's services are compared to those of peers,

402.1.2. Selection from members' utilization profiles,

402.1.3. Referrals from Division personnel, Medicare intermediaries, peer review organizations, and other interested parties, and D) Other computerized reports and investigations.

402.2. Focus

The Division primarily conducts Utilization Review to determine whether:

402.2.1. Services rendered were reasonable, appropriate, and medically necessary.

402.2.2. Providers comply with Federal and Georgia law, and all Departmental policies and procedures.

402.2.3. Documentation adequately supports the services billed and correct payment is reimbursed for services rendered.

402.2.4. The quality of services rendered meets professionally recognized standards of healthcare.

402.2.5. Services and items provided were compatible with the provision of appropriate medical care and the services were effectively provided at the most economical level of care available.

402.2.6. The coding of diagnoses, procedures, and revenue codes are correct and in compliance with correct coding initiatives and mandates.

402.2.7. Correction measures or policy modifications should be recommended based on data or information obtained during the review process.

402.3. Coding and DRG Validation Review

Division staff, including its designated agents, ensures that the diagnostic and procedural information billed is supported by the documentation in the medical Record and that correct and appropriate coding is utilized by the provider. Physicians will review procedures and diagnostic information and individuals with training and experience in ICD-10 coding will review technical coding issues.

402.4. Peer Review

The Division may find it necessary to solicit the opinion of one of its peer review organizations with which it contracts. The peer review physicians are licensed physicians of medicine, osteopathy, or dentistry located in Georgia who have active admitting privileges in a hospital in the state of Georgia. Board certified or board eligible physicians or dentists in the appropriate specialty make denial or reconsideration determinations for peer review matters. Peer review matters may entail issues of medical necessity, appropriateness of care, patterns of practice and quality of care.

402.5. Notice

Initial Findings/Notice of Proposed Adverse Action. Pursuant to a Utilization Review, if the Department or an agent for the Department identifies a violation of any Medicaid program regulation, rule, policy, discrepancy or error which warrants and adverse action, the Department or its agent, shall notify the provider in writing of the results of the review. The Initial Findings/Notice of Proposed Adverse Action shall be mailed via certified mail, return receipt requested. The Notice shall include a summary of the review findings with a list of identified violations or deficiencies.

402.6. Requesting Administrative Review (In State and Border Providers)

If the provider disagrees with the determination of the Division following its Utilization Review, the provider may request an Administrative Review pursuant to Chapter 500. The provider must submit additional documentation in addition to comments and explanations, by electronically submitting a DMA 520/DMA520A Provider Inquiry

Form Request via our web portal at www.mmis.georgia.gov, supporting the request for administrative review.
Additional documentation shall not be submitted and will not be accepted during the review process or after the administrative review/reconsideration has been completed. Written letters sent via facsimile, mail, or email requesting an Administrative Review shall not be accepted or considered. If the provider's grounds for administrative review concern only procedural or policy aspects of the matter (e.g., calculation errors, program policy concerns), the Division will reconsider its decision based on all documentation, information, and arguments submitted by the provider.

The Division or its agent may submit the matter and all supporting material to its peer consultant organization for revaluation. Following the peer consultant's or the Division's reevaluation of the issue raised during the administrative review, a final decision will be made during the administrative review, a final decision will be issued in writing to the provider. If the provider disagrees with the final decision, provider may request an Administrative Law Hearing pursuant to Chapter 500.

402.7. Corrective Action Plans

In an effort to correct deficiencies noted during the Utilization Review process, the Division can require the submission of a Corrective Action Plan. The Division reserves the right to determine which providers will be subject to this requirement. Corrective Action Plans must be specific and must, at a minimum, include provisions aimed toward correction of the deficiencies, indicate reasonable completion dates, fully describe methodology used to accomplish complete and permanent corrective action, and describe methods for ensuring full compliance with the corrective action plan. The Division, at its discretion, may determine that execution of a Corrective Action Plan is the most efficient resolution of an adverse action. The Corrective Action Plan shall be subject to review by the Division to ensure compliance. Violation of the Corrective Action Plan, including, but not limited to, failure to implement as directed, will subject the provider to further adverse action up to and including further monetary recoupment and termination. Adverse actions may be based upon both the initial utilization review and the Corrective Action Plan.

402.8. Overpayment Recovery

A refund of amounts identified as overpayments by the Division following Utilization Review are due within thirty (30) days after the date of a formal Request for Refund unless the provider has requested and been granted an extension by the Director of Program Integrity. A request for an Administrative Law Hearing will not alter this deadline.

Refunds should be made payable to the Georgia Department of Community Health and forwarded to:

The Georgia Department of Community Health
Benefits Recovery Section
P.O. Box 403502
Atlanta, Georgia 30384-3502

If no refund has been received by the Division within the applicable timeframe, other

appropriate recovery proceedings will ensue without separate notice to the provider. Should recoupment procedures become necessary, the Division's payment for all other claims submitted by that provider shall be reduced by one hundred percent (100%), or such other amount as the Division may elect, until such time as the amount owed is recovered.

The provisions stated in this Section shall not prevent the Division from pursuing other means of other means of recovering an overpayment
Payments shall be for the entire amount of the overpayment. A payment submitted for less than the entire amount of the overpayment shall be treated as an installment payment and applied to the total amount of the overpayment. The balance will still be required. This action shall not stay the thirty (30) daytime period noted above.

402.9. Limited Endorsements

The Division cannot accept a check with a limiting endorsement of any kind. If the Division receives a check from a provider with an endorsement that limits the Division's future actions, the Division will return the check to the provider and may recoup the amount of the check from Medicaid payments due the provider, which shall not be an acceptance of such endorsement or entitle the provider to enforce such endorsement. Payments that contain limited endorsements, e.g. "paid in full" or "in full and final settlement", etc. will not be accepted by the Department unless accompanied by a separate settlement agreement executed by the Department and the provider. Said agreement shall evidence the original amount of the overpayment and the agreed upon settlement amount.

402.10. Self-Disclosure

The Department of Community Health encourages providers to be active participants in ensuring the financial integrity of our healthcare programs. Providers are urged to self-audit in an effort to identify claims errors and overpayments.

Upon identifying a claims error or overpayment, providers must alert the Department and work toward a resolution or refund. Once a provider has identified claims that are potential overpayments, a self-disclosure letter detailing the potential overpayments should be forwarded to the Program Integrity Unit within the Office of Inspector General. Any self-disclosure submitted to the Department for consideration must include the following information:

402.10.1. Name and address the affected provider;

402.10.2. If the provider is an entity owned, controlled, or otherwise part of a system or network, include a description or diagram of the pertinent business/legal relationships, the names and addresses of any related entities, and affected corporate divisions, departments, or branches. The description should include the name and address of the disclosing entity's designated representative.

402.10.3. Provide Identification Number(s) and NPI number(s) associated with claims;

402.10.4. Tax Identification number(s);

402.10.5. Submit affected claims on the appropriate SDA Analysis Worksheet. Use form SDA-1 for medical claims or form SDA-2 for pharmacy claims. Alternatively, claims submitted electronically may be submitted in Excel or Access and shall include the same information found in the Form SDA-1 and SDA-2. Each provider must have a separate SDA Analysis Worksheet.

402.10.6. A report that includes a full description of the matter being disclosed, the person who identified the overpayment and the manner in which the individual discovered it;

402.10.7. The self-disclosure shall include a detailed account of the provider's investigation of the overpayment. The account shall include a list of all persons interviewed regarding the violation, documentation reviewed, and summarize any audit activity that was undertaken;

402.10.8. A statement disclosing whether the provider is under investigation by any government agency or contractor;

402.10.9. A statement detailing the provider's theory regarding the cause of the violation;

402.10.10. A certification that the information submitted to the Department is based upon a good faith effort to disclose a billing inaccuracy and is true and correct under penalty of perjury, and;

402.10.10.1. The methodology used by the provider in determining the amount of the overpayment (if overpayment amount was determined using a sampling method)

The letter shall be accompanied by a Corrective Action Plan (CAP) that details actions taken to correct the cause of the overpayment and steps to prevent future erroneous claims. IF THE SELF-DISCLOSURE IS REGARDING PATIENT LIABILITY THEN NO CORRECTIVE ACTION PLAN IS NECESSARY. DO NOT SUBMIT A REFUND FOR THE DISCLOSED OVERPAYMENT AMOUNT. The Department must review and approve the self-disclosure and CAP prior to its implementation and determine the overpayment amount.

Documentation should be sent to the following address:

Georgia Department of Community Health
Office of the Inspector General
Attn: Program Integrity Unit
2 Martin Luther King Jr., Drive SE
East Tower – 19th Floor

The Department reserves the right to verify the financial impact of the disclosed matter utilizing its internal auditing procedures. Accordingly, the Department expects to receive documents and information from the entity that relate to the disclosed matter without the need to resort to compulsory methods. Self-disclosed matters are not subject to appeal rights as outline din Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual Chapter 500. Matters uncovered during the verification process which are outside of the scope of the self- disclosure may be treated as new matters subject to further investigation and possible adverse action.

Upon receipt of the self-disclosure letter and CAP, the Program Integrity Unit will verify the accuracy of the information. The Unit will also approve the CAP or suggest revisions. Once a final determination of accuracy is completed and the CAP is approved, the Department will enter into negotiations with the provider regarding a settlement. As a mandatory provision of the settlement agreement, the Department will require an audit of the provider within a 12-month period to assure adherence to the CAP.
If requested by the provider, and approved by the Department, to the extent that payments can be returned through the claim's payment adjustment process, the claims adjustment process will be followed.

If the claims being disclosed cannot be refunded utilizing the claims adjustment process, the Department will advise the provider where to remit payment after verifying the accuracy of the information being disclosed.

NO PAYMENT SHOULD BE SUBMITTED PRIOR TO THE EXECUTION OF A SETTLEMENT AGREEMENT.

Please note that self-disclosure will not absolve the provider of criminal culpability. If the Medicaid Fraud Control Unit or any other federal, state, or local agency determines a crime was committed, any information shared with the Department will be forwarded to the appropriate agency.

403. Investigations and Program Integrity

The Program Integrity (PI) Section of the Office of the Inspector General investigates possible Medicaid/PeachCare for Kids fraud or abuse. The Program Integrity Section is responsible for appropriate follow-up on all information regarding fraudulent or abusive provider and member activities. The investigation of provider activities includes, but is not limited to, billing for services not rendered by the provider, up coding, and illegal use of the provider number. The investigation of member activities includes, but are not limited to, illegal use of Medicaid/PeachCare identification cards and disclosure of resources. The primary responsibility of PI is to develop cases for referral to the State Healthcare Fraud Unit or the appropriate district attorney for prosecution. When a fact pattern is inappropriate for prosecution but fails to comply with program policy, PI will recommend appropriate adverse action.

404. Denial of Application, Non-Renewal of Participation, Suspension, Suspension of Payments in Cases of Fraud, and Termination

In determining whether to take an adverse action, the Division has the ability to: 1) deny an application for enrollment or reenrollment in Medicaid/PeachCare for Kids, 2) not exercise its option to renew a provider's participation in Medicaid/PeachCare for Kids, 3) suspend a provider's participation in Medicaid/ PeachCare, or 4) terminate a provider's participation in Medicaid/PeachCare for Kids for any of the following reasons:

404.1. Revocation, suspension, probation, or restriction of the provider's license or permit, termination or non-renewal of a contract with other State agencies or other form of permission necessary to function as a participating provider. Both participating providers and provider participation applicants are subject to the provisions of §106(A).

404.2. Sanction, suspension, or exclusion from the Medicare program.

404.3. A determination by the Department of Human Resources, the U.S. Department of Health and Human Service, the U.S. Office of Civil Rights, or other federal or state regulatory agency that the provider's practice is conducted in violation of federal or state laws or regulations including, but not limited to, Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, or the Age Discrimination Act of 1975.

404.4. A determination by the Division that the provider has intentionally or negligently failed to comply with the Division policies and procedures.

404.5. Failure to file a lien in accordance with O.C.G.A. §44-14-470.

404.6. A determination by the Division that a provider has violated the terms of the Provider Agreement for Electronic Data Interchange for Claims Submission to the extent that the Division deems itself insecure in allowing the provider to remain enrolled in Medicaid/PeachCare for Kids.

404.7. Failure to provide services in accordance with currently accepted standards of medical practice or applicable laws or regulations.

404.8. Documented program abuse or a pattern of substandard service.

404.9. Making a false representation or omission of any material fact on the provider application.

404.10. Any criminal conviction (as defined in the Definitions section of this Manual) or admission in a court of law, Composite State Board of Medical Examiners proceeding, criminal investigation, or administrative proceeding relating

404.10.1. The provision of services under Medicare, Medicaid/PeachCare for Kids, or other health insurance program.

404.10.2. Neglect or abuse of a patient.

404.10.3. A violation of O.C.G.A. § 30-5-8, relating to abuse, neglect, or

exploitation of a disabled adult or elder person;

404.10.4. A violation of O.C.G.A. § 16-5-1, relating to murder;

404.10.5. A violation of O.C.G.A. § 16-5-2, relating to involuntary manslaughter;

404.10.6. A violation of O.C.G.A. § 16-8-41, relating to armed robbery with a firearm;

404.10.7. A violation of O.C.G.A. § 16-6-5.1, relating to sexual assault against persons in custody, detained persons, or patients in hospitals or other institutions;

404.10.8. A violation of O.C.G.A. § 16-6-22.1, relating to aggravated sexual battery;

404.10.9. A violation of O.C.G.A. § 16-6-5, relating to enticing a child for indecent purposes;

404.10.10. A violation of O.C.G.A. § 16-5-70, relating to cruelty to children;

404.10.11. A violation of O.C.G.A. § 16-5-100, relating to cruelty to a person65 years of age or older;

404.10.12. A violation of O.C.G.A. § 16-6-1, relating to rape;

404.10.13. A violation of O.C.G.A. § 16-6-4, relating to child molestation;

404.10.14. A felony offense under:

404.10.14.1. Chapter 5 of Title 16, relating to crimes against the person;

404.10.14.2. Chapter 8 of Title 16, relating to offenses involving theft;

404.10.14.3. Chapter 9 of Title 16, relating to forgery and fraudulent practices;

404.10.14.4. Chapter 13 of Title 16, relating to controlled substances

404.10.15. A felony offense under:

404.10.15.1. O.C.G.A. § 16-4-1, relating to criminal attempt s it concerns attempted murder;

404.10.15.2. O.C.G.A. § 16-7-1, relating to burglary;

404.10.15.3. O.C.G.A § 16-12-100, relating to child pornography

404.10.16. Any other offense committed in another jurisdiction which, if committed in this state, would be deemed to be such a crime without regard to its

designation elsewhere.

Conviction does not include individuals for which at least 10 years have elapsed since the person has reached a final disposition of their sentence to include, but not limited to, release form incarceration and/or completion of probation.

404.11. Exclusion, suspension, termination, or involuntary withdrawal from participation in Georgia's Medicaid/PeachCare for Kids program or any other state's Medicaid/SCHIP program or from participation in any other governmental or private health care or health insurance program.

404.12. Determination by a licensing, certifying or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided.

404.13. Any sanction administered for violation of federal or state laws, rules, or regulations governing Medicare, Medicaid/PeachCare for Kids, other state's Medicaid/SCHIP program, or any other publicly funded federal or state health care or health insurance program.

404.14. Failure to comply with the terms and conditions of participation as outlined in §106. This provision shall also be applicable to provider participation applicants.

404.15. Failure to comply with the terms and conditions of any settlement agreement or corrective action plan.

404.16. Failure to either obtain or maintain a Letter of Agreement or other Provider Agreement with the Department of Behavioral Health and Developmental Disabilities ("DBHDD"). This includes situations wherein DBHDD has opted to terminate its Letter of Agreement or other Provider Agreement or not renew its Letter of Agreement or other Provider Agreement with the provider.

404.17. The Division shall terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods.

404.18. The Division shall deny enrollment or terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years, unless the Division determines that termination of enrollment is not in the best interests of the Medicaid program and the Division documents that determination in writing.

404.19. The Division shall deny enrollment or terminate the enrollment of any provider that is terminated on or after January 1, 2011, under title XVIII of the Act or under the Medicaid program or CHIP of any other State.

404.20. The Division shall deny enrollment or terminate the provider's enrollment if the provider or a person with an ownership or control interest or who is an agent or

managing employee of the provider fails to submit timely or accurate information, unless the Division determines that termination is not in the best interests of the Medicaid program and the Division documents the determination in writing.

404.21. The Division shall deny enrollment or terminate the enrollment of a provider if the provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner determined by the Division within thirty (30) days of a CMS or a Division request, unless the Division determines that the termination is not in the best interests of the Medicaid program and the Division documents that determination in writing.

404.22. The Division shall deny enrollment or terminate the enrollment of a provider if the provider fails to permit access to any and all provider locations for any site visit unless the Division determines that termination is not in the best interest of the Medicaid program and the Division documents the determination in writing.

404.23. The Division may terminate a provider's enrollment if CMS or the Division

404.23.1. Determines that the provider has falsified any information provided on the application; or

404.23.2. Cannot verify the identity of any provider applicant.

404.24. Intentionally or knowingly order, refer, or prescribe an item and/or service that allows a false or fraudulent claim to be presented for payment by Medicaid

404.25. The Division may suspend or terminate a provider's enrollment if they fail to revalidate their Enrollment as prescribed in Section 105.14.

404.26. The Division may suspend or terminate a provider's enrollment if they fail to revalidate their Enrollment as prescribed in Section 105.3.

404.27. The Division shall deny enrollment or terminate a provider if the owner has an unsatisfactory fitness determination for a disqualifying crime pursuant to Section 404(j) unless the Division determines that denial or termination is not in the best interests of the Medicaid program and the Division documents the determination inwriting.

404.28. The Division shall deny enrollment or terminate the provider's enrollment at all service locations, if the provider is denied enrollment by the Credentialing Committee as part of initial credentialing, enrollment, reenrollment, or re- credentialing unless the Division determines that denial or termination is not in the best interests of the Medicaid program and the Division documents the determination inwriting.

404.29. The Division shall terminate the enrollment of any provider whose Medicare billing privileges have been revoked by CMS or their contractor.

404.30. The Department of Community Health (DCH) works closely with the Department of Behavioral Health and Developmental Disabilities (DBHDD) to ensure ethical and legal practices are conducted and are consistent at all times in working with vulnerable

populations. Therefore, those agency providers who have been terminated from enrollment and do not have a current letter of agreement with DBHDD, will not be allowed to be a subcontractor of a provider in good standing with DCH and DBHDD. Also, DCH shall deny enrollment of Community Behavioral Health providers applying for participation through DBHDD or terminate enrollment at all service locations of such providers who hold a Letter of Agreement,

Provider Agreement, or Contract to provide Community Behavioral Health services with DBHDD if the provider has delegated or relinquished administrative control of operations and/or clinical direction through a contract or other arrangement with another person or agency for the purpose of providing services; or has failed to maintain control and/or clinical direction over day- to-day operations for the purpose of service delivery in compliance with policy; or has entered into a contract or other arrangement for the purpose of providing administrative control or clinical direction over persons who have direct contract with recipients of services without the express permission of DBHDD. Any exception to this prohibition against subcontracting for Community Behavioral Health services must be explicitly set forth in the provider's contract, Letter of Agreement, or Provider Agreement with DBHDD but such exception shall only allow for subcontracting to another credentialed and actively enrolled Medicaid provider.

404.31. Terminations for Unpaid Funds Owed the Division

404.31.1. For purposes of this section:

404.31.1.1. The unpaid balance of funds shall include all unpaid funds owed the Division, plus any applicable fees, that are not included in are payment plan.

404.31.1.2. A Provider's average weekly claims shall be calculated utilizing the sum of the Provider's claims over the most recent twenty-six weeks divided by twenty-six.

404.31.2. The Division may terminate a Provider's participation in the Medicaid/PeachCare for Kids programs for unpaid funds owed the Division when:

404.31.2.1. The unpaid balance of funds equals or exceeds the amount that the Division can collect through 3months of voluntary or automatic reductions to the Provider's reimbursement under Section 406. The unpaid balance of funds owed the Division shall be determined to equal or exceed three months of reductions to the Provider's reimbursement when the unpaid balance plus any applicable fees equals or exceeds thirteen times the Provider's average weekly claims minus the sum of weekly payments of all preexisting repayment plans; or

404.31.2.2. The sum of the Provider's weekly repayment plan payments exceeds the Provider's average weekly claims.

404.31.3. Prior to the termination of the Provider, the Division shall provide written notice to the Provider and give the Provider the opportunity to make payment. The Provider shall have fifteen business days from the receipt of the notice to make payment. The Provider shall be given the following options to make payment:

404.31.3.1. When the unpaid balance of funds equals or exceeds the amount the Division can collect through three months of voluntary or automatic reductions pay to the Provider's reimbursement under Section 404.1(B)(1), a Provider may make payment as follows:

404.31.3.1.1. The Provider may make immediate payment in full for the unpaid balance of funds.

404.31.3.1.2. At the discretion of the Division, the Provider may enter into a three-month repayment plan and make immediate payment for the remaining balance above the amount to be paid through the new three-month repayment plan.

404.31.3.1.3. At the discretion of the Division, a Provider that is a Critical Access Hospital may enter into a six-month repayment plan,

404.31.3.1.4. At the discretion of the Division, a Provider that is a Critical Access Hospital may enter into a six-month repayment plan and make immediate payment for the remaining balance above the amount to be paid in the new six-month repayment plan;

404.31.3.1.5. At the discretion of the Division, the Provider may enter into a twelve-month repayment plan; and

404.31.3.1.6. At the discretion of the Division, the Provider may enter into a twelve-month repayment plan and make immediate payment of the remaining balance above the amount to be paid in the new twelve month repayment plan.

404.31.4. When the sum of the Provider's weekly repayment plan payments exceeds the Provider's average weekly claims under Section 404.1(B)(2), the Provider may make payments as follows:

404.31.4.1. The Provider may make an immediate payment of or the full balance on one or more repayment plans. Such payment must be sufficient to reduce the sum of the Provider's weekly repayment plan payments o that the total weekly payments are equal to or below the Providers' average weekly claims.

404.31.4.2. The Provider may extend a three-month repayment plan to a twelve-month repayment plan. The end date of the extended repayment plan shall be established using the start date of the original three-month repayment plan.

404.31.4.3. The Provider may make payment through a combination of actions under subsections (a) and (b) such that the Provider's weekly repayment plan payments are reduced to equal to or below the Provider's average weekly claims.

If the Division does not receive payment by the end of the fifteen-business day notice period, the Provider shall be placed on Suspended Status. The Division shall send written notice to the Provider of the Suspension. The Provider may return to Active Status if the Provider pays the entire balance of unpaid funds owed the Division, including all unpaid funds incorporated into repayment plans, any new debts owed the Division arising during the period since the date of the Notice letter, and all other applicable fees, within thirty business days of being placed on Suspended Status.

If the Division does not receive payment for the entire balance of unpaid funds owed the Division within thirty business days of the Provider being placed on Suspended Status, the Division shall terminate the Provider. The Division shall send written notice to the Provider of the termination. Following the termination of the Provider, reenrollment into the Medicaid/PeachCare for Kid Program shall be governed by the terms and conditions as solely determined by the Division but shall include repayment of all funds owed to the Division.

404.31.4.4. If a Provider agrees to repayment plan and the Division does not receive a payment under that repayment plan by the payment deadline plus five (5) business days, the Division shall initiate recoupment of 100% of the

Provider's reimbursement until the total balance of funds owed on the repayment plan, plus any applicable fees, has been paid. A provider that fails to make one or more payments may reenter its original repayment plan by bringing its payments to current and paying any applicable fees. The Division shall assess a six percent penalty fee on all payments made after the payment due date plus five business days.

404.31.4.5. Any person or entity that replaces a Provider per Section 105.9 shall be deemed to have accepted liability for any unpaid funds and applicable fees owed to the Division, regardless of the successor's enrollment status or lack of affiliation with the predecessor at the time the debt was incurred. As such, the Division may terminate a successor Provider's participation in the Medicaid/PeachCare for Kids Program for the unpaid funds owed the Division as described in this Section.

404.31.4.6. All appeals shall be governed by Chapter 500. It shall be the responsibility of the Provider to inform the Division of changes to its contact information. The Division shall not consider any appeals in which the basis for the appeal is lack of notice due to the Provider's failure to inform the Division of changes to its contact information

404.32. Suspensions

404.32.1. Suspensions shall apply to all Medicaid/PeachCare for Kids services at all provider locations.

404.32.2. Suspension, other than for inactivity, shall be in effect for the period set forth in the Division's Notice of Suspension or in the Administrative Law Judge's decision, if any.

404.32.3. The Division will re-enroll any suspended provider at the expiration of the period of suspension following receipt of a provider's written request for-enrollment.

404.32.4. The Department's suspension of a Medicaid/PeachCare for Kids provider is neither subject to administrative review nor an administrative law hearing if said action is based on the provider failing to submit a revalidation application within 60 days of the date of the re-credentialing notice.

404.33. Suspension of payments in cases of fraud

Pursuant to federal regulations, the Division must suspend all Medicaid payments to a provider, after the Division determines there is a pending investigation of a credible

allegation of fraud under the Medicaid program, against an individual or entity, unless the Division has good cause not to suspend payments or to suspend payments in part.

The Division may find that good cause exists not to suspend payments or not to continue a payment suspension previously imposed to an individual or entity in the following instances:

404.33.1. Law enforcement officials have specifically requested that a payment suspension not be imposed because a payment suspension may compromise or jeopardize an investigation;

404.33.2. The Division implements other remedies which effectively and quickly protect Medicaid funds;

404.33.3. The Division determines, based upon the submission of written evidence by the individual or entity, that is the subject of the payment suspension, that the suspension should be removed;

404.33.4. Recipient access to items or services would be jeopardized by a payment suspension;

404.33.5. Law enforcement declines to certify that a matter continues to be under investigation; or

404.33.6. The Division determines that a payment suspension is not in the best interests of the Medicaid program.

The Division may find that good cause exists to suspend payments in part or to convert a payment suspension imposed in whole to a payment suspension in part in the following instances:

404.33.7. Recipient access to items or services would be jeopardized by a payment supension;

404.33.8. The Division determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed in part;

404.33.9. The credible allegation focuses solely and definitively on only a specific type of claim or arises from a specific business unit of a provider and the Division determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not going to be paid;

404.33.10. Law enforcement declines to certify that a matter continues to be under investigation; or

404.33.11. The Division determines that a payment suspension only in part is in the best interests of the Medicaid program.

The Division may suspend payments without providing advanced notice to the provider.

Once the Division initiates a payment suspension, the Division must make a fraud referral to the Medicaid Fraud Control Unit or to the appropriate law enforcement agency. All suspension of payment actions will continue until the Division or prosecuting authorities determine that there is insufficient evidence of fraud, or the legal proceedings related to the provider's alleged fraud are completed.

404.34. Terminations

404.34.1. Terminations shall apply to all Medicaid/PeachCare for Kids services at all provider locations.

404.34.2. Termination shall be for a minimum of one (1) year and for that period defined in the Termination Notice or Administrative Law Judge's decision, if any. Terminated providers must reapply for enrollment in accordance with the then- current policies and procedures and submit a new Statement of Participation.

404.34.3. Any application for re-enrollment made prior to the expiration of the period of termination shall be denied and no Administrative Review or Administrative Law Hearing shall be granted. Any application for Medicaid/PeachCare for Kids enrollment submitted by a provider who is, at the time of application, in a period of suspension or termination from the Medicare program or any other state's Medicaid/PeachCare for Kids program shall be denied and no Administrative Review or Administrative Law Hearing shall be granted.

404.34.4. The Department's denial of application, non-renewal of participation, suspension, or termination of a Medicaid/PeachCare for Kids is neither subject to administrative review nor administrative law hearing if said action is based on the want of any license, permit, certificate, approval, registration, charter, or other form of permission issued by an entity other than the Department of Community Health, which form of permission is required by law either to render care or the receive medical assistance in which federal financial participation is available.

404.34.5. Applications rejected pursuant to §105.2 (C) & (D) are not subject to an administrative review or an administrative law hearing.

404.35. Administrative Appeals Process for Denial of Application, Non- Renewal of Participation, and Termination

The Department shall give written notice of the denial or termination to the affected person or entity, which notice shall include the reasons for the denial or termination. Providers wishing to contest the decision of the Department must submit written notice of the appeal, within ten (10) days of the date of the notice of denial or termination to:

Commissioner
Department of Community Health
C/o Legal Services Section

2 MLK Jr. Dr., SE,
East Tower, 18th Floor
Atlanta, Georgia 30334

The Commissioner has designated a hearing officer to adjudicate and render a final administrative decision. A hearing shall be scheduled and commenced within twenty (20) days after the date on which the Commissioner receives the notice of appeal. The hearing will be held at the Department's headquarters in Atlanta. Parties may file a Motion for Summary Determination pursuant to adverse actions from this section. Administrative review is not applicable to denial of enrollment or termination from enrollment in Medicaid.

404.36. Provider Termination-Managed Care Program

Providers also enrolled with a CMO are subject to the following termination provisions:

404.36.1. Providers contracted with Care Management Organizations (CMO) are subject to the termination policies and procedures outlined in the CMO contracts. The Department may request that a CMO terminate its contract with a Provider or the CMO may terminate the contract on its own if a Provider fails to comply with the terms and conditions of the Provider contract with the CMO or if the Provider fails to come into compliance within fifteen (15) calendar days after the receipt of notice from the CMO specifying such failure and requesting such Provider to abide by the terms and conditions of the contract.

404.36.1.1. Any Provider whose participation is terminated pursuant to Section 404.5 (A) shall utilize the applicable appeals procedures outlined in the Provider Contract with the CMO. No additional or separate right to appeal to DCH or the CMO is created as a result of the CMO's act of terminating, or any decision to terminate, any Provider under the CMO contract.

404.36.2. A Provider contracted with CMOs may be further subject to termination by the Department from participation in Medicaid PeachCare for Kids and the managed care program, for any reasons listed under Section 404 of this Manual, including but not limited to, failing to re-credential or if the Credentialing Committee rejects the provider's re-credentialing application. Any such Provider whose participation is terminated by the Department pursuant to Section 404.5(B) shall utilize the applicable appeals procedures outlined in Section 507 of this Manual.

404.36.3. The CMO will notify DCH at least 45 calendar days prior to the effective date of the suspension, termination, or withdrawal of a Provider from participation in the CMO's network. If the termination was "for cause" the Contractor shall provide to DCH the reasons for termination.

404.36.4. The Provider may be further subject to termination by the Department from participation in Medicaid/PeachCare for Kids. Further termination

by the Department shall be governed by §404 of this Manual.

405. Denial of Reimbursement

The Division may deny any portion or all of a provider's claim for reimbursement for any of the following reasons:

405.1. The service for which reimbursement is claimed is not a covered service.

405.2. The patient was not an eligible Medicaid or PeachCare for Kids member when the care or service was furnished.

405.3. The provider failed to obtain prior approval or precertification for furnishing the service when such prior approval or precertification was required.

405.4. The services provided have been determined to be medically unnecessary or of substandard quality through review by the Division or any other authorized entity to make such a determination.

405.5. Noncompliance with any of the Division's applicable policies and procedures.

405.6. The drugs or services for which reimbursement is claimed are ordered by a provider or other professional providing services or goods reimbursed by Medicaid/Peachcare for Kids, that appears on the Department of Health and Human Services, Office of the Inspector General's (OIG) Exclusion List or has been previously terminated or suspended by the Division.

405.7. The Division has suspended payments to the provider due to a pending investigation of a credible allegation of fraud under the Medicaid program.

406. Reduction of Reimbursement

The Division may reduce the amount of reimbursement associated with a claim for any of the following reasons:

406.1. The claim constitutes an overpayment as defined in the Definitions Section #50.

406.2. To correct a reimbursement error made by the Division or its third-party administrator.

406.3. The Division has suspended payments to the provider due to a pending investigation of a credible allegation of fraud under the Medicaid program.

406.4. To collect past due provider fees due the Division under O.C.G.A.§§ 31-8-161 through 38-8-169 and O.C.G.A. §§ 31-8-179 through31-8-179.6.

407. Recoupment of Reimbursement

The Division may recoup payments previously made to a provider in accordance with applicable

policy for any of the following reasons:

407.1. The Division paid the provider for a claim for a service for which reimbursement is not allowed by the State Plan.

407.2. The Division paid the provider an amount in excess of the amount allowed under the State Plan or other policy of the Division.

407.3. A third party paid the provider for a claim (or portion thereof) previously paid by the Division.

407.4. The Division paid the provider for services, items or drugs that the provider did not perform or provide.

407.5. The services provided have been determined to be medically unnecessary, of substandard quality or not in keeping with currently accepted standards of medical practice or applicable statutory law by the Division or by any other entity authorized by the Division to make such a determination.

407.6. The provider has failed to comply with all terms and conditions of participation related to the service(s) for which a claim has been paid.

407.7. The Division paid for claims submitted by a data processing agent for whom a written Trading Partner Agreement was not on file with the Division at the time of submission.

407.8. The provider has submitted electronic media billing in violation of the Provider Agreement for Electronic Data Interchange.

407.9. The Division paid for claims at a rate based upon a provider's submitted cost report, or other cost information report, and the cost report data was adjusted based upon review or audit by the Division or its agents.

407.10. The provider has failed to maintain the proper documentation required pursuant to this Part I or Part II (and Part III where applicable) of the manual or currently accepted standard of medical practice.

407.11. The drugs or services for which reimbursement is claimed are ordered by a provider or other professional providing services or goods reimbursed by Medicaid/PeachCare for Kids, that either appears on the Department of Health and Human Services, Office of the Inspector General's (OIG) Exclusion List or has been previously terminated or suspended by the Division.

The Division will provide a statement in which the basis for the recoupment and methods for calculation is described. The statement will also specify the time allowed for repayment, which will normally be thirty (30) days. Failure to remit the payment within the time allowed or submitting a check with a limited endorsement will result in recoupment from payments due without notice.

408. Withholding Reimbursement

The Division may withhold reimbursement claimed by any provider, whether or not a demand has been made for repayment, for any of the following reasons:

408.1. The Division reasonably believes that the provider may abscond or, by other plan or device, seek to avoid repaying a debt owed.

408.2. The Division receives reliable evidence of fraud or willful misrepresentation concerning the provision of services under Medicaid/PeachCare for Kids.

408.3. If a nursing home provider fee has not been received by the Department by the last day of the month, the Department shall withhold an amount equal to the nursing home provider fee and penalty owed from any medical assistance payment due such nursing home under the Medicaid program.

408.4. The Division has suspended payments to the provider due to a pending investigation of a credible allegation of fraud under the Medicaid program.

409. Rate Adjustment

The Division may adjust the reimbursement rate of any provider whose rate is established specifically for it on the basis of cost reporting, whenever the Division determines that such adjustment is appropriate. The adjustment may be implemented retroactively, prospectively, or both.

An Adjustment may be defined as a prospective rate change and is not considered an Adverse Action as defined in the Definition Section of this Manual.

410. Referral to Law Enforcement Officials

The Division maintains methods and criteria for identifying situations in which providers may have committed unlawful acts. In addition to any other adverse action stated herein, the Division may refer providers to appropriate law enforcement officials when there is a reasonable belief that an unlawful act, as construed in accordance with O.C.G.A. §49-4-146.1 and other applicable state and federal statutes, has been committed.

411. Other Sanctions

The Division is authorized to take additional adverse action not previously stated which it finds necessary to secure compliance with federal and state laws and regulations.

412. Correction of Department Errors

The Department periodically reviews its records to verify provider reimbursement. Should the Department discover errors in payments made to providers, it may correct such errors by taking any action in its discretion, up to and including recoupment. There is no limitation on the period of time in which the Department may reduce a provider's reimbursement to correct such an error.

Chapter 500: Appeals

501. General

This chapter outlines the requirements that a provider must meet in order to contest an adverse action taken by the Division other than those described in §404 of Chapter 400. Please refer to O.C.G.A. §49-4-153(b)(3) for those requirements. This chapter also includes the Medicaid Member administrative hearing process.

Note: DCH Policy is not a rule or a regulation that is subject to compliance with APA rules of inspection and publication (see GA Dep't of Medical Assistance et al. v. Beverly Enterprises, Inc., 261 Ga. 59 (1991).

502. Provider Initial Reviews

502.1. General Claim Payments: A rendering provider (not payee) may request an initial review of a denial of a claim payment by electronically submitting a DMA 520 Provider Inquiry form request via our Web Portal at www.mmis.georgia.gov.

Effective October 1, 2014, DCH and Gainwell Technologies will no longer accept paper or faxed DMA-520's from Medicaid providers. All providers are required to submit their DMA-520 forms online through the Georgia Medicaid Management Information System (GAMMIS - www.mmis.georgia.gov).

Providers must submit requests for an initial review within thirty (30) days of the date of the denial of claim payment. Claims less than or equal to 30 days are not prohibited. If your claim is eligible to appeal, the DMA-520 Inquiry button will appear at the top of your claim screen. Only one DMA-520 may be used per inquiry. All data fields must be completed.

Providers will receive an email response to the inquiry in the same media type as the request. Providers must review the applicable Part II Manual for specific information regarding documentation that must be submitted with the request for an initial review. For previously submitted inquiries, the status will be provided along with the option to electronically upload supporting documentation. If the CTN status is CLOSED, you will not be able to upload supporting documentation. Providers may also make a verbal inquiry by calling the GAINWELLC Provider Inquiry Unit at 1-800-766-4456.

Providers will have 30 days from the date of the initial review determination to request an Administrative Review.

FAILURE TO COMPLY WITH THE REQUIREMENTS REGARDING THE INITIAL REVIEW PROCESS AND THE ADMINISTRATIVE REVIEW PROCESS, INCLUDING THE FAILURE TO SUBMIT ALL NECESSARY DOCUMENTATION, SHALL CONSTITUTE A WAIVER OF ANY AND ALLFURTHER APPEAL RIGHTS, INCLUDING THE RIGHT TOAHEARING.

502.2. Hospital Cost Outliers: A written request for review of a Hospital Cost Outliers should be sent to:

GAINWELL TECHNOLOGIES
Hospital Outlier Claims
P.O. Box 105208
Tucker, GA 30085-5208

Providers will receive a letter notifying them of the Cost Outlier Review determination. Providers must review Part II, Hospital Services Manual for specific information that must be submitted with the request for a Cost Outlier Review.

Providers will have 30 days from the date of the final review determination to request an administrative review regarding a Hospital Cost Outlier.

502.3. Other non-claim related inquiries: A provider may request an initial inquiry by submitting an email request to the GAINWELLC Web Portal www.mmis.georgia.gov (the "Contact Us" function), or by submitting a request to:

Provider Correspondence-Non-Claim (Miscellaneous)
Documents GAINWELL TECHNOLOGIES
P.O. Box 105209
Tucker, Georgia 30085-5209

Please submit your request on letterhead or on the DMA-520 (Provider Inquiry Form) which located on the web (www.mmis.georgia.gov, under the Forms and Documents section). Providers will have 30 days from the date of the action complained of to request an Initial Review.

Providers will receive a response to their inquiry in the same media type as the request was made unless a web registered provider agrees to receive the response in their web "Message Center". Providers must review the applicable Part II Manual for specific information regarding documentation that must be submitted with the request for an initial review.

Providers will have 30 days from the date of the initial review determination to request an administrative review.

Providers may also make a verbal inquiry by calling the GAINWELLC Provider Inquiry Unit at 1-800-766-4456.

502.3.1. DMA-520A Provider Inquiries for Clinical Reviews for Medical Necessity

For inquiries regarding medical/clinical reviews for medical necessity, providers must submit the inquiry electronically via the web portal (www.mmis.georgia.gov) secure home page link: Prior Authorization/Medical Review Portal/Provider Inquiry Form (DMA-520A). The inquiry must be submitted within thirty (30) days from the date of the denial. All inquiries regarding medical/clinical reviews must be submitted utilizing the DMA-520A. Once the electronic inquiry is

submitted, an inquiry reference number will be generated. Only one DMA-520A form may be used per inquiry/ICN. All data fields must be completed by the provider. Prior Authorization reconsiderations should be submitted through the Prior Authorization Medical Review Portal.

Supporting documentation must be submitted simultaneously with the DMA520A. Supporting documentation is to be electronically attached to the inquiry (DMA-

520A). Effective July 22, 2016, and as part of the GA Medicaid Paperless Initiative which went into effect May 1, 2015, faxes for DMA-520A Provider Inquiry/Appeals requests are not accepted. All supporting documentation must be electronically submitted through the GAMMIS Web Portal (www.mmis.georgia.gov) via the Medical Review Portal link located under the Provider Information tab. Mailed hard copy DMA-520A provider inquiry forms will not be accepted and will be discarded. All inquiries must be submitted via the web portal (www.mmis.georgia.gov) secure home page link: Prior Authorization/Medical Review Portal/Provider Inquiry Form (DMA-520A)

Upon completion of the medical review by the Medical Management Contractor, the decision will be available for viewing on the web portal. E-mail notifications will be sent informing providers whenever a decision is available for viewing within the Medical Review Portal on the same day that the decision is made. Providers will also be able to view and download the electronic decision correspondence directly from the Medical Review Portal. All communications to the provider will be attached directly to the review case within their secure Provider Workspace.

The Medical Management Contractor does not review: Medicare crossover appeal claims, timely filing, NDC, request for reprocessing of corrected claims, Health Check, duplicate claims, etc. If you have questions regarding these items, please contact GAINWELL TECHNOLOGIES at 1-800-766-4456.

Should you require assistance completing the DMA-520A, a user guide describing the DMA-520A web submission process is available on the web portal at www.mmis.georgia.gov: Provider Workspace/Education and Training link.

503. Fullard Review (Member)

503.1. Members who have been billed for services rendered by a Medicaid provider are entitled to a review. The member may notify the Department that he or she has been billed for services which may or should have been paid for by the Medicaid program. The Department will investigate the matter to determine whether the member was eligible for Medicaid at the time the services were rendered, whether the person or institution was a participating Medicaid provider, whether the services were covered by

Medicaid at the time they were rendered, and whether the Department has rendered payment to the provider for the services in question. The Department will issue a written decision to the member and send a copy to the provider.

503.2. Requests for a Fullard review may be mailed to:

GAINWELL TECHNOLOGIES
P.O. Box 105200
Tucker, Georgia 30085-5200
Or Fax to 1-866-483-1045

The member must attach a cover sheet that indicates that the request is a Fullard review and includes the member's name, the 12-digit Medicaid/PeachCare for Kids ID number, the reason for the request and a copy of the medical bill.

503.3. Should the Department render a decision that is unfavorable to the member, he or she may request a hearing pursuant to §506 of this Chapter.

503.4. Any person receiving services under the Emergency Medical Assistance Program is not eligible for a Fullard Review. These members will be notified by GAINWELLC of the need to forward documentation to the Department's Legal Services Section. Please note the following related to these claims:

503.4.1. If the provider's claim is denied because the Department has determined that the services rendered were non-emergent, the member is responsible for payment of these services. The member may appeal this determination pursuant to §508 of this manual.

503.4.2. If the provider does not bill the Department for the services rendered to an EMA member, the EMA member is responsible for paying this bill. The member may appeal this determination pursuant to §506 of this manual.

503.4.3. If the provider's claim is denied for failure to submit the claims in compliance with §208.1, the EMA member is not responsible for payment of the bill.

504. Favors Review

504.1. Should the Division deny a provider's request for prior approval of a covered Rev. 10/15 service that (as defined in the "Definitions" section of this Manual) is not medically necessary, the member or through their provider may request within thirty (30) days an administrative review of the initial decision (Providers see §505 of this Chapter). If the Division denies the provider's request for administrative review or if the provider fails to submit further medical evidence of medical necessity, the Division will send a final determination to the member and a copy to the provider. At this stage the provider cannot request a hearing on the denial.

504.2. Members may request additional information related to a Favors review by calling 1-866-211-0950. Members may request a Favors review by mailing any supporting documentation to:

GAINWELL TECHNOLOGIES
P.O. Box 105200
Tucker, Georgia 30085-5200
Or Fax to 1-866-483-1045

Requests for Favors reviews must be in writing with a cover sheet that indicates that the request is a Favors review and includes the member's name,12-digit Medicaid/PeachCare for Kids ID number, the reason for the request, a copy of the adverse action letter and any supporting documentation

504.3. If the Favors review does not result in approval, the Division will send a final determination notice to the member. The member may request a hearing pursuant to §508 of this Chapter.

NOTE: ANY PERSON RECEIVING SERVICES UNDER THE EMERGENCY MEDICAL ASSISTANCE PROGRAM IS NOT ELIGIBLE FOR A FAVORS REVIEW.

505. Medicaid/PeachCare for Kids Provider Administrative Review

With the exception of any action taken by the Department pursuant to §404 of Chapter 4, the Division offers the opportunity for Administrative Review to any provider against whom it proposes to take an adverse action or denial of payment unless otherwise authorized by law to take such action without Administrative Review. Administrative Review shall be completed, if not waived by the provider, at the earliest practical date and prior to implementation of the proposed action. The length of the Administrative Review period varies depending on the complexity of each case.

For a provider to obtain an Administrative Review, including a utilization conducted by Program Integrity, a written request must be received at the address of the office that proposed the adverse action within thirty (30) days of the date the notification of the proposed adverse action, (the initial review determination) was mailed to the provider. The request must include all grounds for Administrative Review and must be accompanied by all supporting documentation and an explanation the provider wishes the Division to consider. Letters requesting an Administrative Review without supporting documentation will not be accepted or considered.

In cases involving an audit of a provider, any documentation submitted for Administrative Review may, at the Department's discretion, subject the case, in whole or in part, to a re-audit.

Requests for an Administrative Review resulting from audits conducted by Integrity Unit, unless otherwise instructed in the initial review letter, should be forwarded to the following:

Georgia Department of Community Health
Office of the Inspector General
Attn: Program Integrity Unit

2 Martin Luther King Jr., Drive SE
East Tower – 19th Floor
Atlanta, GA 30334

FAILURE TO COMPLYWITH THEREQUIREMENTSOF ADMINISTRTAIVE REVIEW, INCLUDING THE FAILURE TO SUBMIT ALL NECESSARY DOCUMENTATIONWITHIN (30) DAYS, SHALLCONSTITUTEA WAIVEROF ANY ANDALLFURTHER APPEALRIGHTS, INCLDUING THERIGHT TO A HEARING.

505.1. Administrative Review (Out of State Providers)

For an out of state (OOS) provider (beyond 50 miles of the Georgia border) to obtain an Administrative Review, a written request must be received at the address of the office below within thirty (30) days of the date the notification of the proposed adverse action, the denial of payment, remittance advice or initial review determination was mailed to the provider. The request must include all grounds for Administrative Review and must be accompanied by all supporting documentation and explanation that the OOS provider wishes the Division to consider. Letters requesting Administrative Review that are not accompanied by supporting documentation will not be accepted or considered. Certain programs, such as Hospitals, may have additional documentation requirements. Please refer to Part II Manual.

All in-state and border providers must submit request for administrative review electronically as outlined in section 402.6.

In cases involving an audit of a provider, any documentation submitted for Administrative Review may, at the Department's discretion, subject the case, in whole or in part, to a re-audit.

Request for Administrative Review for all OOS claims being submitted must be forwarded to:

Georgia Department of Community Health
Attention: Director Medical Policy & Provider Reviews Unit
2 MLK Jr. Dr., SE, East Tower, 19th Floor
Atlanta, Georgia 30303

FAILURE TO COMPLY WITH THE REQUIREMENTS OF ADMINISTRATIVE REVIEW, INCLUDING THE FAILURE TO SUBMIT ALL NECESSARY DOCUMENTATION WITHIN THIRTY (30) DAYS, SHALL CONSTITUTE A WAIVER OF ANY AND ALL FURTHER APPEAL RIGHTS, INCLUDING THE RIGHT TO A HEARING.

506. Medicaid/PeachCare for Kids Provider Administrative Law Hearing

506.1. Whenever the opportunity for Administrative Review is available to the provider, the Administrative Review process must be completed for the provider to be entitled to a hearing. Issues at hearing are limited to those issues that have been through the Administrative Review process.

506.2. A Request for Hearing must be in writing and received by the Division within fifteen (15) business days after the date the provider received the decision of the Division that is the basis for the appeal. However, Requests for Hearing for actions described in Section 404 must be in writing and received by the Division within ten (10) days after the date the notice was transmitted to the provider.

506.3. A Request for Hearing must be sent to:

Georgia Department of Community Health
Legal Services Section
2 MLK Jr. Dr., SE East Tower, 18th Floor
Atlanta, GA 30334

506.4. The Request for Hearing must include the following information:

506.4.1. A clear expression by the provider or authorized representative that he/she wishes to present his/her case to an Administrative Law Judge.

506.4.1.1. Identification of the adverse Administrative Review decision or other Division action being appealed and all issues that will be addressed at hearing. Issues at hearing are limited to those issues that have been submitted for Administrative Review.

506.4.2. A copy of the Adverse Action Letter, Administrative Review Response, or Final Denial Notice.

506.4.3. A specific statement of why the provider believes the Administrative Review decision or other Division action is wrong.

506.4.4. A statement of the relief sought.

506.5. For purposes of determining the timeliness of a request for hearing, the computation of any period of time shall begin with the first day following that on which the action initiating such period of time occurs. When the last day of the period so computed is a day on which the Division is closed, the period shall run until the end of the next business day.

506.6. A Request for Hearing shall not stay the action appealed.

506.7. All hearings shall be conducted in accordance with the Rules of Office of State Administrative Hearings, which can be found at www.osah.ga.gov. The Office of State Administrative Hearings shall issue the Notice of Hearing however, all provider hearings shall be conducted at OSAH's headquarters.

506.8. Administrative Review is not applicable to adverse actions described in Section 404.

507. Medicaid/PeachCare for Kids Provider Administrative Law Hearing- Denial of Application, Non-Renewal of Participation, Suspension, and Termination

507.1. This section is only applicable in those cases where the Department has rendered a decision regarding the provider's participation in Medicaid/PeachCare for Kids. This section is not applicable to providers suspended for failure to revalidate.

507.2. The provider may request a hearing from the Commissioner of the Department of Community Health within ten (10) days of the date of the initial decision issued by the Department regarding a provider's denial of application, non- renewal of participation, suspension, and termination in Medicaid/PeachCare for Kids or any of its associated programs. The provider's request for hearing must contain the following:

507.2.1. A copy of the Adverse Action Letter, Notice of Termination from Medicaid/PeachCare for Kids, Notice of Denial of Application, Notice of Non-Renewal of Participation, Notice of Suspension.

507.2.2. A clear expression by the provider or authorized representative that he/she wishes to present his/her case to an Administrative Law Judge or designated Hearing Officer.

507.2.3. Identification of the action being appealed and all issues that will be addressed at the hearing.

507.2.4. A specific statement of why the provider believes the Department's decision is wrong.

507.2.5. A statement of the relief sought.

507.3. The Commissioner has designated a hearing officer to adjudicate and render a final administrative decision. Said hearing will be scheduled and commenced within 20 days after the date on which the commissioner receives the notice of appeal. The hearing will be held at the Department's headquarters in Atlanta. The notice of appeal should be submitted in writing, with a copy of the initial decision attached to:

Georgia Department of Community Health
Legal Services Section
East Tower, 18th Floor,
2 MLK Jr. Dr, SE,
Atlanta, GA 30334

508. Medicaid Member Administrative Law Hearings (Fair Hearings)

508.1. Should the Department's decision be averse to the member, the member (or member's representative) may request a hearing before an Administrative Law Judge. A hearing must be requested either in writing or by email. The hearing request and a copy of the adverse action letter must be received by the Department within 30 days or less from the date of the adverse action letter. The hearing request should either be emailed to Medicaid.appeals@dch.ga.gov or mailed to the following address:

Department of Community Health
Legal Services Section
East Tower, 18th Floor
2 MLK Jr. Dr., SE
Atlanta, Georgia 30334

508.2. This section does not apply to PeachCare for Kids members. PeachCare for Kids members should consult Appendix D of this Manual for the Review and Appeal Process.

508.3. Children participating in the Georgia Pediatric Program (GAPP) or the TEFRA\Katie Beckett Program shall participate in the administrative review process prior to an Administrative Law Hearing.

508.4. Parents of children in either the GAPP or TEFRA/Katie Beckett Programs may request an Administrative Review within 30 days of the date of the initial decision. During the administrative review additional documentation may be considered to determine the appropriateness of the initial decision. Parents of the children in either the GAPP or TEFRA/Katie Beckett Program will be instructed in the initial decision letter to supply the additional documentation to the appropriate personnel at the Georgia Medical Care Foundation. If the parent fails to request an administrative review or if the parent fails to submit additional documentation, the initial decision will become final on the 30th day after the date of the initial decision. At the end of the administrative review, the member will be sent a notice of the Department's final decision.

508.5. Members may continue their services during the appeal if they submit a written request for continued services before the date that the services change. If the Administrative Law Judge rules in favor of the Division, the member will be required to reimburse the Division for the cost of any Medicaid benefits continued during the appeal.

508.6. The Office of State Administrative Hearings will notify member of the time, place and date of the hearing.

509. Commissioner's Review for a Member

Should the Administrative Law Judge's decision be averse to a member, the member may file a written request to the commissioner for an agency review within 30 days of receipt of the decision.

510. Commissioner's Review for a Provider

Any party may petition the Commissioner for a review of the Administrative Law Judge's decision within ten (10) days from the date of that party's receipt of the decision if the issue on appeal is one other than a denial of enrollment or a provider termination action. A request for review regarding a denial of enrollment or a termination action must be made in writing to the commissioner within 10 days of the date of mailing. Such requests shall be in writing and addressed to the Commissioner and shall state the legal or factual errors upon which the appeal is based. The Commissioner may also elect to review on his own motion the decision of the Administrative Law Judge.

510.1. If any party fails to appeal the Initial Decision of the Administrative Law Judge within the appropriate time shall have waived its right to any further review or revision of that decision.

510.2. If a party requests a transcript of the proceedings, after receipt of the initial decision, that party will have an additional five (5) days from the date of the receipt of the transcript in which to submit a written statement of legal or factual errors. However, a request for a transcript shall not in any manner lengthen the time of ten (10) days from receipt of the decision in which a request for review must be submitted.

511. Appeal of the Commissioner's Decision

Any party adversely affected by a final decision by the Commissioner may seek review of such final decision by filing a Petition for Judicial Review in the Superior Court of the county of residence or to the Superior Court of Fulton County. Such appeal shall be by petition, which shall be filed in the Clerk's Office in such court within thirty (30) days after service of the final decision of the Commissioner. Such appeal shall be held in accordance with the Administrative Procedure Act, O.C.G.A. Section 50-13-19. Such appeal is available only upon exhaustion of all applicable administrative remedies.

512. Interest

No entitlement to interest shall accrue regarding any amount claimed by a provider, regardless of whether or not the amount is the subject of a demand upon the Division which is adjudicated through Administrative Review or Hearing.

Chapter 600: DCH Americans With Disabilities Act and Section 504 of The Rehabilitation Act Policy

601. Policy

No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of the Department of Community Health ("DCH").

602. Scope

This policy of non-discrimination is equally applicable to DCH staff, including volunteers and interns, and its subrecipients, contractors, grantee, agents, and providers of services ("Providers"), who assist with or administer programs, services, and activities that fall under DCH. This policy is not applicable to child welfare and employment matters.

603. Requirements

The Department of Community Health ("DCH") shall:

603.1. Make reasonable modifications in policies, practices, or procedures when necessary to avoid discrimination on the basis of disability, unless it is demonstrated that making the modification would fundamentally alter the nature of the service, program, or activity or would result in undue financial and administrative burdens.

603.2. Provide public notices regarding the right of qualified individuals with disabilities to make a request for reasonable modification and auxiliary aids and services;

603.3. Provide equally effective communication with primary consideration given to the person with a disability by considering the nature, length, complexity, and context of the communication and the person's normal method(s) of communication, and;

603.4. Administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

604. Authorities /References (This list is not exhaustive)

604.1. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794 ("Section 504"), Title II of the Americans with disabilities Act of 1990 ("ADA") and the ADA Amendments Act of 2008, 42 U.S.C. § 12101 et seq., and provisions, directives, and implementing regulations that govern DCH administration of all Medical Assistance programs such as Medicaid and PeachCare for Kids®.

604.2. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794 ("Section 504").

604.3. U.S. Department of Justice regulations (28 C.F.R. Part 35).

604.4. U.S. Department of Health and Human Services regulations (45 C.F.R. Parts 80, 84 and 91).

604.5. R.H. et al. v. Rawlings et al., CAFN: 1:17-CV-01434-TWT (N.D. Ga. 2019) (Consent Order, filed on June 4, 2019).

605. Definitions

*Note: Some of the definitions below are available at www.ADA.gov and are derived from the ADA, The Rehabilitation Act, and implementing regulations.

Auxiliary Aids and Services- Includes but is not limited to qualified sign language interpreters, telephone handset amplifiers, assistive listening devices, closed caption decoders, real time captioning, TTY/TTD relay services for deaf and hard-of-hearing, screen reader software, Braille Embossers, text to Braille converter, large print materials, alternative keyboards for individuals who are blind and have low vision.

Companion- Any family member, friend, or associate of a person seeking or receiving an entity's goods or services who is an appropriate person with whom the entity should communicate.

Disability- With respect to an individual: (i) A physical or mental impairment that substantially limits wone or more of the major life activities of such individual; (ii) A record of such an impairment; or (iii) being regarded as having such an impairment as described in paragraph (f) of 28 C.F.R. § 36.105.

Mobility Aids and Other Power-Driven Mobility Devices- Any mobility device powered by batteries, fuel, or other engines… that is used by individuals with mobility disabilities for the purpose of locomotion, including golf carts, electronic personal assistance mobility devices… such as the Segway® PT, or any mobility device designed to operate in areas without defines pedestrian routes, but that is not a wheelchair.

Qualitied Individual with a Disability- An individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by the Department.

Qualified Interpreter- An interpreter who, via video remote interpreting (VRI) service or an on-site appearance, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Qualified interpreters include, for example, sign language interpreters, oral transliterators, and cued-language transliterators.

Reasonable Modification- Modifications to rules, policies, practices, or procedures, the removal of architectural, or transportation barriers as described in 28 C.F.R. § 35.130(b)(7), 28 C.F.R. § 35.164 and elsewhere.

Note: R.H. et al. v. Rawlings et al., CAFN: 1:17-CV-01434-TWT (N.D. Ga. 2019) (Consent Order, filed on June 4, 2019) considers provision of auxiliary aids and services a reasonable modification. However, the ADA regulations list equally effective communication requirements and auxiliary aids, and services separate and distinct from reasonable modification. DCH will ensure equally effective communication as described in 28 C.F.R. § 35.160 and 28 C.F.R. § 36.303.

Reasonable Modification and Communication Assistance Request Form- A form, either in paper or electronic format than can be used, as the option of the user with a disability, to request a reasonable modification or communication assistance and for purposes of tracking the request and response.

Request for Reasonable Modification and Communication Assistance- Any specific written or oral statement by or made appropriately on behalf of a customer with a disability, including through the "Reasonable Modification and Communication Assistance Request Form" that indicates the individual has a disability for which he or she needs a reasonable modification or communication assistance to access all DCH programs, benefits, or activities. A request for reasonable modification includes instances where the individual initiates the request for assistance.

Service Animal- Any dog that is individually trained to do work or perform tasks for the benefit of an individual with disabilities.

Video Relay Service (VRS)- A free, subscriber-based service for people who use sign language and have videophones, smart phones, or computers with video communication capabilities. For ongoing calls, the subscriber contacts the VRS interpreter, who places the call and serves as an intermediary between the subscriber and a person how used a standard voice telephone. The interpreter tells the telephone user what the subscriber is signing and signs to the subscriber what the telephone user is saying.

Video Remote Interpreting (VRI)- An interpreting service that uses video conference technology over dedicated lines or wireless technology offering high-speed, wide-bandwidth video connection that delivers high-quality video images as provided in 28 C.F.R. § 35.160(d).

Wheelchair- A manually operated or power-driven device designed primarily for use by an individual with a mobility disability for the main purpose of indoor or of both indoor and outdoor locomotion.

606. Coordination of Services/ Self-Assessment/ Monitoring

606.1. ADA Section 504 Coordinator

DCH must designate an individual to serve as the point of contact for staff and the general public regarding ADA disability access matters and to coordinate implementation of this policy. Local government agencies and other public entities with whom the DCH contracts that employ 50 or more persons must also designate at least one employee to coordinate its efforts to comply with the ADA. (Reference:28 C.F.R. § 35.105). The name, office address, and telephone number of the ADA Coordinator/ Section 504 must be provided to all interested persons. (References: 7 C.F.R. § 15(b)(6) and 45 C.F.R. Reference: 28 C.F.R. § 84.7).

For more information about the ADA/ Section 504, contact the DCH ADA/Section 504 Coordinator listed on Attachment 2. The primary responsibilities of an ADA/Section 504 Coordinator are listed on Attachment 3. The DCH ADA/ Section 504 Coordinator must convene regular meetings with ADA/Section 504 Coordinators serving the DCH local agencies, subrecipients and contractors that deliver services directly to the public.

607. Qualified Individual with a Disability

An individual with a disability under the ADA is defined as a person with a physical or mental impairment that substantially limits wone or more major life activity; a person who has a record of such an impairment; or a person who is regarded as having such an impairment. The term "individual with a disability" does not include an individual who is currently engaging in the illegal use of drugs or alcohol.

607.1. "Qualified individual with a disability" means an individual with a disability who, with or without reasonable modification to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

608. Public Notifications

DCH and its Providers must notify individuals with disabilities about the availability of free reasonable modifications and auxiliary aids and services and how to request them in a format that individuals can understand. DCH and its Providers also must notify the public about the right to file a discrimination complaint.

608.1. Notices regarding the rights of people with disabilities and provision of services are available on Gateway, on all applications and renewal forms for Medicaid programs, in all DHS/DFCS and DCH Katie Beckett offices, and online at: https://dch.georgia.gov/forms-notices. Notices will be provided in alternative formats upon request.

608.2. DCH Notice of ADA/Section 504 Rights regarding the rights of people with disabilities and provision of services are available on Gateway, in all applications and renewal forms for Medicaid programs, Katie Beckett, in all county DHS/DFCS offices, and online at: https://dch.georgia.gov/forms-notices and https://dch.georgia.gov/adasection-504-and-civil-rights.

608.3. DCH and its Providers must post signage at inaccessible entrances to each of its facilities directing customers to an accessible entrance or to a location at which customers can obtain information about accessible facilities. The international symbol for accessibility must be used at each accessible entrance of a facility.

608.4. Notices must be provided in alternative formats upon request. Copies of the ADA/Section 504 Notice of Rights and the Request for Reasonable Modification and Communication Assistance Forms must be available in waiting rooms. Staff must read the Notice of ADA/Section 504 Rights to individuals upon request or as necessary to ensure understanding and to complete the Request for Modification and Communication Assistance Form. More information can be found online at: https://dch.georgia.gov/adasection-504-and-civil-rights

608.5. Notices regarding the right to file a discrimination complaint must be posted accordance with federal agency directives. Reference the DCH Civil Rights Compliance Policy.

609. How to Request a Reasonable Modification

Individuals with disabilities may require reasonable modification to assist them with accessing DCH programs and services, complying with program requirements, avoiding potential sanctions for noncompliance. All customers have the right to request a reasonable modification. Customers may submit a request for a reasonable modification to any appropriate DCH staff member at any time.

609.1. Customers may make a request for reasonable modification orally or in any written format. Staff who do not have access to Gateway, such as receptionists, should forward the request to an eligibility worker for processing.

609.2. A customer may also complete the Reasonable Modification and Communication Assistance Request Form (Form 101). Customers are not required to use the form to make a request for reasonable modification. Customers may obtain Reasonable Modification and Communication Assistance Form in the customer waiting room in the Katies Beckett office. The forms is also available on-line at https://dch.georgia.gov/forms-notices and https://dch.georgia.gov/adasection-504-and-civil-rights. Katie Beckett eligibility staff are required to document any oral request or written requests for reasonable modification in the customer's Gateway casefile.

609.3. Staff must provide the Reasonable Modification and Communication Assistance Request Form (Form 101) to any customer upon request and may provide this form to any customer if a staff member believes a customer may require a reasonable modification. Forms are to be made available to customers in alternative formats as requested (i.e., large print or Braille). The Reasonable Modification and Communication Assistance Form 101 are attached hereto in English, Spanish, English Large Print and Spanish Large Print as Attachments 4-7. Staff are required to assist customers with the competition of Form 101, if necessary. If a customer discloses a disability, staff members will inform the customer of his or her right to make a request for reasonable modification and will be provided examples of reasonable modifications.

610. Procedures for Processing Customer Requests for Reasonable Modification (s)

Customers with disabilities may require reasonable modification to assist them with accessing and maintaining eligibility for DCH programs and services complying with CH program requirements and avoiding potential sanctions for noncompliance and participating fully in programs, services, and activities relating to DCH programs. All customers have the right to a reasonable modification. Customers may direct a request for a reasonable modification to any appropriate DCH staff member at any time. Customers may make a request for reasonable modification orally or in a written form. DCH staff are required to convert any oral request for reasonable modification to a written reasonable modification request form for processing and documentation in the customer's Gateway case file by an eligibility worker.

610.1. Customers are not required to use the form to make a request for reasonable modification. Staff must provide a Reasonable Modification and Communication Assistance Form to any customer upon request and may provide a form to any customer a staff member believes may require a reasonable modification.

The request may also be made by using the DCH ADA Reasonable Modification and Communication Assistance Form which is available at the DCH Katie Beckett office or on-line at https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett or by requesting in writing to:

The Georgia Department of Community Health
Katie Beckett Team ADA/Section 504 Coordinator
2211 Beaver Ruin Road, Suite 150
Norcross, GA 30071

610.1.1. Forms are to be made available to customers in alternative formats as requested. Eligibility workers are required to assist customer with the completion of the request for reasonable modification form, if necessary. If a customer discloses a disability, staff members will inform the customer of his or her right to make a request for reasonable modification and will be provided examples of modifications.

610.1.2. Once a customer requests a reasonable modification, eligibility workers are required to document the following in Gateway: The date(s) and type(s) of reasonable modification(s) requested by the customer, the date a request for reasonable modification was granted or denied, the reason the request for reasonable modification was denied, if applicable, and the specific approved or denied reasonable modification(s).

610.1.3. If the customer expresses a need for assistance related to a disability, expresses difficulty completing any task in the application or renewal process, and/or has a disability that is documented in Gateway, eligibility workers are required to explain tasks that the customer must complete in the application and/or renewal process, inquire whether the customer will have difficulty completing any task or may need assistance completing any task, the reason(s) for the difficulty and/or need for assistance and possible reasonable modification with the customer.

610.2. When an eligibility worker becomes aware that a customer has a disability that substantially limits the customer's ability to see or hear, the eligibility worker is required to inquire as to the customer's potential need for auxiliary aids and services. If a customer expresses a need for assistance related to a disability, or if to customer has a disability that is documented in Gateway, the eligibility worker will be required to discuss the possible need for a reasonable modification with the customer using the Gateway written prompts. If a customer indicates that he or she does not choose to disclose a disability or discuss a potential reasonable modification, the eligibility worker will not make further inquiry on the subject.

610.3. When a written request for reasonable modification is mailed, faxed, emailed, or hand-delivered, it will be processed by the Katie Beckett Team. Eligibility workers are required to consult the customer's case file in Gateway prior to or during every interaction with the customer, and before taking any action on the customer's case. Eligibility workers are required to review the Gateway Alerts for requests for reasonable modifications and, prior to case closure or denial, take the appropriate action on a pending request that are required to determine the customer's eligibility.

610.4. Staff obligation is to provide reasonable modifications to qualified individuals with a disability at every point of interaction with customers in the eligibility process, whether in person, on-line, by telephone, or by mail, including inquiries applications for benefits. Staff must assess requests for reasonable modifications as part of a collaborate, interactive process, applying a fact-specific, individualized analysis of the person's individual circumstances and the modification requested to assist the individual in complying with DCH program eligibility requirements. Considerations of and decisions concerning a customer's request for reasonable modification may incorporate the following factors, assessed cooperatively with the customer: How the disability limits the customer's ability to comply with program eligibility procedures, reasonable modification options that address those limitations; and the effectiveness and feasibility of the proposed options. Provisions of reasonable modifications are based on a fact-specific inquiry that is to be assessed on a case-by-case basis.

610.4.1. All eligibility workers have the responsibility and authority to offer, grant, and implement necessary reasonable modifications to customers with disabilities if they can be readily provided.

611. Denial of Request for Reasonable Modification(s)

Eligibility workers do not have the authority to deny, in whole or in part, reasonable modification requests or otherwise refuse requests for reasonable modifications. Requests may be submitted to DCHADAassistance@dch.ga.gov.

611.1. DCH and its Providers are not required to provide a reasonable modification that would fundamentally alter the program, service, or activity, or would result in an undue financial or administrative burden. The determination that undue burdens would result must be based upon all resources available for use by DCH or its Providers. If the modification requested would cause undue financial burden on the program or activity to the level that it would make continued operation of the program unfeasible, the modification need not be provided. However, denying a modification under the fundamental alteration exception should not result in the denial of access to the program or other benefits or services. DCH and its Providers still must provide services to the person with a disability as appropriate to the maximum extent possible.

611.2. If eligibility workers are unsure about whether a reasonable modification can or should be provided, they must consult with a supervisor at the time the request for reasonable modification is received or as soon as reasonably possible thereafter. If a supervisor agrees that a reasonable modification can and should be provided, the eligibility worker is required to provide the requested modification can and should be provided, the eligibility worker is required to provide the requested modification to the customer. However, if the supervisor recommends that the request for reasonable modification be denied, the supervisor must submit the DCH Reasonable Modification (RM) and Communication Assistance (CA) Tracking Form and any supporting documentation with recommendations for review to the Katie Beckett Team ADA/Section 504 Coordinator.

611.3. The Katie Beckett Team ADA/Section 504 Coordinator may consult with the Katie Beckett Director and will submit all requests to the DCH ADA/Section 504 Coordinator. Any request for reasonable modification and communication assistance that is recommended for denial will be forwarded to the DCH Deputy Executive

Director who is responsible for making the final agency decision. After the DCH Deputy Executive Director makes the final agency decision, he or his designee is responsible for drafting and providing a written decision to the customer. This decision is to be filed by the Katie Beckett Team ADA/Section 504 Coordinator for inclusion in appropriate reports.

612. Procedures for Equally Effective Communication

DCH and its Providers must ensure communications with applicants, participants, members of the public and companions with disabilities are as effective as communications with others. In some situations, DCH may communicate with the companion of a customer with a disability. A companion is any family member, friend or associate of a person seeking or receiving an entity's goods or services who is an appropriate person with whom the entity should communicate.

612.1. DCH and its Providers must provide appropriate auxiliary aids and services when necessary to ensure effective communication with individuals with disabilities. This includes an obligation to provide effective communication to companions with disabilities. These aids and services must be provided at no cost to the customer and in a timely manner that protects the privacy and independence of customers with a disability.

612.2. Auxiliary aids and services refer to the ways to communicate with people who have communication disabilities (e.g., for DCH customers with hearing, vision, and speech disabilities). Auxiliary aids and services include but are not limited to: qualified sign language interpreters, telephone handset amplifiers, assistive listening devices, closed caption decoders, real time captioning, TTY/TTD relay services for deaf and hard of hearing, screen reader software, Braille embossers, text-to-Braille converter, large print materials, alternative keyboards for individuals who are blind or have low vision.

612.2.1. Examples of auxiliary aids and services for people who are blind, have vision loss, or are deaf-blind might be:

612.2.1.1. Providing a qualified reader, information in large print, Braille, or in an electronic format for use with a computer screen-reading program, or an audio recording of printed information.

612.2.2. Examples of auxiliary aids and services for people who are deaf, have hearing loss, or are deaf-blind might be:

612.2.2.1. Providing a qualified note taker, a qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter, real-time captioning, or written materials.

612.2.3. Examples of auxiliary aids and services for people who have speech difficulties might include:

612.2.3.1. Providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly), especially if the person will be speaking at

length, or just taking more time to communicate with someone who uses a communication board.

612.3. Video remote interpreting (VRI) services also provide qualified interpreters. A public entity that chooses to provide qualified interpreters via VRI services must ensure that the computer or other device meets the technological requirements of the ADA at 28 C.F.R. § 35.160(d).

612.4. Eligibility workers are required to provide application and renewal forms, system generated individual and household communications and notices of decision (i.e., approvals, changes, terminations, and denials) and renewal notices in large print, Braille, audio format, or data format to qualified individuals with a disability upon request and as required by law.

612.5. The key to communicating effectively is to consider the nature, length, complexity and context of the communication and the person's normal method(s) of communication. This may also involve verifying that the communication is understood, using multiple methods of explanation to the individual.

612.6. With respect to communication disabilities, state or local government agencies must give primary consideration to the person's choice of auxiliary aid and service, unless it can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or a financial or administrative undue burden. [28 C.F.R. § 35.160(b)(2)]. If the choice expressed by the person with a disability would result in an undue burden or a fundamental iteration, the public entity still has an obligation to provide an alternative aid or service that provides effective communication if one is available. The decision that a particular aid or service would result in an undue burden or fundamental alteration must be made on behalf of DCH by the DCH Deputy Executive Director of the Policy, Compliance and Operations Office of Medical Assistance Plans or his designee and must be accompanied by a written statement of the reasons for reaching that conclusion.

612.7. Public accommodations (e.g., private community partner agencies) that provide DCH services are encouraged to consult with the person with a disability to discuss what aid or service is appropriate. The goal is to provide an aid or service that will be effective, given the nature of what is being communicated and the person's method of communicating.

612.8. When an eligibility worker or other staff becomes aware that a customer has a disability that substantially limits the customer's ability to see hear or speak, the eligibility worker or staff must inquire as to the customer's potential need for auxiliary aids and services. If a customer expresses a need for assistance related to a disability or if the customer has a disability that is documented in Gateway, eligibility workers who have access to Gateway are required to discuss the possible need for auxiliary aids and services with the customer using the Gateway written prompts. If a customer indicates that he or she does not wish to disclose or to discuss the disability, staff will not make further inquiries on the subject.

612.9. Individuals with disabilities may request an auxiliary aid or serve by completing the Reasonable Modification and Communication Assistance Request Form (Form 101).

Please refer to the Reasonable Modifications Section above for procedures handling documenting requests for assistance in Gateway.

612.10. DCH and its Providers must assure that any interpreter used to communicate with a DCH customer with a disability is qualified to do so. This includes qualified interpreters (i.e., American Sign Language, signed exact English interpreters, cued speech interpreters, oral interpreters, tactile interpreters, and Computer Assisted Real-time Transcription [CART]). When a customer who is deaf or hard-of hearing notifies staff that the interpreter provided is not qualified to interpret for that customer, either DCH or its Provider staff must arrange for a qualified interpreter service or other appropriate auxiliary aid and service, as required by law.

612.11. DCH and Provider staff are prohibited from requiring a customer to bring a person to serve as the interpreter. Staff will not rely on an adult accompanying a customer with a disability to interpret or facilitate communications except (a) in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available, or (b) where the customer with a disability specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances

612.12. Staff will not rely on a minor child to interpret or facilitate communications with a customer, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available.

613. Wheelchairs, Mobility, Aids and Other Power-Driven Mobility Devices

DCH and its Providers must allow individuals with disabilities who use wheelchairs, mobility aids or other power-driven mobility devices (OPDMD) into al areas where the public is allowed to go, unless the entity can demonstrate that the particular type of device cannot be accommodated because of legitimate safety requirements. Such safety requirements must be based on actual risks, not on speculation or stereotypes about a particular class of devices or how individuals will operate them.

613.1. Staff must consider the following factors in determining whether to permit OPDMDs on their premises:

613.1.1. The type, size, weight, dimensions, and speed of the device;

613.1.2. The volume of pedestrian traffic (which may vary at different times of the day, week, month or year);

613.1.3. The facility's design and operational characteristics, such as its square footage, whether it is indoors or outdoors, the placement of stationary equipment, devices, or furniture, and whether it has storage space for the device if requested by the individual;

613.1.4. Whether legitimate safety standards can be established to permit the safe operation of the device; and

613.1.5. Whether the use of the device creates a substantial risk of serious harm to the environment or natural or cultural resources or poses a conflict with Federal land management laws and regulations.

613.2. Communicate clearly to the public any OPDMD not permitted in an area were DCH programs, services and activities are offered. Staff may not ask individuals using such devices about their disability but may ask for a credible assurance that the device is required because of a disability. If the person presents a valid, state-issued disability parking placard or card or a state-issued proof of disability, that must be accepted as credible assurance on its face. If the person does not have this documentation but states verbally that the device is being used because of a mobility disability, that also must be accepted as credible assurance, unless the person is observed doing something that contradicts the assurance.

614. Service Animals

Under the ADA, a service animal is defined as a dog that has been individually trained to do work or perform tasks for a person with a disability. DCH and its Providers must provide individuals with disabilities with service animals an opportunity to participate in DCH programs, services and activities.

614.1. Staff may ask two questions in relation to a service animal:

614.1.1. Is the dog a service animal required because of a disability?

614.1.2. What work or task has the dog been trained to perform?

614.2. Service animals must be allowed in all areas of a facility where the public is allowed except where the dog's presence would create a legitimate safety risk or would fundamentally alter the nature of a public entity's services. Service animals may be excluded only if, 1) the dog is out-of-control, and the handler cannot or does not regain control; or 2) the dog is not housebroken. If a service animal is excluded, staff must allow individuals to enter the facility without the service animal.

614.3. A service animal must have a harness, leash, or other tether, unless the handler is unable to use a teether because of a disability or the use of a tether would interfere with the service animal's ability to safely perform its work or tasks. In these cases, the service animal must be under the handler's control thorough voice commands, hand signals, or other effective means. If a service animal is excluded, the individual with a disability must still be offered the opportunity to obtain goods, services, and accommodations without having the service animal on the premises.

614.4. DCH employees may ask an individual with a disability to remove a service animal if the animal is not housebroken or is out-of-control and the individual is not able to control it. If DCH properly excludes a service animal, DCH cannot unlawfully exclude the customer from accessing its series, programs, or activities and must give the individual with a disability the opportunity to participate in programs, services or activities without the service animal being present.

614.5. Staff may not require individuals with disabilities provide documentation, such as proof that the animal has been certified, trained, or licensed as a service animal, as a condition for entry. Service animals are not required to wear service animal vests or patches, or to use a specific type of harness.

614.6. Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals. When a person who is allergic to dog dander and a person who uses a service animal must spend time in the same room or facility, they both should be accommodated by assigning them, if possible, to different locations within the room or different rooms in the building. But, as with a reasonable modification, determination on how to address allegations involving allergies or tother direct threat or safety concerns is done on a case-by-case basis.

615. Miniature Horses

Although not service animals, miniature horses have similar protections under the ADA. DCH and its Providers must permit access where reasonable for miniature horses that are individually trained to do work or perform tasks for individuals with disabilities. Federal regulations set out for assessment factors to assist staff in determining whether miniature horses can be accommodated in their facility. The assessment factors are (1) whether the miniature horse is housebroken; (2) whether the miniature horse is under the owner's control; (3) whether the facility can accommodate the miniature horse's type, size, and weight; and (4) whether the miniature horse's presence will not compromise legitimate safety requirements necessary for safe operation of the facility.

616. Access To Websites and Online Systems

DCH and its Providers must ensure program websites and on-line systems are accessible to persons with disabilities. DCH and its Providers should ensure that in- house staff and contractors responsible for web page and content development are properly trained. DCH and its Providers must provide a way for visitors to request accessible information or service to the extent required by law. Information for web developers interested in making their web pages as accessible as possible, including the current version of the Web Content Accessibility Guidelines (and associated checklists), can be found at www.w3c.org/WAI/Resources. (See also Attachment 13.)

617. Physical Access to Buildings and Facilities

DCH and its Providers must ensure individuals with disabilities are not excluded from programs and services because facilities are unusable or inaccessible to them. These entities must ensure that individuals with disabilities have access to programs and services under the same terms and conditions as individuals without disabilities. These entities must abide by the ADA Standards for Accessible Design. (See Attachment 12.)

618. Safety

DCH and its Providers may impose legitimate safety requirements necessary for the safe operation of its services, programs, or activities. However, the public entity must ensure that its safety requirements are based on real risks, not on speculation, stereotypes, or generalizations about individuals with disabilities.

619. Direct Threat

"Direct Threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practice or procedures, or by the provision of auxiliary aids or services as provided in 28 C.F.R. § 35.139 (Title II) and 28 C.F.R. § 36.208 (Title III).

619.1. The ADA does not require DCH or its Providers to permit an individual to participate in or benefit from the services, programs, or activities of that DCH when that individual poses a direct threat to the health or safety of others (not to self). In determining whether an individual poses a direct threat to the health or safety of others, DCH and its Providers must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk.

620. Fundamental Alternations/ Undue Burden

The State agency, local agency, subrecipients and contractors are not required to modify its policies, practices, or procedures if the entity can demonstrate that making the modification would fundamentally alter the nature of the service, program, or activity. If the modification required would cause undue financial burden on the program or activity to the level that it would make continued operation of the program unfeasible, the modification need not be provided. However, denying a modification(s) under the fundamental alteration exception should not result in the denial of access to the program or other benefits or services.

620.1. The decision that a particular aid or service would result in an undue burden or fundamental alteration must be made by DCH Deputy Executive Director of the Policy, Compliance and Operations Office of Medical Assistance Plans or his designee and must be accompanied by a written statement of the reasons for reaching that conclusion. The State agency, local agency, subrecipients and contractors still must provide services to the maximum extent possible.

621. Training Staff

All DCH staff are required to participate in annual ADA/Section 504 training, currently available on the DCH training site, https://dchacademy.mkscloud.com/. Additionally, Katie Beckett workers may be required to take additional training (such as ADA/Section 504 training related to Gateway).

622. Complaint Processing

All DCH customers and he public have a right to file a complaint of discrimination on the basis of race, color, national origin, disability, age, sex, or religion, or for reprisal or retaliation. For more information, refer to the DCH Civil Rights and ADA/Section 504 Complaint Process and the DCH Civil Rights, ADA/Section 504 Complaint Form.

623. Filing an ADA/Section 504 Complaint

Filing a Verbal or Written Complaint

Any person or representative for a Katie Beckett applicant or participant may file a verbal or written complaint alleging unlawful discrimination regarding requests for reasonable modification or for failing to provide a requested reasonable modification under the ADA/Section 504, by contacting the DCH ADA/ Section 504 and Civil Rights Coordinator, Policy, Compliance and Operations Office, Medical Assistance Plans Division, DCH at (local) 404-967-0401, or via email to DCH.ADARequests@dch.ga.gov, DCH.CivilRights@dch.ga.gov, or via U.S. mail to:

The Georgia Department of Community Health
ADA/ Section 504 and Civil Rights Coordinator
Policy, Compliance and Operations Office
Medical Assistance Plans Division
2 MLK Jr. Dr., SE
East Tower, 19th Floor
Atlanta, GA 30334

Individuals who are deaf or hard of hearing may call "711" for an operator to help connect with us. Customers have a right to free interpreter services.

623.1. Time period for submitting complaints.

A complaint is timely filed if it is filed within 180 calendar days of the alleged discriminatory act or if it alleges that the discriminatory act is on-going. The United States Secretary of Health and Human Service may accept complaints filed after the 180-calendar day deadline if the complainant can provide a "good cause" explanation for the delay. DCH will forward any complaint that does not meet the 180-calendar day deadline to HHS. The time for filing a complaint with HHS is not governed by this policy.

623.2. Written Complaints

Written complaints may be submitted to DCH via hand-delivery, facsimile, e-mail or US mail, utilizing DCH ADA/Section 504 Complaint Form. DCH staff are required to provide an ADA/Section 504 Complaint form to a DCH customer who requests such form. The DCH ADA/Section 504 Complaint Form is not required to make a written complaint. A complaint may also be summitted via letter or e-mail if that is the complainant's or representative's preferred method of communication.

623.3. Verbal Complaints

623.3.1. An applicant, member or representative may make a complaint verbally or in-person. The Katie Beckett staff person to whom the allegations are made must write up the elements of the complaint using the DCH ADA/Section 504 Complaint Form. At a minimum, the DCH staff person must obtain the following information.

623.3.1.1. Name, address, and telephone number or other means of contacting the person alleging discrimination;

623.3.1.2. The location and nae of the office delivering the service or benefit;

623.3.1.3. The nature of the incident or action that led the complainant or his/her representative to feel that discrimination was factor, and an example of the method of administration that is having a disparate effect on the public, potential eligible persons, applicants or participants;

623.3.1.4. The basis on which ethe complainant believes discrimination exists;

623.3.1.5. The names, telephone numbers, titles, and business or personal addresses of personal who may have knowledge of the alleged discriminatory action; and

623.3.1.6. The date(s) during which the alleged discriminatory actions occurred, or if continuing, the duration of such actions.

623.3.2. The DCH staff to whom the ADA/Section complaint is made is required to assist a person or his/her representative in navigating the complaint process, including completing the DCH ADA/Section 504 Complaint Form and providing alternative formats upon request. DCH much ensure translated complaint forms, qualified interpreters, and auxiliary aids wand services are available free of charge to the complainant or his or her representative with limited English proficiency and/or individuals with disabilities.

623.4. Tracking Complaints and Maintaining Complaint Files

623.4.1. Complaints received by the Katie Beckett Team must be logged in a manual or computerized tracking system by the Katie Beckett ADA/Section 504 Coordinator. These complaints are to be kept separate from program complaints and forwarded to the DCH ADA/Section 504 Coordinator in the Policy, Compliance and Operations Office, Medical Assistance Plans Division within three (3) business days of receipt of the complaint. Anonymous complaints must be processed as any other complaint, to the extent feasible, based on available information.

623.4.2. The DCH ADA/Section 504 Coordinator in the Policy, Compliance and Operations Office, Medical Assistance Plans Division or designee will review a complaint to see if it contains an allegation of discrimination on the basis of a protected class.

623.4.3. The DCH ADA/Section 504 Coordinator in the Policy, Compliance and Operations Office, Medical Assistance Plans Division or designee shall maintain a file on all ADA/Section 504 complaints. The files must be stored in a central location for review by DCH's Policy, Compliance and Operations Office, Medical Assistance Plans Division, state authorities, or federal authorities.

Appendix A
Medicaid/Peachcare for Kids Reimbursable Categories

A. Medicaid

i. Ambulance Services

ii. Ambulatory Surgical Services

iii. Autism Services

iv. Certified Registered Nurse Anesthetists

v. Childbirth Education Services

vi. Children's Intervention Services

vii. Community Behavioral Health Rehabilitation Services

viii. Diagnostic, Screening and Preventive Services (Health Departments)

ix. Dental Services

x. Dialysis Services

xi. Durable Medical Equipment Services

xii. Family Planning Services

xiii. Health Check (Early and Periodic Screening, Diagnosis and Treatment)

xiv. Health Insurance Premium Purchase Program (HIPP)

xv. Health Insurance Premiums (Medicare Part A and Part)

xvi. Home Health Services

xvii. Hospice Services

xviii. Inpatient and Outpatient Hospital Services

xix. Intermediate Care Facility Services for the Developmentally Disabled

xx. Laboratory and Radiological Services

xxi. Medicare Crossovers

xxii. Mental Health Clinic Services

xxiii. Non-Emergency Transportation Services

xxiv. Nurse Midwifery Services and Nurse Practitioner Services

xxv. Nursing Facility Services

xxvi. Oral Surgery

xxvii. Orthotic and Prosthetic Services

xxviii. Pharmacy Services

xxix. Physician Services

xxx. Physician's Assistant Services

xxxi. Podiatric Services

xxxii. Pregnancy-Related Services

xxxiii. Psychological Services

xxxiv. Rural Health Clinic/Community Health Center Services

xxxv. Swing Bed Services

xxxvi. Targeted Case Management Service

1. Adults with HIV/AIDS*
2. Children at Risk of Incarceration
3. Early Intervention
4. Perinatal
5. Adult and Child Protective Services

xxxvii. Psychiatric Residential Treatment Facility

xxxviii. Vision Care Services

xxxix. Waiver Services

xl. Community Care Services Program

xli. SOURCE

xlii. Independent Care Waiver Program

xliii. New Options Waiver and Comprehensive Waiver

xliv. Georgia Pediatric Waiver

B. PeachCare for Kids

i. Ambulance Services

ii. Ambulatory Surgical Services

iii. Certified Registered Nurse Anesthetists

iv. Childbirth Education Services

v. Children's Invention Services

vi. Community Behavioral Health Rehabilitation Services

vii. Community Mental

viii. Health Check (Early and Periodic Screening Diagnosis and Treatment)

ix. Home Health Services

x. Dental Services

xi. Diagnostic, Screening and Preventive Services (Health Departments)

xii. Dialysis Services

xiii. Drugs

xiv. Durable Medical Equipment Services

xv. Family Planning Services

xvi. Federally Qualified Health Center

xvii. Health Clinic

xviii. Hospice Services

xix. Inpatient and Outpatient Hospital Services

xx. Laboratory and Radiological Services

xxi. Mental Health Clinic Services

xxii. Nurse Midwifery Services

xxiii. Nurse Practitioner Services

xxiv. Optometry

xxv. Oral Surgery

xxvi. Orthotics and Prosthetics

xxvii. Pharmacy Supplies

xxviii. Physician Services

xxix. Physician's Assistant Services

xxx. Podiatric Services

xxxi. Pregnancy-Related Services

xxxii. Psychiatric Residential Treatment Facility (A child must not be an inmate of a public institution or a patient in an institution for mental diseases at the time of initial application or any redetermination of eligibility.)

xxxiii. Psychology Services

(Non-emergency transportation, targeted case management, nursing home, and waivered services are specifically excluded categories of services.)

xxxiv. Rural Health Clinic /Community Health Center Services

xxxv. Vision care services

Appendix B
Eligibility Criteria for Major Coverage Groups

SSI Recipients	
Aged, blind, or disabled individuals who receive Supplemental Security Income (SSI).	
Income Limits Individual - $ 771 per month ($9,252 per year) Couple - $ 1157 per month ($13,884 per year)	Resource Limits Individual - $2,000 Couple - $3,000
Nursing Homes	
Aged, blind, or disabled individuals who live in nursing homes and have low income and limited assets.	
Income Limits Resource Limits $2,349 per month ($ 28,188 per year)	 Individual -$2,000 Couple - $3,000
Community Care	
Aged, blind, or disabled individuals who need regular nursing care and personal services but can stay at home with special community care services.	
Income Limits $ 2,349 per month ($28,188 per year)	Resource Limits Individual - $2,000 Couple - $3,000
Qualified Medicare Beneficiaries	
Aged, blind, or disabled individuals who have Medicare Part A (hospital) insurance, and have income less than 100 percent of the federal poverty level and limited resources. Medicaid will pay the Medicare premiums (A&B), coinsurance and deductibles only.	
Income Limits Individual - $1,061 per month ($12,732 per year) Couple - $ 1,430 per month ($ 17,160 per year)	Resource Limits Individual - $ 7,730 Couple - $ 11,600
Hospice	
Terminally ill individuals who are not expected to live more than six months may be eligible for coverage. Members must agree to receive hospice services through a Medicaid participating hospice care provider.	
Income Limits $2,349 per month ($28,188 per year)	Resource Limits Individual - $2,000 Couple - $3,000

Parent/Caretaker with Child(ren) Limits (formerly Low-Income Medicaid (LIM)

Adults and children who meet the standards under age 19 based on MAGI (Modified Adjusted Gross Income) converted AFDC (Aid to Families with Dependent Children) payment standards as of 05/01/1988.

Family Size	Income Limits
1	$310 per month ($3,720 per year)
2	$457 per month ($5,484 per year)
3	$551 per month ($6,612 per year)
4	$653 per month ($7,836 per year)

Each additional person: $50 per month ($600 per year

Pregnant Women and Newborns

Pregnant women with family income at or below 220 percent of the federal poverty level.

Family Size	Income Limits
1	$ 2,290 per month ($ 27,480 per year)
2	$ 3,101 per month ($37,212 per year)
3	$ 3,911 per month ($ 46,932 per year)
4	$ 4,721 per month ($ 56,652 per year)

Each additional family member: $ 811 per month ($ 9,732 per year)

Children under age 19 – 205 % FPL

Children under 1 whose family income is at or below 205 percent of the federal poverty level.

Family Size	Income Limits
1	$2,134 per month ($25,608 per year)
2	$2,889 per month ($34,668 per year)
3	$3,644 per month ($43,728 per year)
4	$4,399 per month ($ 52,788 per year)

Each additional family member: $ 755 per month ($ 9,060 per year)

Children under age 19 – 149 % FPL

Children between 1 and 5 whose family income is at or below 149 percent of the federal poverty level.

Family Size	Income Limits
1	$1,551 per month ($18,612 per year)
2	$2,100 per month ($25,200 per year)
3	$2,649 per month ($31,788 per year)
4	$3,198 per month ($ 38,376 per year)

Each additional family member: $ 549 per month ($ 6,588 per year)

Children under age 19 – 133 % FPL

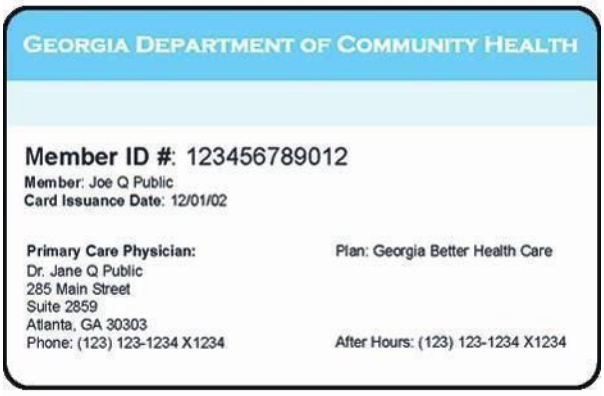
Children between 6 and 19 whose family income is at or below 133 percent of the federal poverty level.

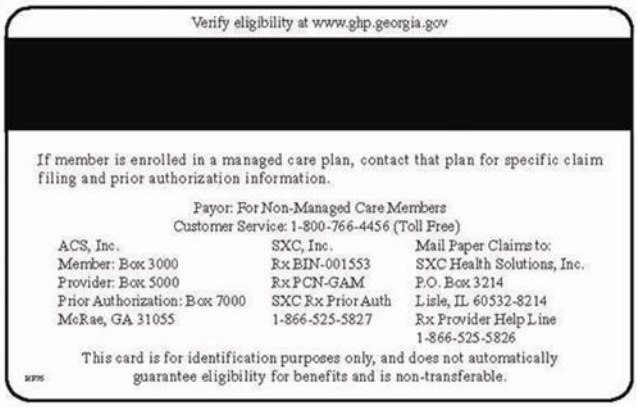
Family Size	Income Limits
1. 2 3 4	$ 1,385 p r month ($ 16,620 per year) $1,875 pe r month ($ 22,500 per year) $ 2,365 p r month ($ 28,380 per year) $ 2,854 p r month ($ 34,248 per year)
Each additional family member: $490 per month $5,880 per year	
PeachCare for Kids	
Children up to age 19 whose family income is at or below 247 percent of the federal poverty level.	
Family Size	Income Limits
1 2 3 4	$2,571 er month ($30,852 per year) $3,481 er month ($41,772 per year) $4,391 er month ($52,692 per year) $5,301 er month ($63,612 per year)
Each additional family member: $910 per month ($10,920 per year)	
Medically Needy	
Pregnant women, children, aged, blind, and disabled individuals whose family income exceeds the established income limit may be eligible under the Medically Needy program. The Medically Needy program allows a person to use incurred/unpaid medical bills to “spend down” the difference between their income and the income limit to become eligible.	
Pregnant Women and Children	

Family Size	Income Limits	Resource Limits
1	$208 per month	$2000
2	$317 per month	$4000
3	$375 per month	$4,100
4	$442 per month	$4,200 (Add $100 for each additional family member)

Aged, Blind, or Disabled	
Income Limits	Resource Limits
Individual - $317 per month Couple - $375 per month	Individual - $2,000 Couple - $4,000

Appendix C
Identification Card Example





Appendix D
Monthly Premiums

PeachCare for Kids®

Children ages 0-5 **None**

Children ages 6-18

FPL	One Child	Family Cap
139%–158%	**$11.00**	**$16.00**
159%–170%	**$22.00**	**$44.00**
171%–190%	**$24.00**	**$49.00**
191%–210%	**$29.00**	**$58.00**
211%–231%	**$32.00**	**$64.00**
232%–247%	**$36.00**	**$72.00**

Premiums are due the first of the month, prior to the month of coverage. If a premium payment is not received on the first, a late letter is sent to the family approximately four days after the late premium was due informing them that if payment is not received by the end of the month, they will be given a 45 day grace period before the coverage termination process begins, with coverage being canceled at the end of the 2nd month of the grace period. This notification also explains their option to opt out of receiving coverage for the grace period months. If the family does not pay the past due premium at the end of the month that it is due, the grace period begins the following month. The State will send a notice no later than the 8th of the first grace period month, informing the family that failure to make a premium by the 15th of the 2nd grace period month will initiate the termination process and coverage will ultimately be terminated at the end of the 2nd grace period month.

Payments received after the 15th day of the 2nd grace period month will not stop the termination process. Once coverage is terminated due to non-payment of premium, reinstate will not occur until a payment is received. Families may request reinstatement in the cancelled month after the payment is received. Otherwise, the payment will be used to give coverage for the following month.

Appendix D-1
PeachCare for Kids® Co-payments

A. For children ages 6 and over, the following co-payments apply for fee for service and CMOs:

Category of Service	Co-Payment
Ambulatory Surgical Centers / Birthing	$3.00
Durable Medical Equipment	$2.00
Federally Qualified Health Centers	$2.00
Free Standing Rural Health Clinic	$2.00
Home Health Services	$3.00
Hospital-based Rural Health Center	$2.00
Inpatient Hospital Services	$12.50
Oral Maxillofacial Surgery	Cost-Based
Orthotics and Prosthetics	$3.00
Outpatient Hospital Services	$3.00
Pharmacy - Preferred Drugs	$0.50
Pharmacy - Non-Preferred Drugs	Cost-Based
Physician Assistant Services	Cost-Based
Physician Services	Cost-Based
Podiatry	Cost-Based
Vision Care	Cost-Based
Cost-Based Co-Payment Schedule	
Cost of Service	Co-Payment
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

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

Appendix D-2
Peachcare For Kids Review and Appeal Process for Eligibility and Enrollment Disputes

A. General

This chapter provides the review process for eligibility and enrollment disputes submitted by PeachCare for Kids applicants and participants. Any eligibility decision, be it a denial of eligibility or a cancellation of enrollment, is subject to an impartial review. Reviews must be impartial and conducted by a person (or contractor) who has not been directly involved in the matter under review. All adverse action letters must provide enrollees and applicants timely written notice of any determination required to be subject to review under 42 C.F.R. §457.1130 of the State Children's Health Insurance Final Rule. The letter shall include the reason for the determination, an explanation of the applicable rights to review of that determination, and the manner in which a review can be requested.

B. Eligibility Review - Impartial Administrative Review (Level One)

PeachCare for Kids will provide information about its dispute review process in key correspondence sent to families (such as rejection and cancellation letters), making them aware of the existence and availability of a dispute review process.

PeachCare for Kids will also provide information about its dispute review process when a member requests an impartial review or when a customer service representative (CSR) determines that a dispute cannot be resolved through telephone interface alone and would be better handled in writing.

In any event where the member is unsatisfied with a determination of PeachCare for Kids (PCK), the CSR shall readily and clearly inform the member of the impartial review process. The CSR shall provide the manner in which a review may be requested, including the address for sending a written request for review, the timeframes for review, and the circumstances under which enrollment may continue pending review.

i. A written request to initiate the dispute review process (Dispute Notice) shall be routed to the Resolution Coordinator. Requests to initiate the dispute review process must be submitted by a parent, guardian, or authorized third party.

ii. Upon receipt of a Dispute Notice, the PCK Resolution staff shall take the following steps:

1. Locate the Applicant/Participant's account within the PCK system.

2. Enter information from the Dispute Notice into a Dispute file

(a) Information regarding whether or not the child(ren) may continue coverage pending review.

(i) Determine whether the Applicant/Participant's account was active or canceled on the date PCK received the Dispute Notice.

(ii) If the account was active as of the date PCK received the dispute notice, and the Participant requested continuation of coverage, PCK will ensure that the account remains active until the dispute is resolved. Note: Only the account of the child who is the subject of

the dispute will remain active.

(iii) If the account was active as of the date PCK received the dispute notice, and the Participant requested continuation of coverage, but has since been canceled, PCK will reinstate the child (only the child who is the subject of the dispute) at the earliest possible reinstatement date. Note: PCK may subsequently cancel the account depending upon the result of the dispute review process.

(iv) If the account was canceled as of the date PCK received the dispute notice, the account will remain canceled. The account will be reactivated if the dispute review process reverses the cancellation (retroactive to the date of cancellation) or the Participant has been reinstated with PCK after the 1-month waiting period for late premium payment.

(v) If the application was rejected as of the date PCK received the dispute notice, the application will remain rejected. The account will not be activated unless and until the dispute review process reverses the rejection or the Applicant has reapplied and been determined eligible for coverage with PCK.

3. An acknowledgement letter must be generated within 10 days of receipt of the dispute notice. Letter should include:

   (a) Acknowledgement of receipt of the dispute notice

   (b) Inform that the dispute notice has been referred to the Resolution Coordinator

   (c) Inform that the review shall be completed within 30 days of the receipt of the dispute notice

   (d) Include date the letter was generated/sent

   (e) Inform the Applicant/Participant whether child(ren)'s coverage will continue pending review

4. Resolution Staff shall review the case under dispute along with any additional materials relevant to the case.

5. The Resolution Staff shall make the recommendation to reverse the account cancellation in the following circumstances:

   (a) An administrative error on the part of PCK caused the premium to be posted late or not received at all.

   (b) Income of Applicant/Participant was low enough in the month prior to the due date of the premium that the Applicant/Participant would have been eligible for a lower premium or another program. Documentation of income is required in this case.

6. If the Resolution staff overturns the original determination the following process takes place:

   (a) If the Applicant/Participant was not eligible to retain coverage during the review process, a retroactive eligibility span shall be given that is the first day of the month in which the completed application was originally received, or in the case of a cancellation, the first day of the month in which the cancellation took effect.

   (b) A dated letter shall be sent to the Applicant/Participant advising them of the decision and the retroactive date of the enrollment span.

7. If the Committee upholds the original determination:

   (a) A dated letter shall be generated noting 1) a brief summary of the dispute 2) a description of the reason for the decision 3) an explanation of applicable right to review of that determination 4) the manner in which a review may be requested, and 5) the circumstances under which enrollment may continue pending review.

C. Management Review Committee (Level Two)

i. If the Applicant/Participant is dissatisfied with the results of the Level One Request, the Applicant/Participant may file a request for a Level Two Dispute Review Process in writing.

ii. The Resolution Coordinator shall notify the Applicant/Participant, in writing, of the referral to the Level Two Dispute Review Process.

iii. The Resolution Coordinator shall also send the Applicant/Participant a copy of the PCK Dispute Review Process guidelines. The Resolution Coordinator shall also forward all pertinent documents to the Management Review Committee.

iv. The Management Review Committee shall be comprised of the Resolution Coordinator, the Department of Community Health Policy Specialist and the PeachCare for Kids Program Director (or Designee).

v. The Management Review Committee shall review all relevant information regarding the Applicant/Participant's dispute and shall render a decision approving or denying the same.

vi. The Management Review Committee shall notify the Applicant/Participant of the decision in writing within twenty calendar days of the referral to the Level Two Dispute Review Process.

D. State Formal Grievance Committee (Level Three)

i. The Department of Community Health PeachCare for Kids staff shall coordinate with the Formal Appeals Committee to schedule a formal appeal meeting.

ii. A formal grievance meeting will be held within 90 days of request, allowing both parties adequate time to prepare documentation and schedule of the appeal, either in person or through written communication.

iii. Resolution Staff at Department of Community Health will schedule a meeting between the State

Formal Grievance Committee and the Applicant/Participant within 30 days from the date of their quest.

iv. All the materials in the Dispute Review File that has been escalated to the State Formal Grievance Committee shall be printed out or copied and put together in a packet along with the decision of the Impartial Administrative Review and the Management Review Committee.

v. The following considerations apply to the grievance meeting:

1. The Applicant/Participant shall be given a reasonable and adequate opportunity to examine the contents of the Dispute Review file and all other relevant documents and records prior to the hearing. The Applicant/Participant may request and receive a complete copy of the materials provided to State Formal Grievance Committee members prior to the hearing at no charge.

2. The Applicant/Participant may represent himself or herself at the hearing or be assisted by are presentative.

3. Applicants/Participants should provide the names of any additional attendees (and their affiliations) they would like to have present at the hearing to the Resolution Coordinator in advance to be added to the hearing agenda.

vi. If the Formal Grievance Committee overturns the Level1reconsideration:

1. A retroactive eligibility span shall be given that is the first day of the month in which the completed application was originally received, or in the case of a termination, the first day of the month in which the termination took effect.

2. A letter shall be dated and sent by the Formal Grievance Committee to the appellant informing them of the decision.

vii. If the Formal Grievance Committee upholds the Level1reconsideration:

1. A letter shall be dated and sent by the Formal Appeals Committee to the appellant informing them of the decision. The letter shall inform the appellant that this decision is final and binding.

E. Expedited Review of Grievances

In accordance with 42 C.F.R. §457.1160, an expedited appeal will be completed within 72 hours of the time an enrollee requests external review if the enrollee's physician or health plan determines that operating under the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. If the enrollee has access to internal and external review, then each level of review may take no more than 72 hours. The State may extend the 72-hour time frame by up to 14 calendar days, if the enrollee requests an extension.

F. Member Medical Review Process – for PeachCare members not enrolled in a Care Management Organization (CMO)

Upon denial of covered benefits, a parent will notify Georgia Health Partnership (GHP) at 1-866-211-0950 toll-free if they believe that the service should be covered. The information provided by the parent

in the phone call will be forwarded to DCH and a review will be initiated. DCH will research the situation, including reviewing the medical policy, the claims system and any documentation submitted by the physician, if applicable. If the initial review does not result in a change in the decision to deny a service, the parent will be notified of the reason the denial was upheld. If the parent would like additional reconsideration of the decision, the parent may submit a request in writing to PeachCare for Kids. The request will be reviewed by DCH management staff including, but not limited to, the policy director of the service area and the Chief of the Division of Medical Assistance or his or her designee. The request should be sent to:

PeachCare for Kids
2 MLK Jr. Dr., SE
East Tower, 19th Floor
Atlanta, Georgia 30334

If the decision of this review maintains the denial of service, a letter will be sent to the parent detailing the reason for denial. If the parent elects to dispute the decision, the parent will have the option of having the decision reviewed by the Formal Grievance Committee. The decision of the Formal Grievance Committee will be the final recourse available to the member. In reference to the Formal Grievance level, the State assures:

i. Enrollees receive timely written notice of any documentation that includes the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

ii. Enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, termination of health services, failure to approve, or provide payment for health services in a timely manner. The independent review is available at the Formal Appeals level.

iii. Decisions are written when reviewed by DCH and the Formal Grievance Committee.

iv. Enrollees have the opportunity to represent themselves or have representatives in the process at the Formal Grievance level.

v. Enrollees have the opportunity to timely review their files and other applicable information relevant to the review of the decision. While this is assured at each level of review, members will be notified of the timeframes for the appeals process once an appeal is file with the Formal Grievance Committee.

vi. Enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or inwriting.

vii. Reviews that are not expedited due to an enrollee's medical condition will be completed within 90 calendar days of the date of a request is made.

viii. Reviews that are expedited due to an enrollee's medical condition are completed within 72 hours of the receipt of the request.

G. Member Medical Review Process – for PeachCare members enrolled in a Care Management Organization (CMO)

If a parent believes that a denied service should be covered, the parent must send a written request for review to the Care Management Organization (CMO) in which the affected child is enrolled. The CMO will conduct its review process in accordance with Section 4.14.4 of the CMO contract.

If the decision of the CMO review maintains the denial of service, a letter will be sent to the parent detailing the reason for denial. If the parent elects to dispute the decision, the parent will have the option of having the decision reviewed by the Formal Appeals Committee. The decision of the Formal Appeals Committee will be the final recourse available to the member. The parent may submit a request in writing to PeachCare for Kids, for a review by the State Formal Appeals Committee. The request should be sent to:

PeachCare for Kids
2 MLK Jr. Dr., SE
East Tower, 19th Floor
Atlanta, Georgia 30334

The decision of the Formal Grievance Committee will be the final recourse available to the member. In reference to the Formal Grievance level, the State assures:

i. Enrollees receive timely written notice of any documentation that include the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

ii. Enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, termination of health services, failure to approve, or provide payment for health services in a timely manner. The independent review is available at the Formal Grievance level.

iii. Decisions are written when reviewed by DCH and the Formal Grievance Committee.

iv. Enrollees have the opportunity to represent themselves or have representatives in the process at the Formal Grievance level.

v. Enrollees have the opportunity to timely review their files and other applicable information relevant to the review of the decision. While this is assured at each level of review, members will be notified of the timeframes for the appeals process once an appeal is file with the Formal Grievance Committee.

vi. Enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or inwriting.

vii. Reviews that are not expedited due to an enrollee’s medical condition will be completed within 90 calendar days of the date of a request is made.

viii. Reviews that are expedited due to an enrollee’s medical condition are completed within 72 hours of the receipt of the request.

Appendix E
Credit Balance Report Form

PROVIDER NAME:		CONTACT PERSON:	
PROVIDER NUMBER:		TELEPHONE NUMBER (including area code):	
QUARTER ENDING (circle or check one):	06/30 09/30 12/31 03/31	YEAR:	PAGE _____

#	MEMBER NAME	MEDICAID ID NO	TCN	DATE(S) OF SERVICE	MEDICAID PAYMENT	COB PAYMENT	AMOUNT DUE TO MEDICAID	INSURANCE PLAN NAME; REFUND REASON *	POLICY NUMBER POLICYHOLDER NAME **
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
TOTALS									

* IF CREDIT BALANCE NOT RELATED TO OTHER COVERAGE (COB), PROVIDE REFUND REASON. ** IF AVAILABLE, PLEASE ATTACH A COPY OF THE OTHER INSURANCE ID CARD TO THIS FORM

NO REFUNDS IDENTIFIED

COMPLETED BY:

Appendix E – 1
Georgia Department of Community Health Division of Medical Assistance Instructions for Completing Medicaid Credit Balance Report Form

A. Purpose: The purpose of the Medicaid Credit Balance Report is to monitor and recover credit balances owed by providers to the Medicaid Program. A Medicaid credit balance is the amount to be refunded to the Medicaid Program by the provider because of an outstanding overpayment.

i. Complete the Medicaid Credit Balance Report Form as follows:

1. Provider Name: Enter the full name of the provider as it appears on Medicaid provider enrollment documents.

2. Contact Person: Enter the name of the person to call regarding questions about information submitted on the report.

3. Provider Number: Enter the Medicaid provider identification number.

4. Telephone Number: Enter the full telephone number, including area code, of the contact person.

5. Quarter Ending: Circle or check the quarter ending date (circle or check only one).

6. Year: Enter the year of the quarter circled or checked.

7. Page of : Enter page number in the first field. If multiple pages required, enter total number of pages in the report in the second field.

8. Member Name: Enter the last name and first initial of the Medicaid member. Medicaid ID No.: Enter the complete Medicaid identification number of the member. ICN: Enter the ICN for the claim identified as having a credit balance.

9. Date(s) of Service: Enter first and last dates of service (mm/dd/yy) for the claim identified as having a credit balance.

10. Medicaid Payment: Enter the amount paid by Medicaid on the claim identified as having a credit balance.

11. COB Payment: Enter the total amount received from any third payment sources(s).

12. Amount Due Medicaid: Enter the overpayment amount owed to Medicaid for the claim identified as having a credit balance.

    IMPORTANT: SECTION 303.4 OF THE PART I – POLICIES AND PROCEDURES MANUAL STATES THAT "THE AMOUNT TO REFUND SHALL BE THE LESSER OF (A) THE AMOUNT RECEIVED FROM ALL THIRD PARTIES (INCLUDES ALL CASH PAYMENTS AND DISCOUNTS, INCLUDING NEGOTIATED DISCOUNTS OR ADJUSTMENTS IN MANAGED CARE ARRANGEMENTS) FOR THAT SERVICE, OR (B) THE AMOUNT OF THE MEDICAID PAYMENT. A THIRD-PARTY PAYMENT AND MEDICAID PAYMENT CANNOT BE ADDED TOGETHER TO SATISFY THE TOTAL BILLED AMOUNT FOR THE SERVICES."

13. Insurance Plan Name; Refund Reason: Enter the name of the insurance carrier or benefit plan (This may be any third-party payer, including payers in casualty/tort cases). If credit balance is not associated with a COB/insurance payment, please enter the reason for the refund (i.e., duplicate payment).

    IMPORTANT: If refund is due to a Medicare payment, attach the related Explanation of Medicare Benefits (EOMB) or Remittance Advice (RA).

14. Policy Number/Policyholder's Name: Enter the policy number or member ID number for the third-party payer and the name of the policyholder.

15. Hospitals and Nursing Facilities: When no credit balances are found, indicate by checking the box next to the NO REFUNDS IDENTIFIED and return form to the department at the address indicated. When credit balances are found, the form must be completed in its entirety.

    The provider's representative authorized to release this information to Medicaid must sign this form. In signing, the representative certifies that the information is complete and accurately reflects the provider's credit balance obligation to Medicaid.

Appendix F
Pending Eligibility Affidavit

State of [1] _____
County of [2]_____

PENDING ELIGIBILITY AFFIDAVIT

Personally before the undersigned officer duly authorized by the laws of the State of [3] _____ to administer oaths came and appeared [4] _____(Name of Medicaid Provider) who having done duly sworn, deposes and says as follows:

1.

I provided medical services to [5] _____(Name of Medicaid Member),[6] _____(Medicaid Number) on [7] _____(Dates of Service) and have submitted a claim for reimbursement thereof on [8] _____.

2.

When I provided these services, the determination of this patient's Medicaid eligibility was pending. This patient officially became eligible on [9] _____and I first became aware of this on or after [10] _____.

3.

I am aware that Medical Assistance payments are made from state and federal funds, and that the submission of any false claims, information, or documents, or the concealment of any material facts relating to Medical Assistance claims is a crime under federal and state law. All statements made in this affidavit and on the Medical Assistance claim to which this affidavit pertains are complete, true, and accurate, and are based upon my personal knowledge.

[11] _____(Provider Signature)

[12] _____ (Provider Number)

Sworn to and subscribed before me this

[13] _____Day of _____, 20 _____[15]

[14] _____(Notary Public)

(Seal)

Appendix G
SDA-1 Self Disclosure Analysis Worksheet for Medical Claims

Claims Count	Mbr MHN ID	Mbr Name	Proc Cd	Service From Dt	Service to Dt	Billed Amt	Paid Amt	Paid Dt	Refund Amt	Clm TCN
PLEASE NOTE: Each provider must have a separate SDA-1 Analysis Worksheet										
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
						Total Billed	**Total Paid**		**Total Refund**	
Please indicate the reason this error occurred										

Appendix H
SDA-2 Self Disclosure Analysis Worksheet for Pharmacy Claims

Pharmacy Name:
abc Pharmacy
Pharmacy Medicaid ID #:
0000000000
NCPDP #:
0000000

	1	2	3	4	5	6	7	8
RX Number **Claim Number (if known)**								
Date of Service								
Product								
NDC								
Quantity								
AWP	$0.00	$0.0	$0.00	$0.00	$0.0	$0.0	$0.0	$0.0
Dispensing Fee **Amount Billed**	$0.00	$0.0	$0.00	$0.00	$0.0	$0.0	$0.0	$0.0

Reimbursed Amt	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Appendix I
Physician's Statement for Emergency Medical Assistance

Patient's Name:_____DOB:_____
Patient's Address:_____
_____
Patient's Telephone#: _____

Individuals who do not meet Medicaid citizenship/alienage requirements may be eligible for Emergency Medical Assistance (EMA). EMA provides payment for the treatment of emergency when such care and services are necessary for the treatment of an emergency medical condition of the alien, provided such care and services are not related to either an organ transplant procedure or routine prenatal or postpartum care. An emergency is defined as:

"**Acute symptoms"** of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part"

The individual will have to be determined eligible for Emergency Medical Assistance under one of the Department's existing regular Medicaid coverage groups:

- Aged, blind or disabled;
- Pregnant women;
- Children under 19 years of age; or
- Parents in families with very low income

This form should be completed and signed by the provider after the Emergency has occurred. Forms containing future dates of service are invalid.

I provided EMERGENCY medical services on_____through
(Date of onset)

_____for the individual listed above.
(Not to exceed 30 days from condition onset date)

(Provider's Name) (Provider or Authorized Designee's Signature)

(Provider's Address) (Date)

Appendix J
ICD-10 Overview

On October 1, 2015, the United States' health care system will undergo a major transformation from the use of Ninth Edition of the International Classification of Diseases (ICD-9) set of diagnosis and inpatient procedure codes to the Tenth Edition (ICD-10). ICD-10-CM replaces the ICD-9-CM diagnosis codes (volumes 1-2) and ICD-10-PCS replaces the ICD-9-CM procedure codes (Volume 3). The current system of ICD-9 has several limitations that prevent complete and precise coding and billing of health conditions and treatments. ICD-9 codes are a 35-year-old code set that contains outdated terminology and is inconsistent with current medical practice. The code length and alphanumeric structure limit the number of new codes that can be created, and many ICD- 9 categories are already full.

ICD-10 allows for greater specificity and detail in describing a patient's diagnosis, condition, diagnostic needs, and in classifying inpatient procedures. ICD-10 provides more specific data than ICD-9 and better reflects current medical practice. The added detail embedded within ICD- 10 codes informs health care providers and health plans of patient incidence and history, which allows for more effective case management and better coordination of care.

This ICD-10 transition (which is mandatory) will have a major impact on every HIPAA compliant entity that uses health care information containing a diagnosis and/or inpatient procedure code. All covered entities as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are required to adopt ICD-10 codes for services provided on or after October 1, 2015, the mandated compliance date. GA Medicaid like other payers must institute new policies as a result of the transformation to the new ICD-10 code sets.

A. The following policies are areas in GA Medicaid that are impacted with implementation of ICD-10 on or after October 1, 2015:

i. The Tenth Edition of the International Classification of Diseases (ICD-10) set of diagnosis (CM) and inpatient procedure (PCS) codes must be used on or after October 1, 2015. The Ninth Edition of the International Classification of Diseases (ICD-9) set of diagnosis and inpatient procedure codes will only be allowed on claims or any adjustments for dates of services/treatments rendered prior to October1,2015.

ii. ICD-10 diagnosis (CM) and procedure (PCS) codes are required on all inpatient stays (admission) with discharge dates on or after October 1, 2015. With the ICD- 10 transition on or after October 1, 2015, inpatient (Admission) will be adjudicated based on the member's discharge date using ICD-10 CM and PCS codes. Emergency room (Outpatient) UB claims will be adjudicated based on the member's discharge date too.

iii. The Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes are not impacted by ICD-10 and are not changing.

iv. To process ICD-10 claims or other transactions electronically, providers, payers, and vendors must first implement the "Version 5010" health care transaction standards mandated by HIPAA. The previous HIPAA "Version 4010/4010A1" transaction standards do not support the ICD-10 codes. This implementation was effective January 1, 2012.

v. f using Hewlett Packard's Provider Electronic Solutions (PES) version software to submit ICD-10 claims, all PES users are required to upgrade to version 1.03. To apply for the 1.03 upgrade and for the updated PES manual, please visit the GA Medicaid Management Information System

(GAMMIS) web portal at www.mmis.georgia.gov and select the PES software and manual page from the Electronic Data Interchange (EDI) menu.

vi. Span dates on claims: GA Medicaid will not adjudicate claims submitted with dates that span the October 1, 2015, date except for inpatient stays or PRTF (psych residential) UB claims.

vii. During the ICD-10 transition on and after October 1, 2015, both code sets (ICD-9 and ICD-10) will be supported in GAMMIS for claim processing and adjustments. Any software vendors that provide business intelligence solutions should support both code sets, ICD-9 and ICD-10 codes, simultaneously during the transition.

viii. An ICD-9 code submitted for a service on or after October 1, 2015, cannot be processed or paid under federal law.

ix. Claims submitted for payment with both ICD-9 and ICD-10 (CM or PCS) codes will not be adjudicated in GAMMIS on or after October 1, 2015, and will be denied. Claims with span dates of services rendered prior to or on September 30, 2015, and on or after October 1, 2015, must be submitted on separate claims. The split (separate) claims must be billed with the appropriate ICD-9orICD-10codes.

x. GA Medicaid has conducted mapping of thousands of ICD-9 diagnosis (CM) and procedure (PCS) codes to ICD-10 codes and the reverse. ICD-9 codes were mapped forward and backwards using General Equivalence Mappings (GEMs) to maximize all ICD-9 to ICD-10 code possibilities.

xi. Unspecified or unlisted or non-specific diagnosis (CM) codes should be avoided on claims using ICD-10 codes. Unspecified codes may be acceptable on UB-04 (hospital) claims under ICD-10 but any other provider specialty types and/or Categories of Service must bill the lowest possible level ICD-10 diagnosis code. There may be services and/or procedures that do not have a specified code or procedure and warrants billing an unspecified code. However, providers must bill the most detailed ICD-10 code available for the service rendered. Claims billed with unlisted and/or unspecified codes will be denied if determined that a more appropriate code is available. The physician's clinical documentation should support the specificity of the code(s)being billed.

xii. Prior authorization (PA) requests already approved prior to the ICD-10 transition on October 1, 2015, will not need to be resubmitted. If the PA request is submitted for approval on or after October 1, 2015, the request form must have ICD-10 diagnosis (CM) codes for claim processing. Any PA renewals or requests submitted on or after October 1, 2015, will need to have ICD-10 diagnosis (CM)codes.

NOTE: The PA start date is the key to which code set (ICD-9 or ICD-10) to submit on a PA. The correct diagnosis code set must be used on the claim to be adjudicated in GAMMIS.

xiii. Some ICD-10 diagnosis codes are restricted such as those related to age, gender, and sex. The GAMMIS is configured to accept theserestrictivetypesofICD-10diagnosiscodes.

xiv. ICD-10 procedure (PCS) codes must be used on all inpatient (admit) facility or hospital claims. The GAMMIS is configured for ICD-10 transition to auto-deny any UB-claims that have missing or inappropriate ICD-10 procedure codes. The ICD-10-PCS codes are associated to the appropriate anatomic sites related to each Major Diagnostic Category (MDC).

B. DOCUMENTATION REQUIREMENTS UNDER ICD-10

Implementation of ICD-10 on October 1, 2015, will affect the clinical documentation of providers to payer organizations. ICD-10 coding provides the opportunity for greater accuracy in creating standardized data that describes the patient's condition and supports the billing and payment based on the physician's documentation. Increased code detail contained in ICD-10-CM (diagnosis codes) means that documentation requirements will change substantially. ICD-10CM (diagnosis) includes a fuller definition of severity, comorbidities, complications, sequelae, manifestations, causes, and a variety of other important parameters that characterize the patient's condition.

A large number of the ICD-10-CM (diagnosis) codes are the same except for indicating laterality of a patient's body part: RIGHT, LEFT, BILATERAL, UNILATERAL, or UNSPECIFIED SIDE. Thousands of other codes differ only in the way they distinguish "initial encounter [first visit= A]," versus "subsequent encounter [second or follow-up visit= D]," versus "sequelae [secondary codes produced by an acute phase of illness or injury and cannot be billed without the initial code= S]."

C. RESOURCES AVAILABLE TO EASE THE ICD-10 TRANSITION

There are a number of industry resources available to assist all HIPAA entities in the ICD-10 transition. Below are several resources that provide a wealth of ICD-10 information:

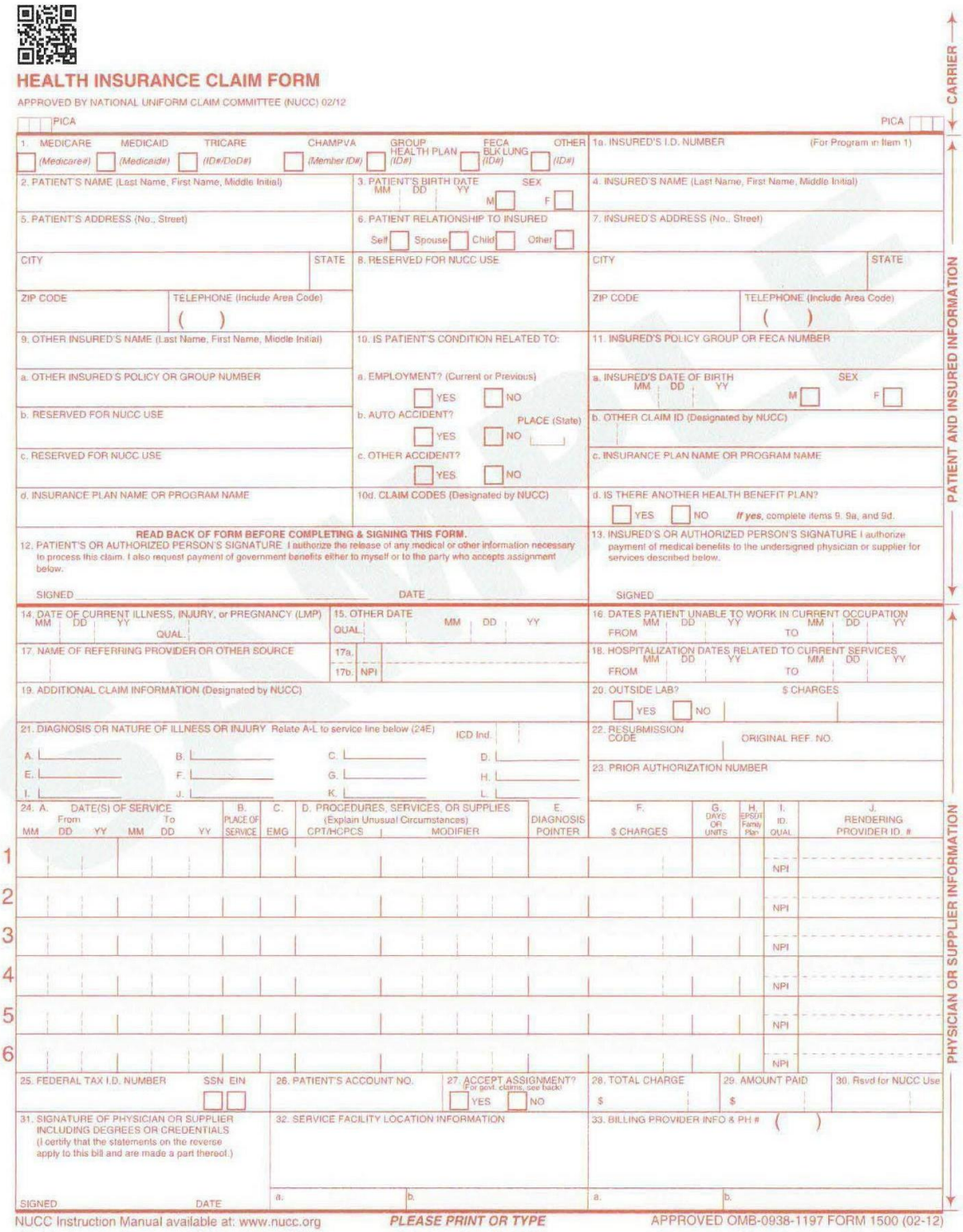
i. General Equivalence Mappings (GEMs) attempt to include all valid relationships between the codes in the ICD-9-CM diagnosis classification and the ICD-10-CM diagnosis classification. The tool allows coders and providers to look up an ICD-9 code and be provided with the most appropriate ICD-10 matches and vice versa. GEMs are not a "crosswalk"; they are merely meant to be a guide. Visit the CMS websiteatwww.cms.gov/ICD10formoreinformationonGEMs.

ii. Centers for Medicare & Medicaid Services (CMS)website:www.cms.gov/ICD10

iii. Georgia Department of Community Health ICD 10 Project website: http://dch.georgia.gov/icd-10

iv. Frequently Asked Questions (FAQs) on ICD-10 (by Georgia Department of Community Health, Medicaid Division) –posted on GAMMIS web portal at www.mmis.georgia.gov under Provider Notices dated September 3,2015.

Appendix K
New CMS1500 Claim Form (version 02/12) & ZFLD Locator Instructions



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? PLACE (State) YES NO

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. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

The following table outlines the **revised changes** on the above CMS1500claim form version 02/12:

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/Gainwell:** 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 2byte 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-bytequalifier." **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 " AIM INFORMATION (Designa NUCC)." move the Health Check logic from **FOR DCH/Gainwell:** an 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 righthand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICDIndicator** - 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, 2014.)**
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 priorclaim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. F **FOR DCH/Gainwell**: 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

Appendix L
Georgia Medicaid FFS Tamper Resistant Prescription Pad (TRPP) Requirement FAQs

Q: What is the origin of this requirement?
A: This requirement is a federal requirement, but the states are required to implement it. The requirement originated from the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (H.R. 2206), section 7002(b).

Q: What is a TRPP?
A: In their final guidance, the federal government requires that by April 1, 2008 that tamper- resistant prescriptions include one or more industry-recognized features designed to:
Prevent unauthorized copying of a completed or blank prescription form
Prevent erasure or modification of information written on the prescription by the prescriber Prevent the use of counterfeit prescription forms

Q: What are industry-recognized features?
A: While the federal government has not identified the industry-recognized features, examples include but are not limited to the following:

Required tamper-resistant characteristics include one or more industry-recognized features designed to:		**Examples include but are not limited to:**
1	Prevent unauthorized copying of a completed or blank prescription form	• High security water mark on reverse side of blank • Thermochromic ink technology Copied prescription blanks show the word "Copy," "Illegal," or "Void."
2	Prevent erasure or modification of information written on the prescription by the prescriber	• Tamper-resistant background ink shows erasures or attempts to change written information
3	Prevent the use of counterfeit prescription forms	• Duplicate or triplicate blanks

Q: Doesn't the law have more stringent requirements by October 1, 2008?
A: Yes. By October 1, 2008, TRPPs will have to meet all three of the above requirements.

Q: Do the April 1st effective dates refer to the date the prescription was filled or written?
A: The April 1st effective dates refer to any prescription filled on or after those dates.

Q: What if I am dispensing a refill on or after the effective date, but the original prescription was filled before the effective date?
A: Refills for prescriptions that were originally filled prior to the effective date are exempt from the requirement.

Q: Can a provider add features to the prescription to make it compliant with the requirement such as:
writing out the drug quantities rather than just the number (i.e."thirty"vs."30")
using indelible or gel inks when writing the prescription using embossed logos

A: No. The statute states that all written prescriptions must be “executed on a tamper resistant pad.” As a result, features added to the prescription after they are printed do not meet the requirement of the statute.

Q: Will prescriptions printed from a computer meet the tamper resistant prescriptions requirements?
A: Between April 1st and September 31, 2008, computer generated prescriptions containing one or more industry-recognized features designed either to prevent the erasure or modification of information contained on the prescription can meet the CMS requirements. Beginning October 1, 2008, prescriptions printed on plain paper will not be able to meet all three baseline characteristics outlined by CMS. Beginning October 1, 2008, computer generated prescriptions must be printed on paper that meets all three requirements.

Q: Does this requirement apply to the Georgia Medicaid members enrolled in one of the Care Management Organizations (Amerigroup, or PeachState)?
A: No. This requirement only applies to Georgia Medicaid members enrolled in traditional fee- for-service Medicaid.

Q: Will the State endorse, credential or otherwise certify print vendors who meet the federal requirements?
A: Not at this time.

Q: What is considered to be a “prescription” under this requirement?
A: Any drug order that is not e-prescribed, faxed to the pharmacy from the prescribers office, or telephoned to the pharmacy by the prescriber.

Q: Are prescriptions printed from a computer at the prescribers office included in this definition of a prescription?
A: Yes. The paper utilized to print such prescriptions must be compliant as well.

Q: Are there any exceptions to the TRPP requirement? A: Yes. Exceptions include prescriptions:

Paid by a Georgia Medicaid Care Management Organization (Amerigroup, PeachState)

Provided in nursing facilities or intermediate care facilities for the mentally retarded (ICF/MR) and the drug is reimbursed as part of a total service and is not reimbursed through the outpatient pharmacy program

Provided in any other institutional or clinical settings for which the drug is reimbursed as part of atotal service and is not reimbursed through the outpatient pharmacy program

Written orders prepared in an institutional setting where the doctor or medical assistant writes the order into the medical record and then the order is given by medical staff directly to the pharmacy

e-prescribed, faxed to the pharmacy from the prescriber’s office, or telephoned to the pharmacy by the prescriber

Refills for which the original prescription was filled before April 1, 2008.

Q: Are nursing homes prescriptions required to comply with this requirement?
A: Written orders prepared in an institutional setting where the doctor or medical assistant writes the order into the medical record and then the order is given by medical staff directly to the pharmacy is considered “tamper resistant,” so long as the patient never has the opportunity to handle that written order.

Q: If the Medicaid recipient has other insurance and Medicaid is not primary, but the prescription is being billed to Medicaid as a coordination of benefits claim, is a TRPP still required?
A: Yes.

Q: If I fill a prescription written for a Medicaid fee-for-service patient from another state, are the rules the same as for Georgia Medicaid?
A: No. Each state may have different rules. Please check the rules and requirements of the other state in which you are an enrolled provider.

Q: What happens if a person is retroactively enrolled in fee-for-service Medicaid?
A: The federal government requires the pharmacy to obtain a compliant tamper resistant prescription. This requirement may be accomplished by verbal verification of the prescription. This requires the pharmacist or licensed pharmacy intern to handwrite on the face of the original prescription the name of the person contacted at the prescriber's office, the date verified, the initials or name of the pharmacist or licensed pharmacy intern who verified the prescription, and the word "Verified."

Q: Can the State make exemptions from the requirement? A: No. This is a requirement of federal law.

Q: Where can I learn more about this requirement? A: The following are resources for your review.

U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability

Appropriations Act of 2007 (H.R. 2206), section 7002(b)

Centers for Medicare& Medicaid Services (CMS) Letter to State Medicaid Director (SMDL #07-012, 8/17/2007)

Banner messages at the Georgiawebportal-www.mmis.georgia.gov

CMS FAQ Document published 9/13/2007
(http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MIPTRPFAQs912200 7.pdf)

Q: If I receive a non-tamper resistant prescription and I cannot verify the prescription with the provider at that time, can I dispense the medication on an emergency basis?
A: Yes, the pharmacy can fill the prescription on an emergency basis as long as the prescription complies with all other Medicaid polices and state, and federal laws. However, the dispensing pharmacist must obtain a verbal, faxed, electronic, or otherwise compliant written prescription within 72 hours after the date on which the prescription was filled. The pharmacist must verify the prescription order with the prescriber's office by handwriting on the face of the original prescription the name of the person contacted at the prescribers' office, the date verified, the initials or name of the pharmacist or licensed pharmacy intern who verified the prescription, and the word "Verified".

Q: If I fill a prescription not written on a tamper-resistant prescription pad on an emergency basis, am I limited to giving the patient only a72-hoursupply?
A: If the prescription complies with all Medicaid policies and is a covered benefit with no restrictions for the member, then you may dispense greater than a 72-hour supply.

Q: If I make every reasonable attempt to contact the prescriber's office and still am unable to verify the prescription, am I still accountable if audited?
A: Yes, based on the federal requirements the pharmacy is still accountable.

Q: Will DCH enforce this requirement?
A: DCH is bound to enforce all federal requirements.

Q. Wasn't the original requirement that TRPPs must be used for all Medicaid FFS prescriptions by October 1, 2007?

A. Yes. However, on September 29, 2007, President Bush signed the Transitional Medical Assistance, Abstinence Education, and QI Programs Extension Act of 2007 which delayed the implementation date for Medicaid FFS TRPPs. Under the new law, all such prescriptions must have at least one of the TRPP characteristics specified by CMS by April 1, 2008, with all three characteristics by October 1, 2008.

Q. Has CMS issued any additional FAQs that I may find helpful?
A. Yes. On 9/13/2007, CMS issued FAQs on the TRPP requirement. These FAQs can be found at: http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MIPTRPFAQs9122007.pdf

A. Additional Resources

i. U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (H.R. 2206), section 7002(b)

ii. Centers for Medicare & Medicaid Services (CMS) Letter to State Medicaid Director (SMDL #07-012, 8/17/2007)

iii. Centers for Medicare & Medicaid Services (CMS) Frequently Asked Questions Document published 9/13/2007 (http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MIPTRPFAQs912200

Appendix M
Identification of Georgia Medicaid/PeachCare for Kids Providers

The Covered Entity identified in the Attestation of Compliance with Section 6032 of the Federal Deficit Reduction Act includes the following Georgia Medicaid/PeachCare for Kids Providers:

NAME	ADDRESS	PROVIDER ID	FEIN

Appendix N
Georgia Families Eligibility Categories

Included Populations	Excluded Populations
PeachCare for Kids®	**Nursing home**
Low-Income Medicaid (LIM)	**Federally Recognized Indian Tribe**
Right from the Start Medicaid (RSM)	**Georgia Pediatric Program (GAPP)**
Women's Health Medicaid (WHM)	**Community Based Alternative for Youths (CBAY)**
Transitional Medicaid	**Children's Medical Services program**
Refugees	**Medicare Eligible**
Planning for Healthy Babies	**Supplemental Security Income (SSI)**
Children (Newborn)	**Medicaid Medically Needy**
Breast and Cervical Cancer	**Long-term care**
	GF360 program members

Included Categories of Eligibility

COE	*DESCRIPTION*
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr. Trans Med Ast Adult
119	LIM – 1st Yr. Trans Med Ast Child
120	LIM – 2nd Yr. Trans Med Ast Adult
121	LIM – 2nd Yr. Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
126	Stepchild
135	Newborn Child
136	PCK/MA
137	PCK/MA Foster Care
138	PCK/MA DJJ
139	PCK MA DJJ/RYDC
140	PCK/MA IVB Children
156	Waiver – previous Foster Care
157	Waiver – previous DJJ commitment
170	RSM Child

171	RSM Pregnant Woman
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr.
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	BCC Waiver
471	RSM Child - Exparte
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	PeachCare 101 < 150% FPL
791	PeachCare 151– 200% FPL
792	PeachCare 201 – 247% FPL
793	PeachCare > 247% FPL
794	360° FC Peach 101%-150% FPL
795	360° FC Peach 151%-200% FPL
796	360° FC Peach 201%-247% FPL
797	360° FC Peach >246% FPL
800	Presumptive BCC
835	Newborn

Excluded Categories of Eligibility:

COE	***DESCRIPTION***
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
133	IV-E Foster Care
134	IV-E Adoption Assistance
147	Family Medically Needy Spend down

148	Pregnant Women Medically Needy Spend down
150	Dept. of Juvenile Justice – Community Placement
151	CHAFEE Medicaid
152	Former Foster Children
153	Waiver Child in Foster Care
154	Waiver Child w/ Dept. of Juvenile Justice Placement
155	Wavier Child w/ Adoption Assistance
158	Dept. of Juvenile Justice – RYDC Placement
159	IV-B Foster Care Children – Living Out of State
172	RSM 150% Expansion
177	Family Planning Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
228	Disabled Adult Child – Blind
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled

239	ADB Med. Needy Defacto – Aged

240	ADB Med. Needy Defacto – Blind
241	ADB Med. Needy Defacto – Disabled
242	ADB Med Spend down – Aged
243	ADB Med Spend down – Blind
244	ADB Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
308	SSI Work Continuance – Blind
309	SSI Work Continuance – Disabled
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind

323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged

388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
865	Pregnant Woman – presumptive
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

Appendix O
Georgia Families Regions

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

Appendix P
Georgia Families 360 Eligibility Categories

Included Populations	Excluded Populations
Child Welfare Foster Care	**All Georgia Families populations**
State Funded Adoption Assistance	**All Managed Care Healthy Babies**
Dept. of Juvenile Justice – select youth	**Federally Recognized Indian Tribe**
	Georgia Pediatric Program (GAPP)
	Community Based Alternative for Youths (CBAY)
	Children's Medical Services program
	Medicare Eligible
	Supplemental Security Income (SSI)
	Medicaid Medically Needy
	Long-term care

Included Categories of Eligibility:

COE	*DESCRIPTION*
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
133	IV – E Foster Care
134	IV – E Adoption Assistance
150	Dept. of Juvenile Justice
151	CHAFEE Medicaid
152	Former Foster Children
153	Waiver child in Foster Care
154	Waiver child with Dept. of Juvenile Justice
155	Waiver child with Adoption Assistance

Excluded Categories of Eligibility:

COE	*DESCRIPTION*
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr. Trans Med Ast Adult
119	LIM – 1st Yr. Trans Med Ast Child
120	LIM – 2nd Yr. Trans Med Ast Adult

121	LIM – 2nd Yr. Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
126	Stepchild
135	Newborn Child
156	Waiver – previous Foster Care
157	Waiver – previous DJJ commitment
158	Dept. of Juvenile Justice/RYDC Placement
159	IV-B Foster Care – Living out of State
170	RSM Child
171	RSM Pregnant Woman
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC – LIM
183	P4HB ROMC – ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr.
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	ABD Med. Needy Defacto – Aged
240	ABD Med. Needy Defacto – Blind
241	ABD Med. Needy Defacto – Disabled
242	ABD Med Spend down – Aged
243	ABD Med Spend down – Blind
244	ABD Med Spend down – Disabled
245	BCC Waiver
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged

281	Hospice – Blind

282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
308	SSI Work Continuance – Blind
309	SSI Work Continuance – Disabled
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind

448	Widower – Disabled
460	Qualified Medicare Beneficiary

466	Spec. Low Inc. Medicare Beneficiary
471	RSM Child - Exparte
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
575	Refugee Med. Needy Spend down
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp. Child DOB </= 10/01/83
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
790	PeachCare < 150% FPL
791	PeachCare 150 – 200% FPL
792	PeachCare 201 – 235% FPL
793	PeachCare > 235% FPL
800	Presumptive BCC
815	Aged Inmate
817	Disabled Inmate
835	Newborn
865	Pregnant Woman – presumptive
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

Appendix Q
Georgia Families 360 Regions

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

Appendix R
COB Notification Form

DMA – 410: EB-TPL | ICN:

DEPARTMENT OF COMMUNITY HEALTH – DIVISION OF MEDICAL ASSISTANCE
COB NOTIFICATION FORM

Member Name:_____ Medicaid ID#: _____

I. CO-PAYMENT NOTIFICATION

No EOB Available. Coverage is through: _____
Insurance / benefit plan. The co-payment for their service is _____

II. COB NON-COVERAGE AFFIDAVIT

I submitted my claim(s) to _____ *(Insurance Carrier)* on_____*(date)* for payment. After receiving no response, I contacted the carrier on_____*(date)* for confirmation.

Insurance Representative: _____ Telephone #: _____

☐ Insurance was cancelled on_____(date)

☐ Service is non-covered, annual/lifetime service limits exceeded.

☐ Member not covered under this policy.

☐ Out-of-Network Provider, No In-Network provider available to provide Medicaid covered services (explain below).

☐ Other (explain) _____

_____

By signing, I certify that, to the best of my knowledge, the information above is verified and accurate, and that this notification form applies to any associated claim(s) and is made a part thereof.

Signature of Patient Account Representative	Date	Provider #

Note: This statement must be in accordance with the provisions of Part 1, Policies and Procedures, Chapter 200 – Timely Submission, Section 202.2(b).

Attach this form to your claim(s) for paper claim submission, or if claim submitted electronically, indicate the associated ICN above and forward to DXC for processing.

III. COB INFORMATION UPDATE

When completing only this portion of the form, upload member's information and a scanned image of the member's insurance card via the GAMMIS Web Portal at www.mmis.georgia.gov.

THIS FORM MAY BE PHOTOCOPIED

DMA 410 Rev.
(10/2018)

Attach this form to your claim(s) for paper claim submission, or if claim submitted electronically, indicate the Associated ICN above and forward to Gainwell Technologies for processing.

A. COB INFORMATION UPDATE

When completing only this portion of the form, upload member's information and a scanned image of the member's insurance card via the GAMMIS Web Portal at www.mmis.georgia.gov.

THIS FORM MAY BE PHOTOCOPIED

DMA 410
(Rev 04/2017)