PART II

POLICIES AND PROCEDURES
FOR
HOSPICE SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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Policy Revisions Record

Part II Policies and Procedures Manual for Hospice Services
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06/01/2021	Appendix I	Removed CMO contact information that is no longer applicable.	A/D	CMS

PART II - POLICIES AND PROCEDURES FOR

HOSPICE SERVICES – JANUARY 2022

HOSPICE SERVICES

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PART II - CHAPTER 600
SPECIAL CONDITIONS OF PARTICIPATION AND ELECTION PROCEDURES

601. General Criteria

Rev. 04/11

A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. Hospice services are forms of palliative medical care designed to meet the physical, social, psychological, emotional, and spiritual needs of terminally ill individuals and their families.

The focus of hospice services is palliative care rather than curative care for adults. Effective 03/23/2010, children will no longer be required to forego curative care when electing hospice. These children may concurrently receive palliative and curative treatment. This new concurrent care provision enables States' to make hospice services available to children eligible for Medicaid and Medicaid-expansion CHIP programs without forgoing any other treatment to which the child is entitled under Medicaid. Concurrent care does not change the criteria for hospice services eligibility or the policies, procedures or responsibilities hospice providers have in providing services to the terminally ill child. Hospice services and supports to children continue to include pain and symptom management and family counseling provided by specialty-trained hospice staff. Duplication of concurrent curative care and hospice care services is not permitted.

Rev. 07/15

Individuals may elect to receive hospice care during one or more of the following election periods that require written certification by the physician, Election periods are as follows: two (2) initial periods of ninety (90) days each, and an unlimited number of subsequent sixty (60) day periods each. Benefit periods can be used consecutively or at different times during the individual's life span. Each benefit period requires a physician to certify at the beginning of the period that the individual has a terminal illness with a prognosis that the individual's life expectancy is six (6) months or less if the illness runs its normal course. A single election remains in effect through physician certified periods if the individual does not revoke or discharge out of hospice.

The certification of terminal illness of an individual who elects hospice shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness while understanding that making medical prognostication of life expectancy is not always exact. The certification must remain on the individual's file.

In addition to the general conditions of participation identified in Section 106 of the Part I Policies and Procedures manual, providers in the Hospice Services Program must meet the following conditions:

601.1 Licensure and Certification

A) The hospice agency must be currently licensed under the provision of State law and must not be operated primarily for the care and treatment of patients with mental disease or special disorders.

B) The hospice agency must meet Title XVIII Standards for Medicare participation as currently determined and be certified as eligible for participation.

C) The hospice agency must develop written policies and procedures on advance directives in compliance with Section 1902 (a) (57) of the Social Security Act.

In compliance with Section 1902 (a) (57) of the Social Security Act, the hospice agency must:

1) Provide written information to individuals regarding their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

2) Provide written information to individuals regarding the institution's or program's written policies respecting the implementation of the right to formulate advance directives;

3) Document in the individual's medical record if an advance directive has been executed;

4) Comply with all requirements of State law respecting advance directives;

5) Provide (individually or with others) education for staff and the community on issues concerning advance directives;

6) Not condition the provision of care or otherwise discriminate against an individual who has executed an advance directive;

601.2 Provider Enrollment Application

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

A) A letter from the State licensing unit showing the permit number and effective date of permit;

B) A document from the State licensing unit showing that the hospice has been recommended for certification or that it meets the requirements for the Medicare Program;

C) A copy of the written notification to the hospice from the Medicare fiscal intermediary showing the approved reimbursement rate, the fiscal year end, and Medicare provider number;

D) Advance Directives Letter of Agreement (See Appendix H);

E) A copy of the letter from the Office of Civil Rights indicating services are provided in compliance with Title VI of the Civil Rights Acts of 1964.

F) A copy of the completed Office of Regulatory Services (ORS) Ownership Disclosure Form.

The information requested above should be submitted in one packet along with a completed DMA Statement of Participation.

Rev. 01/14
Rev. 07/15

G) Gainwell Technologies Enterprise Services post office box is closed effective May 1, 2015. Gainwell Technologies Enterprise Services will no longer receive Provider Enrollment paper documents via the US mail. All supporting Provider Enrollment documentation should be uploaded via the GAMMIS web portal to pending applications. Please refer to the Part I Policy and Procedures Manual for Medicaid and PeachCare for Children, Chapter 100, Section 112.

If you need to submit updated documentation, please fax it to Gainwell Technologies Provider Enrollment at 1-866-483-1045. All faxes must be accompanied with a Gainwell Technologies Provider Enrollment fax cover sheet. The form can be found under >Provider Enrollment>Forms.

601.3 Agency Responsibilities

A) The hospice agency must maintain current medical records on all individuals as described in Section 908. All hospice forms (Includes the Election, Revocation, Discharge, Transfer, Hospice Care Communicator (HCC), certifications and a copy of the nursing facility (NF) DMA-59's when applicable) must be completed and in the individual's medical record at the hospice agency.

B) All Medicaid forms submitted to the Division after receipt of the new provider number must be incompliance with Part I Policies and Procedures Manual applicable to all Medicaid providers and with Part II Policies and Procedures for Hospice Services Manual.

- This includes maintaining 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 five (5) 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.

- 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.

C) All claims submitted to the Division after receipt of the new provider number must be compliant with Part I Policies and Procedures Manual applicable to all Medicaid providers.

D) All member forms (except claims) for persons who were served between the submission date of the enrollment packet and the effective date of enrollment must be received by Gainwell Technologies Enterprise Services within thirty (30) days of the date of the provider

enrollment letter from the Division. A copy of the Provider Enrollment letter indicating the new provider number effective date must be attached to **each** hospice form.

E) If the forms are received after the thirty (30) day timeframe, the effective date of the election will be amended to the date of receipt by the Division.

F) The hospice agency is responsible for ensuring that all services furnished to individuals are provided in a safe and effective manner by qualified personnel and in accordance with a written Plan of Care.

G) Hospice agencies, which provide services under contract or subcontract with individuals or other companies, must maintain copies of such contractual agreements in the agency file. Such agreements must specify which hospice services are being subcontracted and must specify that the Medicaid enrolled hospice agency retains administrative and supervisory responsibility for staff and service subcontracted. The hospice is responsible for the payment of hospice staff services that have been provided under a contractual arrangement, or any applicable nursing facility charges. Copies may be requested by the Division at any time as needed.

   Hospice providers entering into agreements with nursing facilities to provide services to nursing facility residents must maintain in the agency files the name of each nursing facility with whom the hospice has an agreement and the effective date of the agreement.

H) The hospice is responsible for assuring the continuity and quality of patient care whether the individuals receiving services by hospice staff or by a contracted individual or entities.

I) Each hospice agency location must be separately licensed and submit separate applications for enrollment even if owned or operated by the same person(s), business or corporation, and may be conducting business under the same trade name.

J) The hospice agency must notify Provider Enrollment at the fiscal agent and the Division in writing of changes in enrollment status such as name change, new address and telephone number, dissolution of corporation, voluntary termination from the program, loss of certification or licensure, filing of bankruptcy petitions or changes in

ownership. Each notice of change must include the date on which the change is to be effective.

Rev. 07/15

K) The hospice agency must disclose ownership information pursuant to Section 106 of the Part I Policies and Procedures manual to the Division upon initial enrollment and annually thereafter. The hospice agency may provide a copy of the Office of Regulatory Services Ownership Disclosure Form or a copy of the completed Division's Ownership Disclosure form. These documents must be submitted to the Provider Enrollment Unit.

L) The hospice agency must agree to periodic, on-site patient care reviews and financial audits by authorized representatives of the Division.

M) The hospice agency must have established policies on informing patients of the Patient Bill of Rights, provide information on the Patient's Bill of Rights and clinical records must contain documentation that such information was provided.

Rev. 07/19

N) The claim life cycle is the timeline for the total claim process from the date of service to original submission and through the last date by which resubmission (provider adjustment) must occur to remain timely.

All claim submissions and adjustments for denied claims are to be completed according to DCH policy by no later than 365 days. After which, no adjustments or override requests will be honored.

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.

If a member has a type of Medicaid in GAMMIS (SSI, Title XIX, QMB, SLMB, S99, etc.), during the time in which a member is in a Nursing Facility and/or Hospice, the provider should bill and receive those denials; which will lock in their rendering service/span dates and prevent claims from denying untimely.

If a member has active eligibility with SSI or Title XIX, claims are to be submitted within 6 months and kept timely until the Nursing Home segment/Level of Care/Aid Category or Hospice lock-in has been

approved/updated. Retro eligibility will not be automatically granted if the member has active eligibility with Medicaid during the dates of service.

All Hospice Date of Death (DOD) lock-in requests will be considered and approved through Gainwell Technologies if all necessary documentation is submitted complete, legibly signed, and within 30 days of the member electing to receive Hospice services. A DOD lock-in will not be granted if the provider fails to meet timely requirements, therefore a timely override request would not be appropriate.

Once Long-Term Care eligibility is established, the claims will process in the cycle as the system is designed to do. Providers are not to wait for the Department of Family & Children Services (DFCS) to change the category of service in order to bill when the member has Medicaid eligibility in the system. For more detailed information, providers should review the timely submission of claims policy outlined in Chapter, 200, Section 202 of the Medicaid/PeachCare for Kids (Part I) Policies and Procedures Manual.

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

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. 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.

602. Change in Ownership

Rev.10/07

A) Any enrolled provider that undergoes a change including, but not limited to, dissolution, incorporation, re-incorporation, reorganization, change of ownership of assets, merger or joint venture so that as a result, the provider either becomes a different legal entity or is replaced in the program by another provider, must give the Division ten (10) days prior written notice before effecting a change.

B) The new owner of an already existing agency must complete and submit the Provider Enrollment Application packet. Failure of the successor to execute a new enrollment agreement will prevent the Division from reimbursing the new owner for any future services as of the date of change.

C) The same Medicaid Provider Number of the previous hospice agency will transfer to the new hospice agency.

D) Change of ownership does not require election, discharge, revocation, or transfer forms to be held by the new owners. During the change of ownership of an existing agency the new owner should continue faxing/sending forms to Gainwell Technologies Enterprise Services.

E) It is up to the new owner if they choose to submit claims prior to the change of their payee information. Reimbursement will go to the "payee of record".

F) All Hospice Policies and Procedures should continue and be seamless and continuity of care not interrupted.

G) Please refer to Part I Policies and Procedures for Medicaid/PeachCare for Kids for additional information regarding Provider Enrollment.

H) A change in ownership of a hospice agency is not considered a change in the individual's designation of hospice and requires no action on the member's part.

603. Members with a Medicaid Pending Status or Undetermined Eligibility

Rev. 01/12
Rev. 10/18

If an individual, other than SSI recipients with an Aged, Blind & Disabled designation (ABD) choosing to receive hospice services has a pending Medicaid status or undetermined eligibility, the hospice forms should not be sent to Gainwell Technologies by the agency until the individual is determined by Division of Family and Children Services (DFCS) to be Medicaid eligible and has been assigned their Medicaid number. For reimbursement, it is the responsibility of the hospice agency to frequently monitor and verify the individual's Medicaid eligibility. This applies to all applicants except individuals with Social Security Income (SSI with ABD); those members are previously determined by the Social Security office to be eligible for Medicaid. SSI members that are nursing facility applicants or residents may be subject to an expanded review by DFCS after admission.

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Rev. 10/18

"If an individual (other than SSI recipients whose eligibility for full ABD Medicaid has already been established) choosing to receive hospice services has a pending Medicaid

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Rev. 10/18

status or undetermined eligibility, the hospice forms should not be sent to Gainwell Technologies by the agency until the individual is determined by Division of Family and Children Services (DFCS) to be Medicaid eligible and has been assigned their Medicaid number." Those such as SSI/ABD recipients with Medicaid only, may receive a lock-in upon review through a direct submission to Gainwell Technologies. Providers are to submit applications to DFCS prior to sending them over to Gainwell Technologies for lock-ins but, may submit the applications to both DFCS and Gainwell Technologies simultaneously. Gainwell Technologies will then send a *Member Enrollment Acknowledgement Letter* to the provider as notification of the receipt of documents.

Once DFCS has assigned the individual's Medicaid number, the agency must submit the initial Medicaid Hospice Election Form (DMA-579) and a copy of one of the following as proof of Medicaid eligibility:

- Web Portal print screen. The Election Form and Web Portal Screen print are sent 30 days from the effective date of eligibility under the Retro Eligibility Spans.

- Notification of Benefits Letter (NOBL) sent to member from the DFCS. The Election Form and Notification of Benefits Letter are sent 30 days from the posted date on the NOBL.

- Hospice Care Communicator (HCC) returned to the Hospice Agency from DFCS. The Election Form and HCC are sent 30 days from the date of the DFCS Caseworker signature.

To be considered timely, the proof of eligibility must be submitted with the Medicaid Election Form.

If the election form is received without one of the three (3) documents, the member will be locked in per the date the election form is received by DCH.

The effective date of the hospice election date cannot be prior to the date of Medicaid eligibility.

Rev. 07/18

If the aid category is updated after 30 days, Gainwell Technologies shall give the provider the initial lock-in date upon confirmation that the DMA-579 was sent timely. A lock-in will not be applied without an updated aid category, unless the member is a SSI recipient.

If a member expires before achieving a Hospice eligibility update, it is no longer a DFCS/eligibility matter and must be submitted to Gainwell Technologies. Members cannot obtain eligibility updates once a DOD is updated in a members file. However, a lock-in can still be granted through Gainwell Technologies from the first date of service through the DOD (given that all necessary documentation submitted complete, legibly signed, and within 30 days of the member electing to receive Hospice services). Gainwell Technologies will review them and lock them in accordingly. Providers are to submit lock-In requests for expired members as they would a normal lock-In request to Gainwell Technologies. Providers are welcome to add a note on their documentation stating, "Member has expired and cannot receive a Hospice eligibility update. Please consider for DOD lock-in from the first date of service through date of death.".

Application(s) can be submitted via fax (including all necessary documentation) or through Gateway.

If aid categories are not being updated timely, an "Application" and/or a "Request to Change" can be sent through Gateway.

If the Nursing Facility has submitted an "Application" or a "Request to Change" and attached the Hospice Care Communicator (HCC), 59 and 579, Nursing Facilities should have a tracking number (T) from Gateway and Hospice providers can obtain this number.

If completing the application, and the tracking number is received, the Hospice agency shall fax the forms to DFCS and/or submit an email to the appropriate ABD (Aged, Blind, and Disabled) Customer Service Contact with the tracking number.

***NOTE: DFCS contact list can be found on GAMMIS under Provider Notices.**

The faxed confirmation page from your agency's fax machine will be requested if necessary, to verify these documents were sent timely. Please be sure your agency's fax machine displays the date, time and telephone number where faxed. Please include the member's name on the cover sheet associated with the election form.

604. Record Keeping Requirements

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

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

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

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

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

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

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

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

1. Individual's name and/or other information related to their identification (SS#, Medicaid ID, etc.…)
2. Date and time of admission
3. Admitting Diagnosis
4. Verified Diagnosis
5. The name, address and telephone number of the responsible party to contact in an Emergency
6. Appropriate authorizations and consents for medical procedures
7. Medical necessity of the service being provided
8. Results of testing and/or assessments
9. Records or reports from previous or other current providers, including previous assessments
10. Documented correlation between assessed need and care plan
11. Documentation of treatment that supports billing
12. Financial and insurance information
13. Pertinent medical information;
14. Physicians' progress notes
15. Nurses' notes
16. Practitioner and case management notes
17. Clear evidence that the services billed are the services provided
18. Treatment and medication orders
19. Date and time of discharge or death
20. Condition on discharge

PART II – CHAPTER 700
ELIGIBILITY REQUIREMENTS

701. Special Eligibility Criteria

To qualify for the hospice program, all individuals must:

- Be Medicaid eligible.
- Be certified as terminally ill with a medical prognosis of life expectancy of six (6) months or less if the disease runs its normal course. The certification of terminal illness of an individual who elects hospice shall be based on the attending physician's or medical director's, if designated to be the attending physician, clinical judgment regarding the normal course of the individual's illness while understanding that making medical prognostication of life expectance is not always exact. See Section 704 regarding the member's hospice certification.

Rev. 10/13
Rev. 01/09

- Sign and date a Medicaid Hospice Election Form.

The hospice agency is responsible for verifying Medicaid eligibility. Verify Medicaid eligibility by reviewing the individual's Medicaid card monthly, using the Gainwell Technologies Voice Response System, or the Gainwell Technologies web portal**.** ***If the individual is not currently Medicaid eligible or determined to have SSI,*** the individual or representative must apply for Hospice Medicaid coverage at their local Division of Family and Children Services (DFCS). A Hospice Care Communicator (Form 527A) must be completed and faxed to the local DFCS office (See Appendix C for instructions).

Rev. 01/14

Rev. 01/15

702 Election Procedures

If individual elects to receive hospice care, he or she must sign and file a hospice election form with the hospice agency designated by the individual to provide the benefit. A hospice election form may also be filed by a representative acting pursuant to State law. With respect to an individual granted the power of attorney for the individual, or acting as an agent to the individual under a Durable Power of Attorney for Health Care, State law determines the extent to which the individual may act on the individual's behalf.

An election to receive hospice care will be continued from the initial election period and through subsequent periods as verified by the physician's certification of continuing hospice eligibility and without a break in care if the individual remains in the care of the hospice agency and does not revoke the election or is discharged from hospice services. The hospice election form must be legible and entirely completed with full name, title, relationship of signatory/ representative,

etc. when instructed and must include at a minimum the items of information indicated and listed below:

- Identification of the hospice that will provide care to the individual;
- The individual's or representative's acknowledgement that he or she has been given a full understanding of hospice care;
- The individual's or representative's acknowledgement that he or she understands the Medicaid coverage of hospice services as relating to other Medicaid services;
- The effective date of the election;
- The signature of the individual or representative;

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- The Social Security Number and date of birth of the individual electing the hospice benefit;
- The Medicaid and Medicare numbers (if applicable);

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- The attending physician's full name and his/her Medicaid provider number/NPI number;

Rev. 01/14

- Effective *10/1/2015*, enter the ICD-10 CM Code, the diagnosis code definition information and the date of onset. Hospice providers and certifying physicians may not use Debility and Adult Failure to Thrive (AFTT) codes as the primary diagnosis cited as cause for the terminal illness.

Rev. 04/14
Rev. 10/15

The Division of Medical Assistance requires that the Medicaid specific hospice election form found in Appendix C be used for individuals who are Medicaid eligible and elect to receive hospice services. The hospice agency must ensure that the member's Election form, a copy of the DFCS Communicator for the member and the copy of the DMA-59 (for a NF resident), are submitted to Gainwell Technologies for the initial election lock-in. **The MMIS 'initial' hospice lock-in or span remains at a 13 month' time-period (Example: 9/22/2017 no later than 10/23/2018). However, providers must continue to have the physician certify member for hospice eligibility per federal regulations at the 90, 90, 60 days span. In the event of audits, the Hospices must be able to provide documentation that the certification periods have been followed.** To extend the initial MMIS election span or spans as forfeited, the hospice provider must submit additional information. See Section 704.

Rev. 10/17

702.1 An individual may designate an effective date for the election period that begins with the first day of the hospice care (the date the individual signs the hospice election form) or any subsequent day of hospice care, but an

individual may not designate an effective date that is earlier than the date of the hospice election.

702.2 Upon election of hospice care, the individual will be enrolled in the hospice agency submitting the election form for care for all benefit periods until the agency indicates the individual is discharged, transferred or has revoked the hospice benefit (See Sections 705, 706 and 707). **All services related to the terminal illness are required to be provided by the elected hospice agency. This includes all hospitalizations and physician services related to the terminal illness except those services performed by the attending physician.** A voluntary election of hospice care on behalf of a child does not waive any rights to concurrent curative services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

702.3 When the election is revoked or the adult patient is discharged, all usual Medicaid services will resume without obtaining a prior authorization from the hospice agency.

703. Waiver of Medicaid Services for Adults

An adult individual must waive all rights to Medicaid payment for the duration of the election of hospice care for the following services:

A) Hospice care provided by a hospice agency other than the hospice agency designated by the individual (unless provided under arrangements made by the designated hospice);

B) Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services:

- Provided (either directly or under arrangement) by the designated hospice agency:
- Provided by another hospice agency under arrangements made by the designated hospice agency; and
- Provided by the individual's attending physician if that physician is not an employee of the designated hospice agency or receiving compensation from the hospice agency for the services.

The individual may continue to receive services for conditions unrelated to the terminal illness.

After the hospice episode is ended either by revocation or discharge, the adult patient's coverage under the state plan resumes or remains unaffected.

Rev. 01/12
Rev. 04/13

Individuals receiving waivered services that are not duplicative of hospice services and are considered unrelated to the terminal illness may be continued and provided concurrently with hospice services. See Section 907 regarding Medicaid waivered services and the provision of hospice care.

Rev. 07/13

704. Physician Certification

Rev. 10/13
Rev. 01/14
Rev. 04/14

The hospice agency must obtain certification that an individual is terminally ill in accordance with the procedures outlined. Hospice providers and certifying physicians may not use Debility and AFTT as the primary diagnosis cited as cause for the terminal illness. ''Symptoms, Signs, and Ill-defined Conditions" may not be used as principal diagnoses for a hospice member. The principal diagnosis must be the definitive condition determined by the certifying hospice physician(s) as the diagnosis contributory to the member's terminal decline. Symptoms, Signs, and Ill-defined Conditions are considered secondary or tertiary to the principal definitive diagnosis.

Rev. 10/15

Effective 11/01/2013, election and certification forms that have a primary diagnosis of Symptoms, Signs, and Ill-defined Conditions including, Unspecified Dementia, Debility and/ or Adult Failure to Thrive will not be processed for the hospice member lock-in and will be returned to the provider by the fiscal agent, Gainwell Technologies .

Effective 10/01/2014, the Department will apply these rules to claims processing and deny any claim with a diagnosis that is considered a Symptom, Sign, or Ill-defined Condition. Symptoms, Signs and Ill-defined Conditions are any diagnoses classified as non-billable ICD-10 codes by Medicare. As classified by Medicare, the Unspecified Dementia ICD-10 codes are also non-billable codes. ***Effective 10/1/2015, providers must enter the ICD-10 CM code.*** **All codes must be cross walked to ICD-10 codes. (Do not bill ICD- 9 code sets on or after October 1, 2015.)**

The hospice agency must have the physician certification of terminal illness completed for patient's file per established Division policy before submitting the election form and claims for reimbursement. The Division does not require submission of the physician certification of terminal illness for the initial lock-in of the member except for a request by the Division to make the form available for review when the election form is sent in more than 90 days of the initial election or within other circumstances that a request is made.

Rev. 04/14 The Division requires that the provider make available the certification form(s) for all subsequent extension span requests to the fiscal agent. When the member is entering the 6th Hospice Benefit Period (thru the 360th days of Gainwell Technologies 's system election span) submit all Physician's Certification Form(s) (***ALL F2F encounter attestations***) with the terminal illness diagnosis and the current Plan of Care (showing coordinated care if applicable) to Gainwell Technologies so that the hospice provider lock-in can be extended. Failure to meet the F2F encounter timeframes results in a failure by the hospice provider to certify the patient's terminal illness. This means that the patient would not be eligible for the Medicaid Hospice Benefit or for Medicaid reimbursement. The certification documentation must be submitted within the 30 days prior to the expiration of the current span. The hospice providers may submit to Gainwell Technologies the Medicaid Hospice Physician Certification Form (See Appendix C), or a physician certification form used internally by the hospice agency or the Medicare Hospice Physician Certification Form. The Medicare Physician certification forms are required to remain on file for the dually eligible Medicare and Medicaid NF residents.

Note: Currently, when the member is entering the 6th Hospice Benefit Period (thru the 360th days of Gainwell Technologies 's system election span) submit all Physician's Certification Form(s) (***ALL F2F encounter attestations [see 704.1C])*** with the terminal illness diagnosis and the current Plan of Care (showing coordinated care if applicable) to Gainwell Technologies so that the hospice provider lock-in can be extended. Failure to meet the F2F encounter timeframes results in a failure by the hospice provider to certify the patient's terminal illness. This means that the patient would not be eligible for the Medicaid Hospice Benefit or for Medicaid reimbursement. The certification documentation must be submitted within the 30 days prior to the expiration of the current span.

The hospice agency must fax a Hospice Care Communicator Form to DFCS indicating the initial *or* subsequent certification periods within the appropriate timeframes for individuals that have elected Hospice.

704.1 For the first election of hospice coverage, the hospice agency must obtain no later than two (2) calendar days after hospice care is initiated written certification statements signed by the medical director of the hospice agency or the physician member of the hospice agency interdisciplinary group ***and the individual's attending physician*.**

If the hospice agency cannot obtain a written certification within two (2) calendar days after the initiation of hospice care, a verbal certification must be obtained within these two (2) calendar days and a written certification obtained no later than eight (8) calendar days after care is initiated. A notation must be made on the physician certification form to

indicate the attainment of the verbal certification. The notation must include the date the certification was received and the date, signature and title/position of the person who received the verbal certification.

A) Reimbursement will not be made for any days of hospice care prior to the certification date. **See Appendix M regarding additional information for Medicaid claim reimbursement.**

B) Certifications for the initial election of hospice coverage may be completed up to two (2) weeks prior to the election of hospice care. Two (2) weeks is defined as fourteen (14) calendar days.

C) The attending physician is a physician who is a doctor of medicine or osteopathy and is identified by the individual at the time of election to receive hospice care as having the most significant role in the determination and delivery of the individual's medical care.

D) Physicians may not delegate the initial certification process to a nurse practitioner. Nurse Practitioners may not certify terminal illness with a prognosis of 6 months or less for initial or subsequent.

E) Effective November 1, 2013, the hospice-employed physician or the hospice-employed nurse practitioner (NP) must have a face-to- face (F2F) encounter prior to the 180th day certification period. This face-to- face assessment is required prior to the beginning of the patient's third (3rd) benefit period and prior to each subsequent benefit period thereafter to determine continued eligibility of the individual for hospice care and attest that such a visit took place.

704.2 For all subsequent benefit periods, the hospice agency must obtain a written certification statement prepared by the medical director of the hospice agency or the physician member of the hospice agency interdisciplinary group to keep on file. Certifications for the subsequent hospice benefit periods may be completed up to fourteen (14) calendar days prior to the beginning of the subsequent period, but cannot be obtained later than eight (8) calendar days after the beginning of the benefit period.

A) Effective November 1, 2013, the hospice-employed physician or the hospice-employed nurse practitioner (NP) must have a face-to- face encounter prior to the 180th day certification period. This face-to-face assessment is required prior to the beginning of the patient's third (3rd) benefit period and prior to each subsequent benefit period

thereafter to determine continued eligibility of the individual for hospice care and attest that such a visit took place.

B) The face-to-face encounter should not be more than 30 days prior to the benefit period being recertified by the physician.

C) The physician who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter, and indicate the clinical findings of that visit for use in determining continued eligibility for hospice care.

D) When the hospice NP performs the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of 6 months or less should the illness run its normal course.

E) Both the physician's certification narrative and the F2F encounter attestation MUST remain on file for auditors to review.

F) The attestation must be clearly titled, its accompanying signature, and the date signed, must be on a separate and distinct section of, or an addendum to, the certification form.

G) If the attestation is included on the certification, it must be located above the physician's signature.

H) Where both the encounter attestation and narrative are included as an addendum to the certification, one physician signature can suffice for both the narrative and attestation.

I) Both the narrative and the attestation must be located above the physician's signature.

J) Failure to meet the encounter timeframes results in a failure by the hospice provider to meet the patient's certification eligibility requirement. This means that the hospice provider will not be eligible for Medicaid reimbursement for this member.

K) Providers must submit the election and certification forms to Gainwell Technologies for the initial election and for the certification lock-in time span within the 30-day time limit to receive Medicaid reimbursement.

L) Failure by hospice providers to coordinate the member's care with services being rendered by the member's other Medicaid providers as allowed by policy will be considered non-compliant and all hospice services rendered to that member will be subject to recoupment.

M) The coordinated plan or care for the hospice patient that is a member of another Medicaid program must be available in the member's record for the duration of all hospice election periods.

N) Documentation to support the terminal prognosis must be maintained in the individual's medical record. The documentation must include, where applicable, the following:

a. Terminal diagnosis and all related conditions present at the time of enrollment;

b. Physician documentation, laboratory, radiological or other studies;

c. Clinical progression of the terminal disease;

d. Recent decline in functional status;

e. Supporting documentation that indicates the individual has entered an end-state of a chronic disease.

O) The hospice agency must retain the documentation in the individual's record in accordance with Georgia statute of limitation requirements.

Rev. 01/14

P) The Division may request the documentation of the terminal prognosis for clarification or review as needed.

Rev. 07/12

704.3 The hospice agency must retain the Medicare and/ or Medicaid certification statements in the individual's record in accordance with Georgia statute of limitation requirements. If required for research, reimbursement, or other purposes, the Division will request the hospice agency to submit all copies of the signed physician certification statements.

704.4 An entry on the Certification form must be made to note the exception when the medical director or physician member of the hospice agency interdisciplinary group services as the attending physician.

704.5 Stamped physician signatures are not acceptable on the certification form.

704.6 When the physician's signature is not dated, the hospice agency must stamp the certification form with the date the form is received by the hospice agency. If the stamped date of receipt of the certification by the hospice agency is outside the established time frame for obtaining physician certifications, the Division will not reimburse the agency for days of hospice care prior to the physician certification. If the stamped date of receipt of the certification by the hospice agency is within the established time frame for obtaining physician certifications, reimbursement will be made for all covered days of hospice service.

705. Revocation

An individual or representative may revoke the election of hospice care at any time. To revoke the election of hospice care, the individual must file with the hospice agency a Hospice Revocation Form. The hospice agency must indicate on the Hospice Revocation Form the reason the individual has chosen to revoke hospice services, and the fact that he or she is aware of the revocation. The individual forfeits hospice coverage for any remaining days in that election period. An individual may not designate an effective date earlier than the date the revocation is made. The hospice agency must maintain the revocation form in the individual's medical record at the agency. **Note that verbal revocations of hospice service are not acceptable.**

Upon revoking the election Medicaid coverage of hospice care for an election period, an individual resumes Medicaid coverage of the benefits waived when hospice care was elected, effective the date of revocation. An individual may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible. The hospice agency may advise the individual on the option of revoking the benefit and any advantages or disadvantages of the decision being made.

The Hospice Revocation Form must include at a minimum the items of information below.

- Identification of the hospice agency and/or Medicaid Provider number;
- The effective date of revocation;
- The reason the individual chooses to revoke the benefit
- The signature of the individual or representative;

- The Social Security number and the date of birth of the individual choosing to revoke hospice services;

Rev. 01/14

- The Medicare and Medicaid number (if applicable);

Rev. 04/14

- The individual's representative's acknowledgement that he or she has been given a full understanding of the revocation of hospice care; and

- The individual's or representative's acknowledgement that he or she resumes Medicaid coverage for the benefits waived when hospice care was elected effective the date of revocation.

Rev. 07/18

The Hospice Provider is to provide the DMA-59 with their revocation form when member resides in a Nursing Facility. If the Hospice provider does not provide the DMA-59 and the member is in a Nursing Facility, the Nursing Facility should submit it.

On the Hospice Revocation Form the Hospice Provider must specify where the member will be moved (i.e. home, nursing facility, hospital, etc.)

Gainwell Technologies shall return any member back to the original level of care (i.e. Nursing Facility) (with Medicaid Hospice Revocation Form (DMA

523) and Medicaid Hospice Election Form (DMA 579)) even though the member's record may have a 289 (Institutional Hospice) aid category in the Georgia Medicaid Management Information System (GAMMIS). The Nursing Facility is responsible for notifying and working with DFCS to get the category changed to 210 (Nursing Facility).

The Division of Medical Assistance requires that the Medicaid specific hospice revocation form, found in Appendix C, be used for individuals who are Medicaid eligible and elect to discontinue hospice services. The hospice agency must complete the HCC notifying DFCS of the revocation.

If an individual chooses to re-elect hospice services, the election procedures outlined in Section 702 must be followed. The individual enters the beginning of the benefit period following the period revoked.

706. Discharge

The hospice agency may discharge (not revoke) an individual for any of the following reasons:

- Individual is determined to have a prognosis greater than six (6) months due to improvement in the condition, in which case the member cannot be recertified;

- Individual moves out of the hospice agency's geographically defined service area;

- The member transfers to another hospice agency;

- The safety of the individual or hospice agency staff is compromised; or

- The member dies. **(Effective: 07/01/2014, submission of a hospice discharge form, DMA-524, is required to be submitted to Gainwell Technologies for the formal discharge of the member. This includes a discharge due to death)**

The hospice agency must clearly document in the clinical record and explain on the discharge form the situation(s) surrounding the discharge of the individual when safety issues are the cause. The hospice agency must make every effort to resolve these problems satisfactorily before discharge becomes an option. All efforts to resolve the problem(s) must be clearly documented in detail in the member's medical record and the hospice must notify the Division in writing using the hospice discharge form in Appendix C and the State Survey Agency of the circumstances surrounding the impending discharge. The hospice agency must complete the Hospice Care Communicator notifying DFCS of the discharge. The hospice may need to make appropriate referrals to other relevant state/community agencies as appropriate (e.g. Adult Protective Services).

The individual forfeits hospice coverage for any remaining days in that election period.

It is the responsibility of the hospice agency to advise the individual when possible regarding discharge from hospice services. The hospice agency must maintain the discharge form in the individual's medical record at the agency.

When discharging an individual, the hospice agency must complete a Hospice Discharge Form. The discharge form must include at a minimum the items of information listed below.

- Identification of the hospice agency;

- The effective date of discharge;

- The Social Security number and the date of birth of the individual;

- The Medicaid and Medicare number (if applicable);
- The reasons for discharge;
- Documentation of explanation of discharge to individual/representative and acknowledgement by the individual or representative;
- Documentation of attempt to inform individual/representative of reason for discharge;
- Signature of the individual/representative when possible;
- Signature/date of hospice representative completing the form.

The effective date of discharge cannot be a date earlier than the date the hospice representative completed the form. The only exception is the situation in which a patient relocates outside the agency's defined service area without informing the agency. The hospice agency must maintain the discharge form in the individual's record at the agency. Once a hospice chooses to admit a Medicaid member, the agency may not automatically or routinely discharge the member at its discretion, even if the care promises to be costly or inconvenient. A hospice agency cannot demand or request the member revoke their hospice election.

The Division of Medical Assistance requires that the Medicaid specific hospice discharge form found in Appendix C be used for individuals who are Medicaid eligible and are discharged hospice services.

707. Change of Hospice/Transfer

An individual may change the designation of the hospice agency from which he or she elects to receive hospice care once in each benefit period. The change of the designated hospice agency is not considered a revocation of hospice benefit. To change the designation of hospice agency providers, the individual must file with the current hospice agency and with the newly designated hospice agency, a signed Hospice Transfer Form. **The transferring hospice agency must specify in writing the last day of service to be included for billing (end date)** and forward a copy to the newly designated hospice agency within five (5) calendar days. The receiving hospice agency must complete a Medicaid Hospice Election Form for the individual transferring to their agency compliant with Section 702. The hospice agency must notify DFCS of the Medicaid individual transfer by completing the top portion and Remarks Section of the Hospice Care Communicator.

Rev. 01/14

The receiving hospice must specify on the transfer from the start date of hospice service with their agency. Medicaid will not pay two hospices for services on the

same date. A copy of the current Hospice Election Form and physician certifications must accompany the transfer form to the receiving hospice agency. The transferring and receiving hospice agencies are required to maintain the transfer form, election form and the physician certification form for the current benefit period in the individual's medical record. The receiving hospice agency must submit the Medicaid Transfer Form and the Medicaid Hospice Election Form completed for their agency to the Division. The Change of Hospice/Transfer form must include the following information at a minimum:

- Individual's name, address, telephone number, date of birth, Social Security Number, and Medicaid number;
- Transferring Hospice name, address, telephone number and Medicaid Provider Number;
- Effective date of transfer (End Date of Service). This is the last date that the transferring hospice agency can bill.
- Receiving Hospice name, address, telephone number and Medicaid Provider Number;
- Effective Date of service (Start Date). This is the date that the receiving agency will begin providing services. The start date cannot be the same as the end date.
- Comments Section;
- Hospice Diagnosis;
- Date the form is completed by the transferring hospice;
- Signature of the authorized representative of the transferring hospice;
- Signature of the authorized representative of the receiving hospice and date;
- Signature of individual or individual's representative;
- Effective date of receipt (This is the first date the receiving hospice may bill).

A change of ownership of a hospice agency is not considered a change in the member's designation of hospice and requires no action on the member's part. Refer to Section 602 regarding change of ownership of hospice agencies.

The Division of Medical Assistance requires that the Medicaid specific hospice transfer form found in Appendix C be used for individuals who are Medicaid eligible and are transferred to another hospice services.

708. Medicare and Medicaid Eligible Individuals

If an individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected, discharged and revoked simultaneously under Medicaid and Medicare. The appropriate Division of Medical Assistance hospice forms must be completed and submitted within the established timeframes; this includes notifying DFCS by completing the Hospice Care Communicator. The Medicare election and certification(s) are required for the Medicaid nursing facility room and board. Medicaid will reimburse the hospice agency for no services other than the nursing facility room and board payment or if later the patient should need to be admitted into a nursing facility. Revocation, discharge, transfer and change of hospice agency procedures must be followed and designated forms completed in both programs as specified.

Rev. 10/13

Rev. 01/14

If an individual becomes eligible for Medicaid while already enrolled in the Medicare hospice benefit, Medicare hospice coverage continues. The Medicaid hospice coverage will begin on the first day of the signed election form for Medicaid but end on the same date as the last day of the current Medicare hospice benefit period. Subsequent benefit periods for Medicare and Medicaid will begin and end concurrently. The Hospice Election Form must be completed upon notification to the hospice agency the individual has applied for Medicaid or is receiving Medicaid benefits. Refer to Section 603 and Section 709.

709. Submission of Hospice Forms

(See Appendix C for Forms)

To be timely, Hospice Election (DMA 579), Certification, Revocation, Transfer and Discharge forms must be submitted to the Division within thirty (30) calendar days of the date that the patient signs and/ or elects, certified, recertified, revokes, transfers or is discharged from hospice care.

Gainwell Technologies Enterprise Services will no longer receive Provider Enrollment paper documents via the US mail. All supporting Provider Enrollment documentation should be uploaded via the GAMMIS web portal to pending applications. If you need to submit updated documentation, please fax it to Gainwell Technologies Provider Enrollment at 1-866-483-1045. All faxes must be accompanied with a Gainwell Technologies Provider Enrollment fax cover sheet. The form can be found under >Provider Enrollment>Forms.

To dispute a lock-in date you must contact Gainwell Technologies Enterprise Services in writing via fax at the fax number indicated above.

Verification of the date that your agency faxed or mailed the document to the Division will be required when a request is made to alter any hospice effective dates. A copy of your agency's fax confirmation sheet that includes the date the fax was sent, the phone number and the name of the patient should be maintained to use as verification if the hospice agency should need to dispute the lock-in date of any individual. The copy is subject to Division review for approval or denial.

Mailing the forms does not provide a viable means to verify the timeliness of your submission. Therefore, the hospice agency must track their forms to make sure they are submitted and received by the Division timely. Contact Provider Inquiry at 800-766-4456 or use the Web Portal to verify information regarding your hospice forms and effective dates.

NOTE:
DO NOT fax hospice forms to DCH unless requested to do so. Forms faxed to DCH without prior authorization will be sent to the fiscal agent and could further delay the entry of the forms into the system.

NOTE:
Election forms received by the fiscal agent past the 30-day timeframe are approved on the date of receipt. When the election form is received after the established timeframe and the client's date of death is noted to be before the date of receipt, the fiscal agent <u>will not</u> process the election form. The election form will be returned to the provider with the above reason indicated on the cover letter. (The fiscal agent or Division will take no further action on election forms in this category.)

Rev. 07/12

The Division will not reimburse for any forms submitted to the fiscal agent that have been altered in a manner inconsistent with acceptable standards of medical practice. The fiscal agent will return any altered forms of this nature to the provider. The effective date of the form will be amended to the date of receipt of the resubmitted form.

Rev. 01/14

710. Hospice Care Communicator (HCC)/ DFCS

Rev. 04/14

Hospice agencies and the county Department of Family and Children Services (DFCS) offices should provide information to each other regarding individuals whose eligibility is being determined under the Hospice Medicaid coverage group. The HCC and the HCC Status Change located in Appendix C should be used for this exchange of information. *These forms should not be submitted to the Division of Medical Assistance; however, <u>a copy</u> of everyone's form is sent to Gainwell Technologies Enterprise Services*, the fiscal agent for the member's hospice elections and certifications for extended hospice span requests.

The HCC is to be used to communicate the individual's Hospice Medicaid eligibility status and patient liability amounts. **The hospice agency will complete top portion, Section I with signature, and fax to the county DFCS office in the Region where the individual resides.** (See Appendix C). When the review of eligibility is completed, providers can access section II for the eligibility status, patient liability amount (if one is assessed), the effective date and Medicaid identification number that is needed for claim purposes.

An eligibility review by the county DFCS office should be completed within forty-five (45) to sixty (60) calendar days from the date of application; however, eligibility can be made retroactive to the month of application, including up to three (3) months prior.

The HCC Status Change form should be completed, signed and forwarded to the county DFCS office whenever changes occur in any of the five (5) situations specified on the form. The HCC Status Change form should be used to verify an individual's election status on hospice care services when a certification period expires, including revocation and discharge of hospice care services. This form must be forwarded to the county DFCS office no later than the last day of each certification period so that Medicaid eligibility under the hospice care coverage group continues without interruption for those individuals electing continued services. The forms may be photocopied for use as needed.

If there is a problem with patient liability, the hospice agency should contact the local Department of Family and Children Services (DFCS) to resolve the issue.

711. Individuals Residing in the Nursing Facility

Rev. 04/14

For purposes of the Medicaid hospice benefit, the nursing facility is considered the residence of the Medicaid and/or Medicare enrolled individual. An individual who meets the eligibility criteria for hospice services residing in such a setting may elect the hospice benefit according to the procedures outlined in Chapter 700. The hospice agency must have a written + with the nursing facility in which the individual resides and the nursing facility must concur with the hospice Plan of Care (See Chapter 900). The individual must be formally discharged from the nursing facility (NF). A DMA-59 must be completed by the NF and submitted to the Department of Family and Children Services (DFCS). The hospice agency must submit a copy of this DMA-59 to Gainwell Technologies with the member's election form and a copy of the HCC form for the hospice election provider lock-in.

A hospice agency may furnish routine or continuous (limited) home care to the Medicaid only enrolled individual who resides in a nursing facility. Individuals residing in the nursing facility who elect the hospice benefit are ineligible to receive respite care services from Medicare or Medicaid.

General Inpatient Care and Nursing Home Room and Board cannot be reimbursed for the same individual for the same covered days of service (See Section 902). Nursing Home Room and Board cannot be reimbursed for an individual on the day of discharge or death.

PART II - CHAPTER 800
PRIOR APPROVAL

801. General

The Division does not require prior approval of hospice services**.**

801.1 Same Day Services

Rev. 07/01/13

When individual transfers out of a hospice service to elect *another* hospice service, the transferring hospice provider cannot submit a claim for reimbursement for the date of the individual's transfer to the other hospice. The hospice provider that admits the transferring individual can claim the admission date for reimbursement.

When an individual receives *another* Medicaid covered service and chooses to enroll in hospice services on the same day, the hospice provider and the other Medicaid service provider will both be allowed to submit claims for processing to be reimbursed for that day. Similarly, when individual revokes or is discharged from hospice service and receives services from another Medicaid provider, the Medicaid provider and the hospice agency will both be allowed to submit claims for processing to be reimbursed for that day, except for Revenue Code 659, Nursing Facility room and board.

802. Non-Hospice Related Services

Services provided by certain Medicaid providers for care not related to the terminal illness may be reimbursed by the Division directly to the non-hospice providers. Non-hospice related conditions are not related to the terminal illness and are not included in the hospice plan of care. Services that may be non-hospice related include but are not limited to:

- Hospital;
- Pharmacy;
- Durable Medical Equipment;
- Emergency and non-emergency transportation;
- Laboratory; and
- Specialty physician services.

The hospice agency must provide the non-hospice service provider with a Hospice Referral Form for Non-Hospice Related Services (See Appendix C). A copy of the referral form must be maintained in the individual's hospice medical

record. The Division will not reimburse the non-hospice provider for non-hospice related services without the Hospice Referral Form. Non-Hospice Services provided through Medicaid programs must follow the policies and procedures manual applicable to the service. If a prior approval is required for the service that is not hospice related, a prior approval must be obtained by the non-hospice provider.

The hospice agency is responsible for all services related to the terminal illness and any condition related to the terminal illness, including inpatient care and outpatient services.

If care/services are required by a hospice patient that is **Unrelated** to the hospice diagnosis, the provider of that care/service must first contact the hospice agency to obtain the hospice diagnosis of the patient before rendering care/service.

Rev. 01/12

The provider of the non-hospice related care/service also has the option of obtaining the form. The form can be accessed by downloading the Non-Hospice Related Referral Form. Go to www.mmis.georgia.gov, select the Provider Information tab, click on Forms, scroll down to and click on the DMA -521 form.

The Non-Hospice Service Provider must obtain the hospice diagnosis to be inserted on the Non-Hospice Related Referral Form **PRIOR TO RENDERING CARE/SERVICE.** Failure to do so may result in the denial of the provider's claim.

803. Children's Concurrent Care Hospice Services and GAPP

Rev. 10/19

Children are not required to forego curative care when electing hospice and may concurrently receive palliative and curative treatment. Hospice services are available to children eligible for Medicaid and Medicaid-expansion CHIP programs without forgoing any other treatment to which the child is entitled under Medicaid. Hospice palliative services and supports to children continue to include pain and symptom management, and family counseling provided by specialty-trained hospice staff. Effective August 1, 2019 for Children from ages 0 to 21 (20 years + 11 months), the DMA-521A form for non-related Hospice diagnosis / non-palliative care services are no longer required to be submitted with the claim. This modification is for all non-hospice providers rendering services for care not related to the *terminal illness*.

803.1 GAPP: In-Home Skilled Nursing Care and Waiver Services

An individual currently enrolled in the GAPP Program's In-Home Nursing Care Program that has been diagnosed with a terminal illness may elect to enroll in the Hospice program. The GAPP member may receive some services that are determined not to be duplicative of

hospice services.

803.2 Concurrent Care

Effective 3/23/10, children are not required to forego curative care when electing hospice. Hospice Services and supports to children continue to include pain, symptom management and family counseling provided by specialty trained hospice staff. Duplication of concurrent curative care and hospice services is not permitted. If a member has elected hospice and is in another Medicaid program, it is incumbent upon the Hospice provider to coordinate the multiple plans of care and eliminate the duplication of Medicaid services. Once conducted, both the hospice and other Medicaid provider must document coordination activities and retain such documentation and resulting coordinated plans of care in the member's medical record.

Hospice skilled nursing is intermittent in nature for symptom and crisis management while the GAPP nursing is provided in shifts for routine nursing care relating to all member's skilled nursing needs based on medical necessity.

It would be anticipated that the hospice nurse and the GAPP nurse would sometimes be in the home at the same time which would allow for assuring that the coordinated plan of care continues to be current and applicable to the member and family needs.

The hospice provider will initiate contact with the GAPP nursing agency to develop a coordinated POC. This coordinated POC will be kept in the member's home as well as sending a copy to the AHS Medical Review Team with the member's PA request for GAPP services.

Upon choosing hospice services, the member will maintain a hospice lock-in with the hospice as the primary for care coordination with the hospice nurse providing in home services at least once per week to assure continued coordination of care with GAPP services.

803.3 Billing for Concurrent Services

If a GAPP provider is providing services under an active PA while the member is locked into hospice, the GAPP provider should continue to utilize the Pediatric DMA 521A which documents that the GAPP provider has provided non-hospice related and/or concurrent services. This document must be submitted with each claim submitted while the member is locked into hospice.

Put the GAPP diagnoses under both "Non-related services as well as under "Concurrent Care".

Please make sure that if the member is receiving hospice services that you note this on the Appendix I when requesting an initial and/or

recertification of GAPP services.

Make sure that you mark the checkbox for both “Non-related services” and “Concurrent Care before attaching the DMA 521 A to the GAPP claim.

PART II - CHAPTER 900
SCOPE OF SERVICES

901. Requirements of Coverage

To be covered, a certification that the individual is terminally ill must have been completed as set forth in Section 704 and hospice services must be reasonable and necessary for palliative care management of the terminal illness and related conditions. The individual must elect hospice care in accordance with Section 702. A plan of care must be established before services are provided. To be covered, services must be rendered consistent with the plan of care. Only individuals through the age of twenty (20) may receive curative care management concurrent with palliative care.

Rev. 10/13

902. Plan of Care

Rev. 04/13

In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member (nurse, physician, medical social worker or counselor) before writing the initial plan of care. At least one of the persons involved in developing the initial plan must be a nurse or physician. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care. The plan of care must be dated on the day it is first established. The other two members of the basic interdisciplinary group, the attending physician, and the medical director or physician designee must review the initial plan of care and provide their input to the process of establishing the plan of care within two (2) calendar days following the day of assessment.

The hospice provider must ascertain if a Medicaid member who has elected hospice is enrolled or participates in another Medicaid program to coordinate the multiple plans of care, therefore, avoiding overlapping services and to eliminate the duplication of Medicaid services. *A coordinated POC must also reference curative care for pediatric patients scheduled to receive such medical care concurrent to hospice care.* The hospice provider must document coordination activities and retain such documentation and resulting coordinated plans of care in the member's medical record. The coordinated POC must be submitted with the election and/or recertification forms to Gainwell Technologies within a 30-day period prior to lock-in for the Medicaid provider lock-in or member certified span extension by Gainwell Technologies.

Failure of the Hospice provider to coordinate care of the member enrolled in other Medicaid programs will be considered a failure to comply with the terms of hospice policy. Coordination of care must be evidenced in the member's hospice POC and primary record. Documentation reflecting the coordination of care must accompany the submission of the election form in the request for lock-in. Lack of evidence of coordinated care in documentation submitted for election, lock-in, etc., will result in hospice forms that are not processed for the hospice member lock-in and are returned to the provider by the fiscal agent, Gainwell Technologies. *All claims are subject to recoupment when failure to coordinate care is not evidenced.*

Failure to comply with any of the above policy means that the hospice patient would not

be eligible for the Medicaid Hospice Benefit. Forms and other information submitted will not be processed for the hospice member lock-in and /or extension and will be returned to the provider by Gainwell Technologies as applicable. The hospice may continue to serve the patient under hospice care, but in doing so assumes all financial responsibility and Medicaid will not reimburse the hospice provider for that care. The patient becomes a Medicaid hospice member only when all Medicaid eligibility criteria are met.

903. Covered Services

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The services below are covered hospice services:

903.1 Nursing Care provided by or under the supervision of a registered nurse. (This includes care provided by an advanced nurse practitioner and LPN or Home Health Aide supervised by a RN).

903.1.a. Advance Nurse Practitioners may enroll and provide hospice care in four categories of service: pediatric, family, adult and gerontological, OBGYN and certified registered nurse anesthetist (CRNA).

903.2 Medical Social Services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

903.3 Physicians' Services provided by the hospice medical director or physician member of the interdisciplinary group must be performed by a Doctor of Medicine or osteopathy or a nurse practitioner for the Medicaid only member.

Revenue Code 657 is used on a line item to indicate the physician's or nurse practitioner's hands-on visit to the Medicaid member. The hospice provider submits the UB-04 claim using Revenue Code 657 on the line item for the professional service of the hospice physician/nurse practitioner, the appropriate HCPCS code for the applicable time spent (one [1] unit allowed) and the date of the service. Note: non-hospice physicians, e.g. consultants, should bill on the CMS-1500 for the member's professional services that are not related to the terminal illness.

The allowed procedure codes for use with Hospice Revenue Code 657 are listed below:

99212
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- A problem focused history;
- A problem focused examination;
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are self -limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family

99213
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- An expanded problem focused history;
- An expanded problem focused examination;
- Medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of low to moderate severity.
Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- A detailed history;
- A detailed examination;
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate to high severity.
Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate to high severity.
Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Hospice providers (Provider Contract, COS 690) who have experienced these claims denials will be able to submit new claims to replace those that denied using the correct procedure code(s). Hospice Providers will have thirty (30) days from the posting date of this notice to do so. Following the thirty (30) day period of resubmission, Georgia Medicaid will perform a Mass Adjustment to reprocess the new claims to override timely filing only. Only those claims submitted cleanly and which only deny for timely filing only will successfully adjudicate in this one-time mass adjustment to allow hospice claims for physician services.

See Chapter 1000, Section 1002 for additional payment of physician services not related to the above.

The following services performed by hospice physicians are included in the reimbursement rates:

A) General supervisory services performed by the medical director. Hospice services must be related to the terminal diagnosis of the member and are professional (hands-on) in nature for a physician and/or nurse practitioner identified as the member's attending physician at the time of election. These services are separately billable by the hospice and can be included on the hospice claim that is submitted to Medicaid.

B) Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of care plans and establishment of governing policies by the physician member or nurse practitioner of the interdisciplinary group. Administrative activities, e.g. care-planning, face-to-face certifications, etc., are not separately billable as these services are included in the per diem rate.

C) Hospice Providers must maintain 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.

a. Physician Progress Notes must remain in the patient's medical record whether services are furnished directly or under arrangements made by the hospice agency.

b. Progress Notes must include complete documentation of the hands-on services and events including evaluation, treatments, problems/needs identified by the individual or family member/caregiver, etc., to support billing.

D) Providers must comply in a timely fashion with all requests for records, information, and documentation made by the Division. For additional information, see Part 1 Medicaid Policy, Section 106, R) and S).

E) See Chapter 1000, Section 1002 for additional payment of physician services not related to the above.

903.4 Counseling Services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for training the individual's family or other caregiver to provide care, and for helping the individual and those caring for him or her to adjust to the individual's approaching death.

903.5 Short-Term Inpatient Care provided in a participating hospice inpatient unit or a participating hospital that meets the special hospice standards regarding staffing and patient areas. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings.

903.6 Inpatient Respite Care is short-term inpatient care required to provide relief from care for the individual's family or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five (5) consecutive days at a time. **Respite care <u>may not</u> be provided when the hospice individual resides in the nursing facility on a permanent basis.**

Services provided in the facility must conform to the hospice agency's Plan of Care. The hospice agency must have a contract with the inpatient facility to provide respite care delineating the roles of each provider in the hospice agency's Plan of Care. However, the hospice agency is the professional manager of the individual's care, despite the physical setting of that care or the level of care.

Documentation in the individual's record must indicate the reason respite care was necessary. For more than one respite care admission in a short amount of time, the documentation must clearly identify reasons multiple admissions were necessary.

Rev. 04/01/13

See Chapter 1000, Section 1001 for additional coverage regarding inpatient respite care.

903.7 Medications/Pharmacy

Medicaid members who elect to enroll in the Hospice program receive all care related to their terminal illness from the hospice. Prescriptions filled for these members relating to the terminal illness are to be paid by the hospice and should not be billed to the Medicaid drug program. Pharmacy hospice claims do not require paper or attachments and can be billed through POS effective 10/1/2000. However, should the Medicaid hospice patient require covered drugs that do NOT relate to the terminal illness, these prescriptions may be billed to Medicaid with some restrictions.

Effective 03/23/2010, children less than 21 years of age will no longer be required to forego curative care when electing hospice. They may concurrently receive palliative and curative treatment related to the terminal illness. All palliative treatment is to be provided by the hospice provider through hospice services reimbursed by Medicaid. Pharmacy services prescribed as curative treatment for children less than 21 years of age will also be paid by Medicaid when eligibility for concurrent care criteria is met. Providers wishing to prescribe drugs for curative treatment from the list of medications below should use the pharmacy services PA process to request an exception.

DCH considers the following drugs palliative in nature and therefore ineligible for coverage in the outpatient pharmacy program for hospice members. These include but are not limited to:
analgesics

antibiotics*

antidepressants*

anti-emetics

antifungals

antihistamines for sleep

anxiolytics

appetite stimulants

folic acid, multivitamins, iron

hematopoietic (Procrit, Epogen, etc.)

HIV drugs

hypnotics

interferons

laxatives

megestrol

anti-migraine drugs

muscle relaxants

non-steroidal anti-inflammatory agents

oncology drugs

sedatives

stool softeners

*approval on a case-by-case basis.

903.8 Medical Appliances and Supplies

Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care and relate to the terminal illness or conditions related to the terminal illness.

903.9 Home Health Aide Services for personal support- Home Health Aide services will be performed by individuals who have successfully completed Home Health Aide training and competency evaluation.

Training at a minimum must include classroom and practical training totaling at least 75 hours of practical training that must include at least 16 hours devoted to supervised practical training.

Home Health Aides may provide personal care services. Services may include bathing, grooming, dressing, and performance of household services necessary to maintain a safe and sanitary environment in areas of the home used by the patient. Household service may include changing the individual's bed, light cleaning, and laundering essential to the comfort and cleanliness of the patient. Aid services must be provided under the general supervision of a registered nurse.

A registered nurse (RN) must visit the home at least every 2 weeks when aide services are provided. The visit must include an assessment of the aide services (This shall mean observation of the aide). Documentation of the supervisory visit by the RN must be filed in the individual's medical record.

903.10 Physical Therapy, Occupational Therapy and Speech-Language pathology services provided for purpose of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

904. Core Services

Rev. 03/20/2015

Nursing services, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted to meet unusual staffing needs that cannot be anticipated and that occur so infrequently it would not be practical to hire additional staff to fill these needs. You may also contract to obtain physical specialty services. If contracting is used for any services, the hospice agency must maintain professional, financial and administrative responsibility for the services and assure that all staff meets the regulatory qualification requirements.

905. Hospice Care in the Nursing Facility

Rev. 04/11
Rev. 07/12

When a resident of a Medicare/Medicaid Nursing Facility (NF) elects the Medicare/ Medicaid hospice benefit or Medicaid only hospice benefit, the hospice agency and the NF must communicate, establish, and agree upon a coordinated Plan of Care for both providers which reflects the hospice philosophy, and is based on an assessment of the individual's needs and unique living situation in the NF. The hospice agency assumes full responsibility for professional management of the individual's hospice care and makes any arrangements necessary for inpatient care. Even though the NF is the hospice individual's residence for purposes of the hospice benefit, the NF must still comply with all NF requirements for participation in Medicare or Medicaid.

905.1 The coordinated Plan of Care must reflect, at a minimum, the following:

A) Identification of the care and services which the SNF/NF and hospice agency will provide to be responsive to the needs of the individual;

B) Establishment of the time frame for the revision and update of the Plan of Care as necessary to reflect the individual's status;

C) Identification of the individual's current, physical, psychosocial and spiritual needs.

The hospice agency must designate an RN from the hospice agency to coordinate the implementation of the Plan of Care.

905.2 All covered hospice services must be available as necessary to meet the needs of the individual.

905.3 All core services must be routinely provided directly by hospice agency employees and cannot be delegated to the SNF/NF (See Section 904). The hospice agency may involve the SNF/NF nursing personnel in assisting with the administration of prescribed therapies included in the Plan of Care only to the extent that the hospice agency would routinely utilize the services of a hospice individual's family/caregiver in implementing the Plan of Care.

905.4 Drugs and medical supplies must be provided as needed for the palliation and management of the terminal illness and related conditions. Drugs must be furnished in accordance with accepted professional standards of practice.

905.5 The hospice agency may arrange to have non-core hospice services provided by the SNF/NF if the hospice agency assumes professional management responsibility for these services and assures that these services are performed in accordance with the policies of the hospice agency and the individual's Plan of Care.

905.6 The hospice agency receives the room and board payment in addition to the appropriate level of care rate from the Division. The hospice agency is responsible for reimbursing the nursing facility for the room and board according to the contract between the hospice and the nursing facility.

Rev. 07/01/13

NOTE:

The Division will only reimburse the hospice for room and board for those days the individual is in the nursing facility.

<u>The Division does not pay room and board</u> on the day of discharge or death when a hospice member is living in a nursing facility.

***<u>The Division does not pay to reserve a bed</u>* when a hospice individual living in a nursing facility goes into the hospital or goes to visit family members.**

The hospice reimbursement of the nursing facility for room and board is *<u>dependent on the contract between the hospice provider and the nursing facility</u>* when the individual is outside the nursing home.

Rev. 01/12

Room and board services include:

- Performing personal care services
- Assisting with activities of daily living;
- Administering medications;
- Socializing activities
- Maintaining the cleanliness of an individual's room; and
- Supervision and assisting in the use of Durable Medical Equipment (DME) and prescribed therapies.

Refer to Chapter 1000, Section 1009 - regarding reimbursement of nursing facility room and board.

906. Special Coverage Requirements

906.1 **Continuous Care** is a continuous home care day on which an individual who has elected to receive hospice care in his/her own home (including a nursing facility in which the individual resides) requires continuous "around the clock" nursing care. Continuous Home Care is to be provided only during a period of crisis and only as necessary to maintain the terminally ill patient at home. The crisis is managed by primarily providing nursing care to the patient to achieve palliation or management of acute medical symptoms.

<u>A nursing facility must immediately notify the hospice if clinical complications, i.e. acute medical symptoms, appear that suggest a need to alter the plan of care and must document notification to the hospice of the need for continuous care in the patient file.</u>

Rev. 01/12

Types of symptoms that might require continuous nursing care at home or while in the nursing facility may include uncontrolled:

- Severe pain
- Nausea and vomiting
- "Terminal restlessness" or agitation
- Bleeding
- Acute respiratory distress
- Frequent medication adjustment to control symptoms
- Symptom management/rapid deterioration/imminent death

Nursing care may be covered on a continuous basis for a maximum of 24 hours a day during periods of crisis to prevent hospitalization or inpatient hospice care. The 24-hour day begins and ends at midnight. A minimum of 8 hours of care per 24-hour day must be warranted to qualify for Continuous Care. The 8 hours of care need not be consecutive, i.e., 4 hours could be provided in the morning and another 4 hours provided in the evening of that day.

Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half or over 50% of the period of care each day. Homemaker and aide services may also be provided to supplement the nursing care for less than half of the period of care.

Continuous nursing care needs for the patient must be re-evaluated at the end of each qualified period of 8 to 24 hours. The qualified hours per month may total up to 72 hours within a maximum of 3 days per calendar month.

Rev. 10/11

During continuous home care, all progress notes must substantiate the nursing care and supplemental staff hours for all hours billed. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

Supporting documentation by all hospice staff is required to remain on patient file

906.2 **Respite Care** is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the hospice patient is residing in a nursing home on a permanent basis.

906.3 **Bereavement Counseling** consists of counseling services provided to the individual's family after the individual's death. Bereavement counseling is a required hospice service but it is not reimbursable.

907. Medicaid Waiver Programs and Hospice Services

An individual currently enrolled in a Medicaid waiver program that is diagnosed with a terminal illness may elect to enroll in the Hospice program. The member may continue to receive some waiver services that are determined by Medicaid as not duplicative of the hospice services. Because the member who is a waiver services recipient may only enroll in hospice *secondary* to the waiver enrollment (*i.e., a member who has elected hospice cannot enroll in a waiver enroll*), it is the responsibility of the hospice provider to ascertain if the member is enrolled or participates in another Medicaid program. Once other programs are identified, it is incumbent upon the hospice provider to coordinate the multiple plans of care and eliminate the duplication of Medicaid services. Once conducted, both the hospice and waiver providers must document coordination activities and retain such documentation and resulting coordinated plans of care in the member's medical record. Applicable waiver programs are:

- New Options Waiver (NOW)
- Comprehensive Supports Waiver (COMP)
- Independent Care Waiver Program (ICWP)
- Community Care Services Program (CCSP)

Rev. 10/13

- Georgia Pediatric Program (concurrent)

Rev. 10/15

- Service Options Using Resources in Community Environment (SOURCE)

The policy and procedure manual for each of the waiver programs listed above has a specified list of services that an individual can continue to receive if they elect the hospice program. Hospice agencies are encouraged to review these policies prior to enrolling an individual that is enrolled in a waiver program. Providers may use the website at www.mmis.georgia.gov to obtain a copy of the applicable waiver program policy and procedure manual.

The hospice agency continues to assume full responsibility for the professional management of the individual's hospice care in accordance with the hospice Conditions of Participation. When an individual enrolled in a waiver program elect's hospice:

A) The hospice agency, the member's waiver case manager and member **must** communicate, establish, and agree upon a coordinated plan of care for both providers that reflects the hospice philosophy and is based on an assessment of the individual's need and unique living situation.

The Hospice provider **must** coordinate care of the member enrolled in other Medicaid programs, i.e., Home and Community-Based Waivers and Nursing Facilities, as evidenced in the member's hospice plan of care (POC). Failure to demonstrate that multiple Medicaid plans of care have been coordinated will be considered a failure to comply with the terms of hospice policy. As such, lack of evidence of coordinated care in documentation will result in a terminated lock-in and any paid claims for hospice services will be subject to recoupment.

B) For pediatric patients scheduled to receive concurrent curative care, a coordinated POC **must** also reference dates of medical care to be administered to the member by supporting Hospitals and Outpatient Clinic services.

C) All hospice services must continue to be provided directly by hospice employees. The services cannot be delegated. When the member is in a waiver program residential facility, the hospice agency may involve the facility staff in assisting the administration of prescribed therapies that are included in the plan of care; this is only to the extent that the hospice would routinely utilize the service of the patient's family/caregiver in implementing the plan of care.

D) When the member is a resident in a waiver program's residential facility, the facility must continue to offer the same services to the individual that elects the hospice benefit. The hospice member should not experience any lack of facility services because of his/her status as a hospice member.

908. Medical Records

The hospice agency must establish and maintain a clinical record for everyone receiving care and services. The record must be complete, accurately documented, readily accessible, and organized to facilitate retrieval.

Each clinical record must be a comprehensive compilation of information regarding all services provided. Clinical notes shall be written for all services provided after each contact with the individual and must be signed and dated by the hospice discipline providing care. Written notes should include all information pertaining to the member. The record must include all services whether furnished directly or under arrangements made by the hospice agency. Everyone's record must contain at a minimum:

- Identification data;
- Initial and subsequent assessments;
- Plan of Care

- Consent, authorization, election, transfer, discharge and/or revocation forms;
- Pertinent medical and psychosocial history;
- Signed certifications of terminal illness;
- A diagnosis and prognosis, including supporting medical data for the terminal illness;
- Complete documentation of all services and events including evaluation, treatments, progress notes, etc.;
- Original written authorization for non-related hospice services in the form of the Hospice Referral Form for Non-Hospice Related Services and the documentation log of non-related services received; and
- Documentation of problems/needs identified by the individual or family member/caregiver.

The hospice agency must safeguard the individual's record against loss, destruction and unauthorized use and retain individual clinical records as original records in accordance with state licensure and HIPAA regulations.

Rev. 04/11

909. On-Site Reviews and Audits

To ensure compliance with the policies and procedures set forth in this manual, representatives of the Division will conduct on-site reviews and audits of hospice agencies enrolled with the Division. The reviews and audits will be conducted to determine whether services provided have been accurately and completely reported, whether all services reported have been performed and whether the services provided meet currently accepted standards of medical practice. All progress notes must substantiate the nursing care, including nursing facility notification regarding a resident's continuous care need, the plan of care revision during the continuous care need, skilled nursing care and supplemental staff hours for all hours billed. The on-site reviews will include but are not limited to in-agency reviews of clinical and billing records and in-home member assessments.

PART II - CHAPTER 1000
BASIS FOR REIMBURSEMENT

1001. Hospice Reimbursement – General

Rev. 07/13

The Affordable Care Act (ACA) requires physicians or other eligible providers to be enrolled in the GA Medicaid Program to order, prescribe and refer items or services for Medicaid beneficiaries. The National Provider Identifier (NPI) of the ordering, prescribing, or referring (OPR) provider should be noted on the GA Medicaid rendering provider's claim. **See Appendix M**.

Rev. 07/16

The Medicaid reimbursement is based on the status of the member's eligibility days and a hospice lock-in span. Effective, January 1, 2016, the Department implemented the Centers for Medicare and Medicaid, two (2) final Medicare hospice payment reform policies for the routine home care (RHC) and the service intensity add-on (SIA) rates:

Rev. 07/15

Rev. 10/16

1) The Medicare hospice final rule replaces the single RHC per diem rate with two different RHC payment rates, a higher payment rate for the first 60 days of hospice care, and a reduced payment rate for 61 days and over of hospice care. If a member has a break within the hospice period that is greater than 60 days, the hospice span starts over.

Rev. 01/12

Rev. 10/16

Rev. 08/17

2) The Service Intensity Add-on (SIA) payment is in addition to the per diem RHC rate when all the following criteria are met: The day is an RHC level of care day. The day occurs during the last 7 days of the patient's life, and the patient is discharged expired. Direct patient care is furnished by a registered nurse (RN) or social worker (SW) that day. The SIA payment will equal the Continuous Home Care (CHC) hourly payment rate, for a minimum of 15 minutes and up to 4 hours total per day. G-codes are used to identify the SW and RN versus LPN visits.

Updates have been made to the Georgia Medicaid Management Information System (GAMMIS) to accommodate the new reimbursement methodology. GAMMIS updates included creating custom pricing methods to handle the different hospice pricing periods for the RHC and the SIA. Providers' claims submitted on or after September 01, 2016, and are now processing with the 2016 methodology.

The following provides instruction on how to bill the Hospice Routine Home Care (RHC) and the Service Intensity Add-on (SIA) claims for members who have elected and receive Hospice care as of January 1, 2016. Effective for claims with a Date of Service (DOS) on or after 09/1/2016, providers should bill as indicated for the hospice pricing periods.

1) The RHC (Revenue Code 651) 'higher' rate, billed for *days 1 through 60* for members who have elected Hospice.

2) The second RHC (also Revenue code 651) 'lower' rate, billed from *day 61 until the date of death*.

3) The last rate is the SIA rate, which is the add-on rate, is billed d*uring the last seven days of life*. The SIA is billed on a separate claim. Successful adjudication of the SIA claim is dependent on the related paid RHC claim in GAMMIS history. The SIA Claim may cover up to the last seven days of life and include the Date of Death (DOD). The Hospice SIA claim's Header through Date of Service (TDOS) must equal the patient's date of death. The SIA payment will be equal to the Continuous Home Care (CHC) hourly payment rate. Billing is to be for a minimum of 15 minutes and maximum of 4 hours in each day per the RHC day. An SIA claim will deny if a claim for CHC for the same member/same day was paid, and vice versa.

    a. The SIA service must be billed on a separate claim, and not with any other Hospice Service billed.
    b. Only one SIA claim is allowed per member for all end-of-life SIAs during the last 7 days of life. Multiple SIA claims <u>are not allowed</u> for the same member.
    c. The SIA must have a distinct DOS, i.e., providers cannot bill multiple days on a single detail line. Multiple detail lines may be billed on a single claim.
    d. Only the Patient Discharge Status (PDS) 40, 41, or 42 may be used for SIA claims. PDS 20 will not be accepted for Hospice SIA claims with DOS on or after 9/1/2016.
    e. The Through Date of Services (TDOS) on an SIA claim must equal the member's DOD.
    f. The SIA Service is limited to 16 units (4 hours) per day.

- If the TDOS does not match the DOD on the member's file, the claim will deny.

- If there is no DOD on the member's file, the claim will suspend.

- The suspended claim will recycle in GAMMIS for 60 days for the Member file to update with the DOD.

- If the DOD is not loaded on the Member file within the 60 days, the SIA claim will deny.

- If the DOD is loaded on the Member file within the 60 days, the SIA claim will be released from suspending and continue processing for applicable editing or payment.

Effective for claims with a Date of Service (DOS) on or after 9/1/2016, when billing the following Hospice Revenue Codes, providers must select the most appropriate CPT code, and a valid CPT code must be present for the claim to adjudicate successfully. The new

hospice pricing periods are as described, below, and billed as indicated in the following Hospice Revenue Code Chart. 1) When billing for the Registered Nurse Service, the claim must be billed with Revenue Code 551, and Procedure Code/Modifier Combination G0299 RN, and Patient Status 40, 41, or 42.

2) When billing for the Social Worker Service, the claim must be billed with Revenue Code 561, and Procedure Code/Modifier Combination G0155 SW, and Patient Status 40, 41, or 42.

3) For Patient Discharge Status -- *Do Not Use Status Code 20* for Hospice SIA claims.

4) No other procedure codes should be included on a SIA claim.

Pricing Period	Rev Code	Modifier	Days	Rate
Routine Home Care	651 With Procedure Code described below	N/A	1-60	Higher
Routine Home Care	651 With Procedure Code described below	N/A	61-up	Lower
Service Intensity Add-On	551 with Procedure Code G0299	RN	Last 7 days of life (billed in 15-minute increments)	Add-on (if applicable)
Service Intensity Add-On	561 with Procedure Code G0155	SW	Last 7 days of life (billed in 15-minute increments)	Add-on (if applicable)

- When billing for revenue code 651, procedure codes (Q5001-Q5010) must be present.
- When billing for revenue code 652, procedure codes (Q5001-Q5003, Q5009-Q5010) must be present.
- When billing for revenue code 655, procedure codes (Q5003-Q5009) must be present.
- When billing for revenue code 656, procedure codes (Q5004-Q5009) must be present.

1002. Levels of Care

There are four levels of care into which each day of care is classified for reimbursement of the Medicaid Only member:

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care
- General Inpatient Care

For each day that an individual is under the care of a hospice, the hospice will be reimbursed an amount applicable to the type and intensity of the four (4) levels of care services furnished to the individual for that day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day. A description of each level of care follows:

1002.1 Routine Home Care

The hospice will be paid the routine home care rate for each day the patient is at home under the care of the hospice, including patients residing in a nursing home. The per diem rate is paid based on the hospice's Plan of Care for the patient rather than the volume or intensity of routine home care services on any given day.

1002.2 Continuous Home Care

The hospice will be paid the continuous home care rate when continuous home care is provided. Continuous home care is to be provided only during a period of crisis (see sections 905 and 906). The continuous home care rate is divided by 24 hours to yield an hourly rate and each hour billed is billed as one unit. The 24-hour day begins and ends at midnight. A minimum of 8 hours of care must be provided to qualify for continuous home care rates. This care need not be consecutive, i.e., ***4 hours*** could be provided in the morning and another ***4 hours*** provided in the evening of that day; however, same date of service combined units ***(8)*** must be billed on one detail line. Three (3) 8-24-hour days are allowed per calendar month. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to a maximum of 24 hours and only as necessary to maintain the terminally ill patient at home. The hospice payment on a continuous care day varies depending on the number of hours (units) of continuous services provided.

1002.3 Inpatient Respite Care

The hospice will be paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving

respite care. Payment for respite care may be made for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

1002.4 General Inpatient Care

Payment at the inpatient rate will be made when general inpatient care is provided for services related to the terminal illness. (See Section 903.5.) None of the other fixed payment rates (i.e., routine home care) will be applicable for a day on which the patient receives hospice inpatient care except as described in Section 1002.5.

Rev. 10/11

NOTE:
Inpatient Care (General or Respite) and Nursing Home Room and Board cannot be reimbursed for the same member for the same covered days of service.

1002.5 Date of Discharge

For the day of discharge, the appropriate home care rate is to be paid for the day of discharge from an inpatient unit unless the patient dies as an inpatient. If the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

Rev. 01/20
Rev. 10/20

1003. Hospice Payment Rates

Hospice payment rates are made in accordance with CMS guidelines and at rates published in the Federal Register each year. Rates will be in effect October 1 of that year through September 30 of the following year.

Routine Home Care Rate (1-60) Revenue Code 651 $**199.51** (1 unit = 1 day)
Routine Home Care Rates (61+) Revenue Code 651 $157.69
Routine Home Care (SIA Hourly) Revenue Code S551 & S561 $59.71
Continuous Home Care Rate- Revenue Code 652 $**1,432.97** (Full Rate 24hrs) Continuous
Home Care Rate- (1 unit = 1 hour) $**59.71 (**Hourly Rate)
Inpatient Respite Care Rate- Revenue Code 655 $**179.97** (1 unit = 1 day)
General Inpatient Care Rate- Revenue Code 656 $**1,045.66 (**1 unit = 1 day)

These rates are in effect for services provided on or after October 1, 2020.

1004. Local Adjustment of Payment Rates

The payment rates above are adjusted for regional differences in wages, using indices published in Appendixes A and B. To select the proper index for a

hospice, determine if the hospice is in one of the Urban Areas listed in Appendix A. If so, use the wage index for that specific urban area. If a hospice is not located in one of the Urban Areas in Appendix A, use the wage index for rural areas of Georgia. If the wage index is less than 0.8, use 0.8. Once the index has been determined, the computation of the rates for a hospice can be made using the data in Appendix B.

Appendix B indicates the portion of each of the rates subject to the wage index.

For dates of service on and after April 1, 2003:

The payment rates for routine home care and continuous home care above are adjusted for regional differences in wages, using indices published in Appendixes A and B. To select the proper index for a member, determine if the geographic location in which the services were furnished is in one of the Urban Areas listed in Appendix A. If so, use the wage index for that specific urban area. If the services were not furnished in one of the Urban Areas in Appendix A, use the wage index for rural areas of Georgia. If the wage index is less than 0.8, use 0.8. Once the index has been determined, the computation of the rates for a hospice can be made using the data in Appendix B.

Appendix B indicates the portion of each of the rates subject to the wage index.

1005. Limitation on Payments for Inpatient Care

Payments to a hospice for inpatient care must be limited according to the number of days or inpatient care furnished to Medicaid patients. During the 12-month period-beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid members during that same period. Effective with services on and after July 1, 1988, this calculation will exclude days for AIDS patients. This limitation is applied once each year, at the end of the hospice's "cap period" (11/1-10/31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. Calculate the limitation as follows:

A) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.20.

B) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

C) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1) calculating a ratio of the maximum allowable inpatient care days to total number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) paid to the provider.

2) multiplying excess inpatient care days by the routine home care rate.

3) adding together the amounts calculated in 1. and 2. above.

4) comparing the amount in 3. above with interim payments made to the hospice for inpatient care during the "cap period".

Any excess reimbursement must be refunded by the hospice to the Division.

1005.1 National Correct Coding Initiative and Medically Unlikely Edits

On October 1, 2010, the Centers for Medicare and Medicaid services (CMS) directed all state Medicaid agencies to implement the National Correct Coding Initiative (NCCI) as policy in support of Section 6507 of the Affordable Care Act of March 23, 2010. NCCI was implemented to promote correct coding methodologies and to control improper coding leading to inappropriate payment.
A part of the NCCI regulations required State Medicaid Agencies to implement Medically Unlikely Edits (MUEs) and units-of-service (UOS) edits. The NCCI /MUEs limit the frequency (number of units) billed for individual procedure codes. Procedure codes submitted with frequencies greater than their MUE or UOS will be mass adjusted, but not paid. Likewise, claims also may not pay for specific services. DCH is willing and has at times requested deactivation of edits to allow claims to adjudicate. However, the permission to deactivate certain edits must come from CMS. Information on new requirements from CMS will be posted on their website.

For additional information on NCCI edits and review sample procedure to procedure (PTP) ode sets, refer to the following CMS website: http://www.cms.gov/MedicaidNCCICoding/ .

1006. Payment for Physician Services

The Division will pay the hospice in accordance with the usual Medicaid reimbursement for physician services (such as direct patient care services) when these services are provided by hospice employees or physicians under agreement with the hospice. This reimbursement is in addition to the per diem rate. Reimbursement for physician services

is included in the amount subject to the hospice payment cap described in Section 1007. Services furnished voluntarily by physicians are not reimbursable.

Consultant specialty services, when necessary for the palliative care and management of the terminal illness (e.g., radiation for pain relief), are covered separately and are reimbursed only to the elected hospice. Services of the patient's attending physician, if he or she is not an employee of the hospice or providing services under arrangements with the hospice, are not considered covered hospice services and are not included in the amount subject to the hospice cap. These services are paid directly to the provider physician. **Reimbursement is provided for enrolled nurse practitioner services, except for certifying the terminal illness with a prognosis of 6 months or less,** to Medicaid member who have elected the hospice benefit and have selected a nurse practitioner as the attending physician. The hospice must notify the Division of the name of the physician who has been designated as the attending physician by the member.

1007. Caps on Overall Reimbursement

The Division will limit overall aggregate payments made to a hospice during a hospice cap period. The cap period runs from November 1 of each year through October 31 of the next year. The total payments made for services furnished to Medicaid beneficiaries during this period will be compared to the "cap amount" for this period. Any payments more than the cap must be refunded by the hospice. "Total payment made for services furnished to Medicaid beneficiaries during this period" refers to payment for services rendered during the cap year beginning November 1 and ending October 31, regardless of when payment is made. Payments are measured in terms of all payments made to hospices on behalf of all Medicaid hospice beneficiaries receiving services during the cap year, regardless of which year the beneficiary is counted in determining the cap.

For example, payments made to a hospice for an individual electing hospice care on October 5, 1989, would be counted as payments made during the first cap year (November 1, 1988 - October 31, 1989), even though that individual would not be counted in the calculation of the cap for that year. (The individual would, however, be counted in the cap calculation for the following year since the election occurred after September 27, see below).

The hospice cap is to be calculated in a different manner for new hospices entering the program if the hospice has not participated in the program for an entire cap year. In this situation, the initial cap calculations for newly certified hospices cover a period of at least 12 months but not more than 23 months. For example, the first cap period for a hospice entering the program on July 1, 1988, would run from July 1, 1988 through October 31, 1989. Similarly, the first cap period for hospice providers entering the program after November 1, 1988, but before November 1, 1989, would end October 31, 1990.

The "cap amount" is calculated by multiplying the number of beneficiaries electing hospice care during the period by a statutory amount of $6,500. This amount will be adjusted in future years as outlined in Section 1003.

The computation and application of the "cap amount" is made by the Division at the end of the cap period. The material is presented here for the benefit of the hospice as an aid of planning. The hospice will be responsible for reporting the number of Medicaid members electing hospice care during the period to the Division. This must be done within 30 days after the end of the cap period.

The following rules must be adhered to by the hospice in determining the number of Medicaid members who have elected hospice care during the period:

- The member must not have been counted previously in either another hospice's cap or another reporting year.

- Those Medicaid beneficiaries who have not previously been included in the calculation of any hospice cap and who has filed an election to receive hospice care from the hospice. Those beneficiaries must file an initial election during the period beginning September 28 (34 days before the beginning of the cap period) and ending on September 27 (35 days before the end of the cap period).

  Once a member has been included in the calculation of a hospice cap amount he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the member was included. (This could occur when the member has breaks between periods of election).

  When a member elects to receive hospice benefits from two or more different Medicaid certified hospices, proportional application of the cap amount will be necessary. A calculation will be made by the Division to determine the percentage of the member's length of stay in each hospice relative to the total length of hospice stay.

  EXAMPLE:

  John Doe, a Medicaid member, initially elects hospice care from Hospice A on May 2, 1989. Mr. Doe stays in Hospice A until June 2, 1989 (30 days) at which time he changes his election and enters Hospice B. Mr. Doe stays in Hospice B for 70 days until his death on December 11, 1989. The State determines that the total length of hospice stay for Mr. Doe is 100 days (30 days in Hospice A and 70 days in Hospice B). Since Mr. Doe was in Hospice A for 30 days, Hospice A should count .3 of a Medicaid member for Mr. Doe in its hospice cap calculation (30 day -- 100 days). Hospice B should count .7 of a Medicaid member in its cap calculation (70 days -- 100 days). Readjustment of the hospice cap may be required if information previously unavailable to the State at the time the hospice cap is applied subsequently becomes available.

  EXAMPLE:

Using the example above, if the State had calculated and applied the hospice cap on October 31, 1989 information would not have been available at that time to adjust the number of members reported by Hospice A, since Mr. Doe did not die until December 11, 1989. The State would recalculate and reapply the hospice cap to Hospice A based on the information it later received. The cap for Hospice A after recalculation would then reflect the proper beneficiary count .3 for Mr. Doe. The cap for Hospice B would reflect the proper member count of .7 for Mr. Doe. An additional step is required when more than one Medicaid certified hospice provides care to the same individual, and the care overlaps 2 cap years. In this case, the State must determine in which cap year the fraction of a member should be reported. If the member entered the hospice before September 28, the fractional member would be included in the current cap year. If the member entered the hospice after September 27, the fractional member would be included in the following cap year.

EXAMPLE:

Continuing with the case cited in the examples above, Hospice A would include .3 of a Medicaid member in its cap calculation for the cap year beginning November 1, 1988, and ending October 31, 1989, since Mr. Doe entered Hospice A before September 28, 1989. Hospice B would include .7 of a Medicaid member in its cap calculation for the cap year beginning November 1, 1989, and ending October 31, 1990, since Mr. Doe entered Hospice B. after September 27, 1989.

When services are rendered by two different hospices to a Medicaid member, and one of the hospices is not certified by Medicaid, no proportional application is necessary. One member will be counted and the total cap for the certified hospice will be used.

1008. Adjustments to Cap Amount

The original cap amount of $6,500 per year is to increase or decrease for accounting years that end after October 1, 1984. Index numbers will be published in the Federal Register annually and the original cap amount of $6,500 will be adjusted each year, as appropriate.

In those situations, where a hospice begins participation in Medicaid at any time other than the beginning of a cap year (November 1st), and hence has an initial cap calculation for a period more than 12 months, a weighted average cap amount will be used. The following example illustrates how this could be accomplished.

EXAMPLE:

7/1/88 - Hospice A is Medicaid Certified.
7/1/88 to 10/31/89 - First cap period (16 months) for Hospice A.
Statutory cap for first cap year (11/1/87 - 10/31/88) = $6,500*
Statutory cap for second cap year (11/1/88 - 10/31/89) = $6,884

Weighted average cap calculation for Hospice A:
Four months (7/1/88 - 10/31/89) at $6,500 = $26,000
12 months (11/1/88 - 10/31/89) at $6,884 = $82,608
16 months period $108,608 divided by 16 = $6,788
(rounded)
In this example, $6,788 would be the weighted average cap amount to be used in the initial cap calculation for Hospice A for the period July 1, 1988 through October 31, 1989.

NOTE:
If Hospice A had been certified in mid-month, a weighted average cap amount based on the number of <u>days</u> falling within each cap period would be used.

** Amount used for purposes of example only.*

1009. Additional Amount for Medicaid Only Nursing Facility Residents

The Division will reimburse the hospice an additional per diem rate for routine home care and continuous home care days of service that are furnished to an individual living in a nursing facility. This rate is designed to cover "room and board" which includes performance of personal care services, including assistance in the activities of daily living, administration of medication, maintaining the cleanliness of the member's environment, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

These additional payments are not subject to the cap on overall reimbursement.

Effective with services rendered on and after April 1, 1990, the rate of reimbursement is 95% of the per diem that would have been paid to the nursing facility for that individual in that facility under the State plan. This rate is in addition to the routine home rate or the continuous home care rate. The additional room and board rate must be billed on the UB04 claim form using revenue code 659.

Rev. 01/12

Hospice agencies should not admit members into a nursing facility that have been issued a denial of payment for nursing facility admissions (DPNA) letter from the Department of Community Health (DCH). Claims submitted for room and board for those members admitted to the nursing facility after the date of the DPNA payment will be denied.

This does not apply to members that were residents in a nursing facility prior to the DPNA who elect hospice.

Rev. 04/07

<u>Residential Hospice Facility Residents</u>

The Division will not reimburse Room and Board for patients residing in Residential Hospice Facilities.

Rev. 07/13

NOTE:
General Inpatient Care and Nursing Home Room and Board cannot be reimbursed for the same member on the same covered days of service.

Nursing Home Room and Board cannot be reimbursed for the member on the day of discharge or death.

1010. Patient Liability

Rev. 01/12

Individuals that have elected Medicaid hospice care and reside in a nursing facility are required to share in the cost of their services. The amount that everyone is required to pay is called the ***patient liability amount***. The patient liability amount is based on the individual's income. The local county **Division of Family and Children Services** (DFCS) where the individual resides will determine the patient liability amount when the individual submits an application for Medicaid eligibility and at any time that the individual has his/her Medicaid eligibility re-determined. The hospice agency must submit a copy of the HCC to the local DFCS office to notify them that the patient has elected hospice services. If the individual is assessed a patient liability amount, DFCS will notify the hospice agency by returning to them the HCC Form that will include the amount and the effective date of the patient liability. The individual and /or the family will also be advised of the patient liability amount and will receive written notification from the DFCS office. The **hospice agency** is responsible for collecting the patient liability from the individual and applying it to the cost of the hospice patient's nursing facility services. The hospice's Medicaid reimbursement amount for everyone residing in a nursing facility and enrolled in the Medicaid Hospice program will be reduced by the patient liability amount.

The nursing facility **is not** responsible for collecting patient liability and the individual is not responsible for paying patient liability outside of a nursing facility residence.

Rev. 04/19

Providers should complete the form 501 for patient liability adjustments on untimely claims. All patient liability adjustments/updates made by DFCS must have support from the DFCS Summary Notification, and this information must be sent to Gainwell Technologies. There should be no adjustments made in GAMMIS of a paid claim that is past timely as these funds are subject to denial and recoupment. Rather, complete the form 501 and send to Gainwell Technologies to request the adjustment. If there is a change to a patient liability amount after a provider's claim has already adjudicated, it will be at the provider's discretion to adjust the claim to capture the new patient liability amount.

1010.01. Hospice agencies have the authority to initiate legal action against any hospice member or their responsible family member that refuses to pay the hospice agency the patient liability amount. In addition, the provider can discharge a member that refuses payment. However, the following procedures must be followed:

A) The hospice agency must have written procedures that advise members of their payment guidelines and of the penalties for non-payment.

B) The hospice agency must provide the member and the member's physician a written notice no less than thirty (30) calendar days in advance of a planned discharge if a decision is made to discharge the member for refusal to pay. The written notice must provide the member with the reason for discharge, the effective date of the discharge, and notice of the right to a hearing pursuant to the Georgia Administrative Procedure Act and Section 15 of the Long-term Care Facilities: Resident's Bill of Rights and of the right to representation by legal counsel. If the member so desires, the facility shall also send a copy of the notice to the community ombudsman, or state ombudsman if there is not community ombudsman.

Rev. 01/20
Rev. 10/20

APPENDIX A

REGIONAL WAGE INDEXES AND COUNTIES

The hospice cap amount for Federal Fiscal Year 2020 is $30,683.93

(Out of State Providers are Italicized and in Red)

EFFECTIVE: OCTOBER 1, 2020

CBSA NAME FY 2021	Index	Region	Counties								
ALBANY,GA	0.8206	1	Dougherty	Lee	Terrell	Worth					
ATHENS,CLARK COUNTY,GA	0.8714	2	Clarke	Madison	Oconee	Oglethorpe					
ATLANTA,-SANDY SPRINGS,ALPHARETTA,GA	0.9463	3	Barrow	Bartow	Carroll	Cherokee	Clayton	Cobb	Coweta	DeKalb	Douglas
			Fayette	Forsyth	Fulton	Gwinnett	Henry	Newton	Paulding	Pickens	Rockdale
			Spalding	Walton	Butts	Dawson	Haralson	Heard	Jasper	Lamar	Meriwether
			Pike	Morgan							
AUGUSTA RICHMOND COUNTY GA-SC	0.8653	4	Burke	Columbia	Lincoln	McDuffie	Richmond	*Aiken*	*Edgefield*		
MACON, GA	0.9136	5	Bibb	Crawford	Jones	Monroe	Twiggs				
SAVANNAH, GA	0.8000	6	Bryan	Chatham	Effingham						
COLUMBUS,GA-AL	0.8000	7	Chattahoochee	Harris	Marion	Muscogee	*Russell*				
GEORGIA - RURAL	0.8000	8	Appling	Atkinson	Bacon	Baldwin	Banks	Ben Hill	Berrien	Bleckley	Bulloch
			Calhoun	Camden	Candler	Charlton	Chattooga	Clay	Clinch	Coffee	Colquit
			Cook	Crisp	Decatur	Dodge	Dooly	Early	Elbert	Emanuel	Evans
			Fannin	Franklin	Gilmer	Glascock	Gordon	Grady	Greene	Habersham	Hancock
			Hart	Irwin	Jackson	Jeff Davis	Jefferson	Jenkins	Johnson	Laurens	Baker
			Lumpkin	Macon	Miller	Mitchell	Montgomery	Pierce	Polk	Pulaski	Putnam
			Quitman	Rabun	Randolph	Schley	Screven	Seminole	Stephens	Sumter	Taliaferro
			Tattnall	Taylor	Telfair	Upson	Thomas	Tift	Toombs	Towns	Treutlen
			Troup	Turner	Union	Wilkinson	Warren	Washington	Wayne	Webster	Wheeler
			White	Wilcox	Wilkes	Ware					
CHATTANOOGA, TN	0.8365	9	Catoosa	Dade	*Hamilton*	*Marion*	Walker	*Sequatchie*			
DOTHAN, AL	0.7819	10	*Houston*	*Geneva*	*Henry*						
GREENVILLE, - ANDERSON, SC	0.8986	11	*Anderson*	Greenville	Laurens	Pickens					
ALABAMA - RURAL	0.7733	12									
GAINESVILLE, - HALL, GA	0.9183	20	Hall								
VALDOSTA GA	0.8000	21	Brooks	Echols	Lanier	Lowndes					
BRUNSWICK, GA	0.8000	25	Brantley	Glynn	McIntosh						
DALTON, GA	0.8847	26	Murray	Whitfield							
SOUTH CAROLINA - RURAL	0.8133	28									
HINESVILLE, GA	0.8527	31	Liberty	Long							
WARNER ROBINS, GA	0.8000	32	Houston	Peach							
ROME, GA	0.8812	34	Floyd								

*** PLEASE SEE ADDITIONAL INFORMATION IN APPENDIX G, PAGE 4. ***

HOSPICE RATES FFY 21

Effective 10-1-2020

REGIONS	CBSA NAME FY 2021	INDEX	CBSA	Routine Home Care (Days 1-60) Revenue Code 651	Routine Home Care (Days 61+) Revenue Code 651	Routine Home Care (SIA Hourly) Revenue Code 651	Routine Home Care (SIA Quarter Hour) Revenue Code 651	Continuous Care (Hourly) Revenue Code 652	Inpatient Respite Care Revenue Code 655	General Inpatient Care Revenue Code 656
1	ALBANY, GA	0.8206	10500	174.92	138.25	52.35	13.09	52.35	438.23	925.58
2	ATHENS-CLARK COUNTY, GA	0.8714	12020	181.88	143.76	54.43	13.61	54.43	451.57	959.58
3	ATLANTA-SANDY SPRINGS-ALPHARETTA, GA	0.9463	12060	192.15	151.87	57.50	14.38	57.50	471.25	1009.72
4	AUGUSTA-RICHMOND COUNTY GA-SC	0.8653	12260	181.05	143.10	54.18	13.55	54.18	449.97	955.50
5	MACON-BIBB COUNTY, GA	0.9136	31420	187.67	148.33	56.16	14.04	56.16	462.66	987.83
6	SAVANNAH, GA	0.8000	42340	172.09	136.02	51.50	12.88	51.50	432.82	911.79
7	COLUMBUS, GA-AL	0.8000	17980	172.09	136.02	51.50	12.88	51.50	432.82	911.79
8	GA RURAL AREA	0.8000	99911	172.09	136.02	51.50	12.88	51.50	432.82	911.79
9	CHATTANOOGA, TN-GA	0.8365	16860	177.10	139.97	53.00	13.25	53.00	442.41	936.22
10	DOTHAN, AL	0.7819	20020	169.61	134.06	50.76	12.69	50.76	428.06	899.68
11	GREENVILLE-ANDERSON, SC	0.8986	24860	185.61	146.70	55.55	13.89	55.55	458.72	977.79
12	AL RURAL AREA	0.7733	99901	168.43	133.13	50.41	12.60	50.41	425.80	893.92
20	GAINESVILLE, GA	0.9183	23580	188.31	148.84	56.36	14.09	56.36	463.90	990.98
21	VALDOSTA, GA	0.8000	46660	172.09	136.02	51.50	12.88	51.50	432.82	911.79
25	BRUNSWICK, BANTLEY, GLYNN, MCINTOSH, GA	0.8000	15260	172.09	136.02	51.50	12.88	51.50	432.82	911.79
26	DALTON, MURRAY, WHITFIELD, GA	0.8847	19149	183.70	145.20	54.98	13.74	54.98	455.07	968.49
28	SOUTH CAROLINA, RURAL AREA	0.8133	50015	173.92	137.46	52.05	13.01	52.05	436.31	920.70
31	HINESVILLE, LIBERTY, LONG, GA	0.8527	25980	179.32	141.73	53.66	13.42	53.66	446.66	947.07
32	WARNER ROBINS, HOUSTON, PEACH, GA	0.8000	47580	172.09	136.02	51.50	12.88	51.50	432.82	911.79
34	ROME, GA	0.8812	40660	183.22	144.82	54.83	13.71	54.83	454.15	966.14

Applicable to last 7 days of life up to 4 hours per day (minimum 15 minutes)

APPENDIX B

Rev.
01/15
01/14
01/13
04/19

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Rev. 04/19

Georgia Department of Community Health
Non-Institutional Reimbursement Unit
2 Peachtree Street NW 39th Floor
Atlanta, Georgia 30303

APPENDIX B
HOSPICE CAP RATE DATA REQUEST FORM

HOSPICE FACILITY: **FREESTANDING** _____ **HOSPITAL BASED** _____

Medicaid Provider Name: _____

Medicaid Provider ID: _____
Street address: _____

City: _____ State: _____ Zip Code: _____

COUNTY: _____

COST REPORTING FY: FROM: _____ TO: _____

CAP RATE REPORTING PERIOD: _____ TO: _____

Enter information from agency's records for CAP reporting period November through October

	Medicaid XIX Beneficiaries	Medicaid XIX Days	Medicaid XIX Medicaid Payments
CONTINUOUS HOME CARE **(Unduplicated Days, Beneficiaries & Medicaid Payments)**			
ROUTINE HOME CARE **(Unduplicated Days, Beneficiaries & Medicaid Payments)**			
INPATIENT RESPITE CARE **(Unduplicated Days, Beneficiaries & Medicaid Payments)**			
GENERAL INPATIENT CARE **(Unduplicated Days, Beneficiaries & Medicaid Payments)**			
ENROLLED AIDS PATIENTS **(Unduplicated Days, Beneficiaries & Medicaid Payments)**			
TOTALS			

How many Medicaid members transferred in from another hospice facility? _____

How many Medicaid members transferred out to another hospice facility? _____

Officer or Administrator of Agency: (Print) _____

Title: _____

Signature: _____

Contact Phone Number: _____

For assistance please contact Burton Miller at (404) 651-7895 or Robin Glenn (404) 656-4546 or email DCH_NIR@dch.ga.gov
Information is requested pursuant to Part II Policies and Procedures for Hospice Services Sections 1005 and 1007

APPENDIX C

MEDICAID HOSPICE ELECTION, PHYSICIAN, CERTIFICATION, REVOCATION, DISCHARGE, TRANSFER, AND HOSPICE CARE COMMUNICATOR FORMS

The Division will make reimbursement to hospice providers only when the hospice individual is determined to be terminally ill as described in Section 704 of this manual. The provider may view a copy of the "Medicaid Hospice Election Form (DMA 579)" on page C-2 of this Appendix. This form must be completed, and a copy received by the Division within thirty (30) calendar days of the individual's signature.

The provider may view a copy of the Medicaid Hospice Physician Certification Form (DMA 522)", Pages C-3,4 "Medicaid Hospice Revocation Form (DMA523)", C-5, "Medicaid Hospice Discharge Form (DMA 524)", C-6 and "Medicaid Hospice Transfer Form (DMA 525),", C-7 on pages of this appendix. The forms must be completed accurately and a copy received by the Division within thirty (30) calendar days of the appropriate signature(s).

The provider must complete and submit the "Hospice Referral Form (DMA 521)", if the patient receives non-hospice related services. You may view instructions for completion of the form on page C-8.

The provider may view a copy of the "Hospice Care Communicator Form (DMA 527)", C-11 and "Hospice Care Communicator Form (Status Change) (DMA 528)", C-12, of this appendix. These forms are included for the convenience of the hospice agency in communicating with the local DFCS office. The forms must be completed accurately and a copy received by the Division within thirty (30) calendar days of the appropriate signature(s). All non-hospice providers should refer to their Billing manual for complete instructions.

All indicated hospice forms can be printed or photocopied from this manual. Please refer to Section 709 regarding the procedure and mailing address for the submission of hospice forms.

PLEASE NOTE: THE PROVIDER MUST NOT ALTER FORMS, WHICH ARE OFFICIAL MEDICAID HOSPICE FORMS.

Rev.
10/13
01/14
07/15
01/16

MEDICAID HOSPICE ELECTION FORM

MEMBER INFORMATION

Name	**Address**
Medicaid Number	
Social Security Number	**Date of Birth**

HOSPICE INFORMATION

Hospice Name	**Address**
Provider Number	**Telephone Number**

Effective Date for Hospice Care _____ **ICD Code of Primary Diagnosis**_____

Primary Diagnosis_____ **Date of Onset** _____

ATTENDING PHYSICIAN INFORMATION

Attending Physician Name	**Attending Physician Medicaid or NPI Number**

Date Last Seen MM/DD/YY

ELECTION STATEMENT

- **I understand that my physician has certified me as being terminally ill with a medical prognosis of six (6) months or less, if the disease runs its normal course.**
- **The Georgia Medicaid Hospice Services Program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of this program and the terms of the election statement.**
- **(Adults over age 21 only) I understand that by signing the election statement I am waiving all rights to regular Medicaid services except for payment to my attending physician, treatment for medical conditions unrelated to my terminal illness, medical transportation, dental services and Medicaid pharmacy services for prescriptions not covered under hospice.**
- **I understand that I will be entitled to Medicaid sponsored hospice services if I am Medicaid eligible and physician certified as required for each benefit period. These services are provided in benefit periods for an initial ninety (90) day period, a subsequent ninety (90) day period and for each subsequent sixty (60) day period.**
- **I understand that I may revoke the hospice benefit at any time by completing the appropriate form, specifying the date when the revocation is to be effective and submitting the statement to the hospice prior to that date; however, that if I choose to revoke hospice services during a benefit period, I am not entitled to coverage for the remaining days of that benefit period. At the same time, I revoke hospice services, I understand my rights to other Medicaid services will resume, provided I continue to be Medicaid eligible.**
- **I understand that I may change the designated hospice provider, one time during a benefit period, without affecting the provision of my hospice benefits. To change the designation of hospice providers, I must dis-enroll with the hospice from which care has been received and elect a new hospice provider.**
- **I understand that if I am a Medicare beneficiary, I must elect to use the Medicare Hospice Benefit.**
- **I understand that if I elected the Medicare Hospice Benefit and am eligible for Medicaid, I must also elect the Medicaid Hospice Benefit.**

- **My choice for my attending physician is: _____**

Signatures:

Member or Representative Signature, Relationship of Representative	**Date**
Hospice Representative	**Date**

Nursing Facility (if applicable)

I understand that this individual's election of the hospice benefit and waiver of Medicaid reimbursement for nursing facility services for the duration of election under the hospice program. Medicaid reimburses the hospice provider for nursing facility room and board when the individual resides in the nursing facility and the hospice reimburses the nursing facility for room and board charges.

NURSING FACILITY REPRESENTATIVE SIGNATURE **DATE**

DMA-579 (Revised 10/13)

GEORGIA MEDICAID HOSPICE PHYSICIAN CERTIFICATION FORM

MEMBER INFORMATION

Name _____ **Address** _____

Medicaid Number _____ _____

Social Security Number _____ **Date of Birth** _____

Primary Diagnosis/ICD Code: _____ **Date of Onset :** _____

CERTIFICATIONS MUST BE DOCUMENTED BY THE ATTENDING PHYSICIAN OR THE HOSPICE AGENCY MEDICAL DIRECTOR OR PHYSICIAN

THE FULL NAME SIGNATURE AND THE DATE OF EACH CERTIFICATION IS REQUIRED ON THIS FORM

PHYSICIANS MUST DOCUMENT EACH CERTIFICATION AND FACE TO FACE ENCOUNTER STATEMENT

First Benefit Period (90 days): Certification #1 for FDOS- _____ **TDOS-** _____

_____ _____

Signature of Member's Attending Physician/ Licensure number **Signature of Hospice Medical / Licensure number**

_____ _____

Date **Date**

Second Benefit Period (90 days): Certification #2 for FDOS- _____ **TDOS** _____

_____ _____

Signature of Member's Attending Physician/ Licensure number **Signature of Hospice Medical / Licensure number**

_____ _____

Date **Date**

SUBSEQUENT Benefit Period (60 days)/ Face to Face Certification Required #3: FDOS _____ **TDOS** _____

Statement of Face-Face Encounter required:

_____ _____

Signature of Physician **Date**

DMA-522A Revised 07/15

SUBSEQUENT CERTIFICATIONS BY THE ALLOWED PHYSICIAN

[PHYSICIANS MUST SIGN FULL NAME AND DATE CERTIFICATION FORM]

SUBSEQUENT Benefit Period (60 days)/ Face to Face Certification Required, #: FDOS TDOS
Statement of Face-Face Encounter required:

_____ _____
Signature of allowed Hospice Physician **Date**

SUBSEQUENT Benefit Period (60 days)/ Face to Face Certification Required, #: FDOS TDOS
Statement of Face-Face Encounter required:

_____ _____
Signature of allowed Hospice Physician **Date**

SUBSEQUENT Benefit Period (60 days)/ Face to Face Certification Required, #: FDOS TDOS
Statement of Face-Face Encounter required:

_____ _____
Signature of allowed Hospice Physician **Date**

SUBSEQUENT Benefit Period (60 days)/ Face to Face Certification Required, #: FDOS TDOS
Statement of Face-Face Encounter required:

_____ _____
Signature of allowed Hospice Physician **Date**

SUBSEQUENT Benefit Period (60 days)/ Face to Face Certification Required, #: FDOS TDOS
Statement of Face-Face Encounter required:

_____ _____
Signature of allowed Hospice Physician **Date**

DMA-522B (Revised 07/15)

GEORGIA MEDICAID HOSPICE REVOCATION FORM

MEMBER INFORMATION

Name _____

Medicaid Number _____

Date of Birth _____

Social Security Number _____

Effective Date _____

PROVIDER INFORMATION

Hospice Name _____

Telephone Number _____

Medicaid Provider Number _____

Revocation Statement:

- **I desire to voluntarily revoke the election of hospice care.**
- **The Georgia Medicaid Hospice Services Program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of the program and the terms of the revocation of these services.**
- **I understand that by signing the revocation statement that, if eligible and applicable, I will resume Medicaid coverage of benefits waived when hospice care was elected.**
- **I understand I will forfeit all hospice coverage days remaining in this benefit period.**
- **I understand that I may at any time elect to receive hospice coverage for any other hospice benefit period for which I am eligible.**
- **I, therefore, revoke the hospice benefit because_____**
  _____
  _____
  _____

Hospice Representative Signature _____

Member or Representative Signature _____
Representative's Relationship

Date _____

Date _____

DMA-523 (Revised 10/13)

MEDICAID HOSPICE DISCHARGE FORM

MEMBER INFORMATION

_____ _____

Name **Address**

_____ _____

Medicaid Number

_____ _____

Social Security Number

PROVIDER INFORMATION

_____ _____

Hospice Name **Address**

_____ _____

Provider Number

_____

Telephone Number

DISCHARGE STATEMENT

Hospice benefits for the above identified individual, enrolled with this agency, has been discharged from hospice services effective _____ for the following reason(s): (check all that apply)

Date

_____ Prognosis is now more than six (6) months.
_____ Individual has moved out of state/hospice service area.
_____ Safety of individual or hospice staff is compromised. (Explanation must appear below)
_____ Death of the individual.

Explanation:

_____

_____

_____

_____ _____

Hospice Representative Signature **Date**

STATEMENT OF UNDERSTANDING

I understand I am to be discharged from hospice services effective the date above. I have been given the opportunity to discuss the services, benefits, requirements and limitations of the program and the terms of the discharge from this service. I understand any Medicaid coverage of benefits waived when hospice care was elected will resume. I understand that I may at any time elect to receive hospice coverage for any other hospice benefit period for which I am eligible.

_____ _____

Member or Representative Signature/ Relationship **Date**

DMA- 524

MEDICAID HOSPICE TRANSFER FORM

END DATE: _____

APPLICABLE BENEFIT PERIOD:
[] First 90 Days
[] Second 90 Days
[] () Period of 60 Days

MEMBER INFORMATION

_____ **Name**

_____ **Address**

_____ **Medicaid Number**

_____ **Social Security Number**

_____ **Date of Birth**

SENDING PROVIDER INFORMATION

_____ **Hospice Name**

_____ **Address**

_____ **Provider Number**

_____ **Telephone Number**

_____ **Signature of Hospice Representative**

_____ **Date**

The sending hospice must complete the above section and forward to the receiving hospice within five (5) business days of the effective date.

RECEIVING PROVIDER INFORMATION

START DATE: _____

The above named individual requests that the designation of their selected hospice be changed to:

_____ **Hospice Name**

_____ **Address**

_____ **Provider Number**

_____ **Telephone Number**

_____ **Signature of Hospice Representative**

_____ **Date**

The receiving provider must forward a completed copy to the Department of Community Health, Division of Medical Assistance. This form must be received by the Department of Community Health, Division of Medical Assistance within thirty (30) days from the effective date of transfer.

Signatures:

As a member of hospice services, I understand that I may change hospice providers only **once** during each hospice benefit period. I also understand that this request for a change of hospice provider is not a revocation of the remainder of my current election period.

_____ **Member or Representative Signature/Relationship**

_____ **Date**

_____ **WITNESS SIGNATURE**

_____ **DATE**

DMA-525

HOSPICE REFERRAL FORM FOR NON-HOSPICE RELATED SERVICES (DMA-521) INSTRUCTIONS

This referral form <u>MUST BE ATTACHED TO THE APPROPRIATE CLAIM FORM</u> to verify non-hospice covered services. This form is initiated by the hospice provider and completed by the non-hospice provider. This form should be returned to Gainwell Technologies Enterprise Services.

HOSPICE REFERRAL FORM FOR NON-HOSPICE RELATED SERVICES

SECTION I - To Be Completed by Provider

1. _____ Recipient Name
2. _____ Address

_____

3. _____ Medicaid Number
4. _____ Social Security Number

NAME OF PROVIDER REQUESTING NON- RELATED HOSPICE SERVICES

ADDRESS & PHONE NUMBER OF HOSPICE

5. _____ Hospice name
6. _____ Hospice Address & Phone #

_____

MEDICAID NUMBER OF PROVIDER SUBMITTING BILL

7. _____ Provider Name
8. _____ Provider Medicaid #

ADDRESS & PHONE # OF PROVIDER REQUESTING NON-RELATED HOSPICE SERVICES

9. _____ Provider Address & Phone Number

10. Type of Service: [] Inpatient [] Outpatient [] Emergency [] Physician [] DME _____ [] Waiver [] Other (Explain)_____

NON-HOSPICE RELATED DIAGNOSIS

11. Non-Hospice Related Diagnosis Condition: _____

_____

12. Hospice Diagnosis: _____

_____

SECTION II - TO BE COMPLETED BY DMA

Date Request for Additional Documentation _____

Approval/Denial Date _____ Analyst Signature _____

DMA-521 (4/97)

HOSPICE REFERRAL FORM
FOR
NON-HOSPICE RELATED SERVICES

SECTION I - To Be Completed by Provider

1. _____ Member Name

2. _____ Member Date of Birth

3. _____ Address

_____

4. _____ Medicaid Number

5. _____ Social Security Number

6. _____ Hospice Name and Provider Number

7. _____ Address & Phone Number

---

8. _____ Provider Name

9. _____ Provider Medicaid #

10. _____ Provider Address & Phone Number

11. Type of Service: [] Inpatient [] Physician [] Medicaid Waiver _____
[] Outpatient [] DME [] Other (Explain)
[] Emergency _____

12. Non-Hospice Related Diagnosis Condition and/or Service(s): _____

_____

13. Hospice Diagnosis: _____

_____

_____

SECTION II - TO BE COMPLETED BY DMA REVIEWER

Date Request for Additional Documentation _____

Approval/Denial Date _____ Authorized Signature _____

DMA- 521 (Revised 10/15)

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HOSPICE CARE COMMUNICATOR

Patient Name	County	Medicaid #	Hospice Care Coordinator
Address	Soc. Sec. #	Telephone #	Hospice Agency Address
City State Zip Code	Date of Birth	Hospice Agency Name	Telephone #

SECTION I COMPLETED BY HOSPICE CARE AGENCY (Check all boxes that apply)

The above-named patient elects to receive routine hospice care services at their residential home or as a resident within a Nursing Facility beginning _____. The patient's doctor certified on _____ that the patient's life expectancy is anticipated to be six months or less.

☐ The patient is **admitted to hospice care in a nursing home** as of _____ and is currently receiving Nursing Home Medicaid. Please change class of assistance to Institutionalized Hospice **(IH).**

☐ The family has been referred to DFCS for Medicaid eligibility and cost share determination

☐ The patient is ***deceased.*** Date: _____.
☐ The patient revokes hospice or discharged from hospice. Effective _____ Destination _____
☐ The certification period extends from _____ through _____.

Hospice Representative Signature	Date	Telephone #	Fax Number

***FOR Gainwell Technologies PURPOSES ONLY*- ENSURE THAT A COPY OF THE ELECTION (initial) OR CERTIFICATION (subsequent) FORM IS ATTACHED**

SECTION II COMPLETED BY DFCS MEDICAID WORKER (Check all boxes that apply)

☐ The date patient applied for Institutionalized Hospice (IH)_____ Medicaid ID# _____.
☐ The patient has been determined Medicaid eligible effective _____.
☐ The patient receiving IH is responsible for contributing toward the cost of care.

☐ The patient monthly cost share amount: $ _____ Effective: _____

☐ The patient has a change in cost share.
$_____ EFFECTIVE _____ $_____ EFFECTIVE_____

☐ The patient has been denied/terminated Medicaid effective _____.
Reason or denial:
_____

DFCS Worker Signature	Date	Telephone Number	Fax Number

SECTION III COMPLETED BY HOSPICE AGENCY or DFCS MEDICAID WORKER

REMARKS:
_____

_____

DMA-527

HOSPICE CARE COMMUNICATOR (STATUS CHANGE)

TO: _____ (County Office of Department of Family and Children Services)

Or

_____ (Hospice Care Agency)

FROM: _____ (County Office of Department of Family and Children Services)

Or

_____ (Hospice Care Agency)

RE: _____/ _____
Member Name Medicaid ID #

_____
Social Security Number

(To be completed by Hospice Care Agency)
The following change has occurred in the above-named member's situation:

[] The member expired on _____
(date of death)

[] The certification period for the member expired effective _____ and the (date m/d/y) member is not electing continued hospice care.

[] The certification period for the member expired effective _____ and the member elects to continue hospice care services for another certification period. The certification period extends from _____ (date m/d/y) through _____ (date m/d/y)

[] The member revoked the election of hospice care for the remainder of the election period. The effective date of revocation is __
(date m/d/y)

[] The member transferred to another hospice care agency on _____
(date m/d/y)

The name and address of the other hospice care agency is _____

[] The member has been discharged/decertified from the election of hospice for the remainder of the election period. The effective date of discharge/de-certification is _____
(date m/d/y)

[] Other: _____

_____

Signature of Director_____Date_____

DMA-528

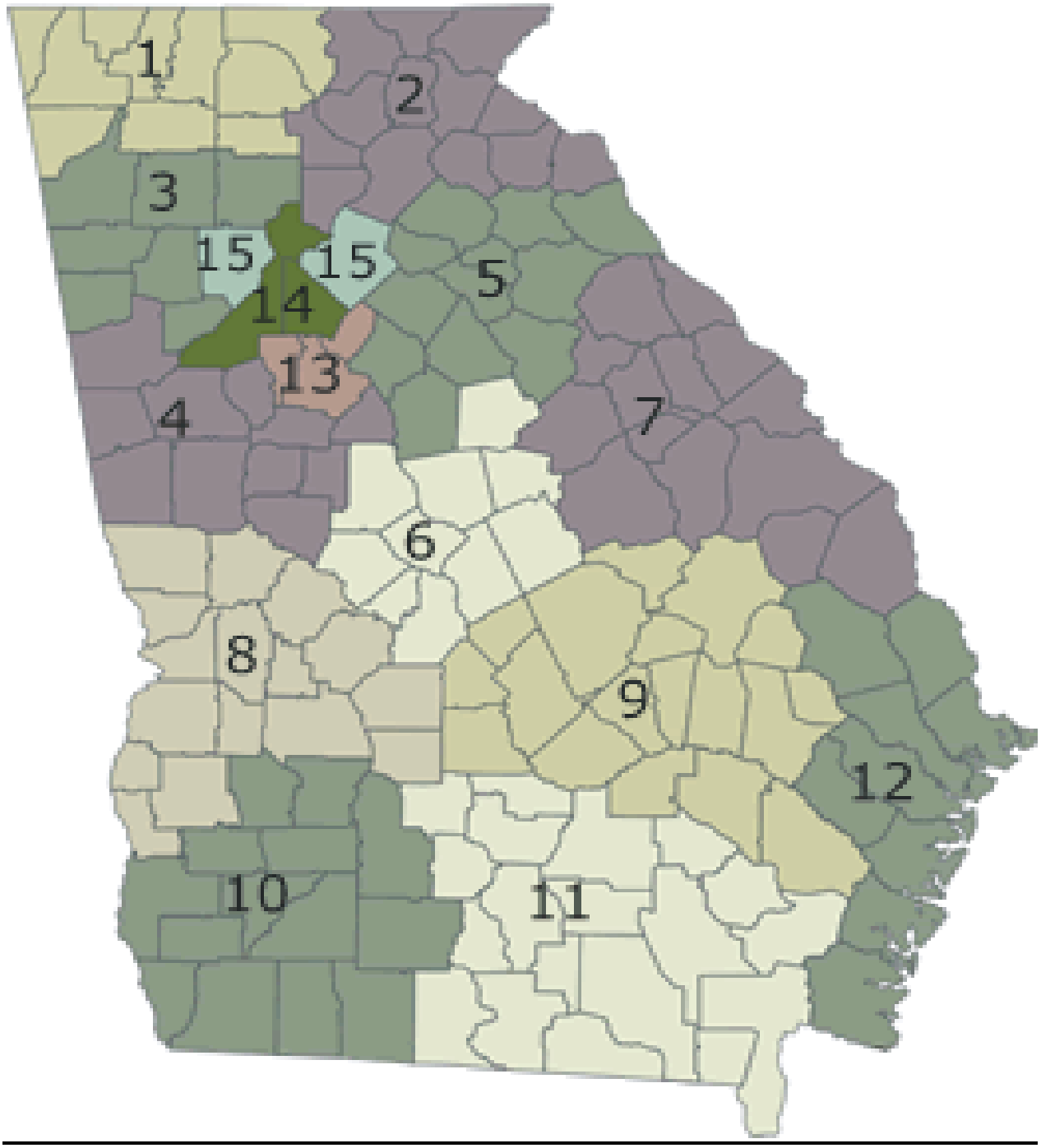
GEORGIA ONE

REGIONAL FAX NUMBERS FOR COMMUNITY PARTNERS TO SUBMIT DFCS FORMS FOR PROCESSING

Aged Blind Disabled Medicaid

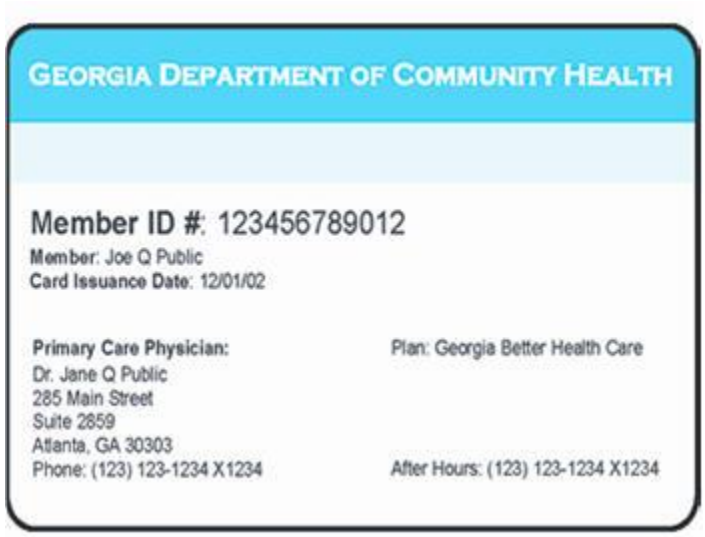
Region	Fax Number
1	770-342-7049
2	770-344-5950
3	678-717-0914
4	706-672-4342
5	706-688-0451
6	478-314-2856
7	706-434- 6195
8	706-256-9390
9	888-704-9391
10	229-238-0131
11	229-238-2403
12	912-544-7622
13	770-898-7527
14 (Dekalb)	404-478-1871
14 (Fulton)	404-206-5664
15 (Cobb)	678-605-6921
15 (Dekalb)	678-747-6814

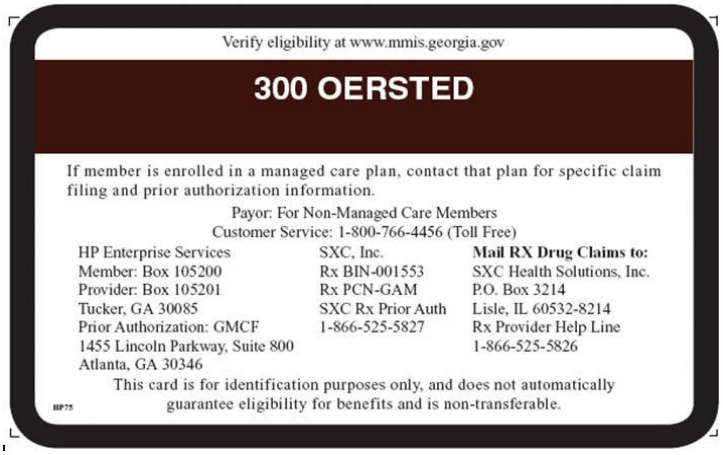
COUNTY OFFICES



APPENDIX D

MEDICAID MEMBER IDENTIFICATION CARD SAMPLE





Rev. 04/07
Rev. 10/28/10

APPENDIX E

STATEMENT OF PARTICIPATION

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

Note: See Part I Policy and Procedures for Medicaid and PeachCare for Kids Manual, Section 112, for the Paperless Initiative requirements and the current Gainwell Technologies ’s mailboxes.

Rev: 07/15

APPENDIX F

GAINWELL TECHNOLOGIES
PROVIDER DATA INFORMATION

Note: See Part I manual, section 112, Paperless Initiative.

Electronic Data Interchange (EDI)
1-877 261-8785

- Asynchronous
- Web Portal
- Physical Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol/Internet Protocol (TCP/IP)

Provider Inquiry Numbers:

1-800-766-4456 (Toll free)

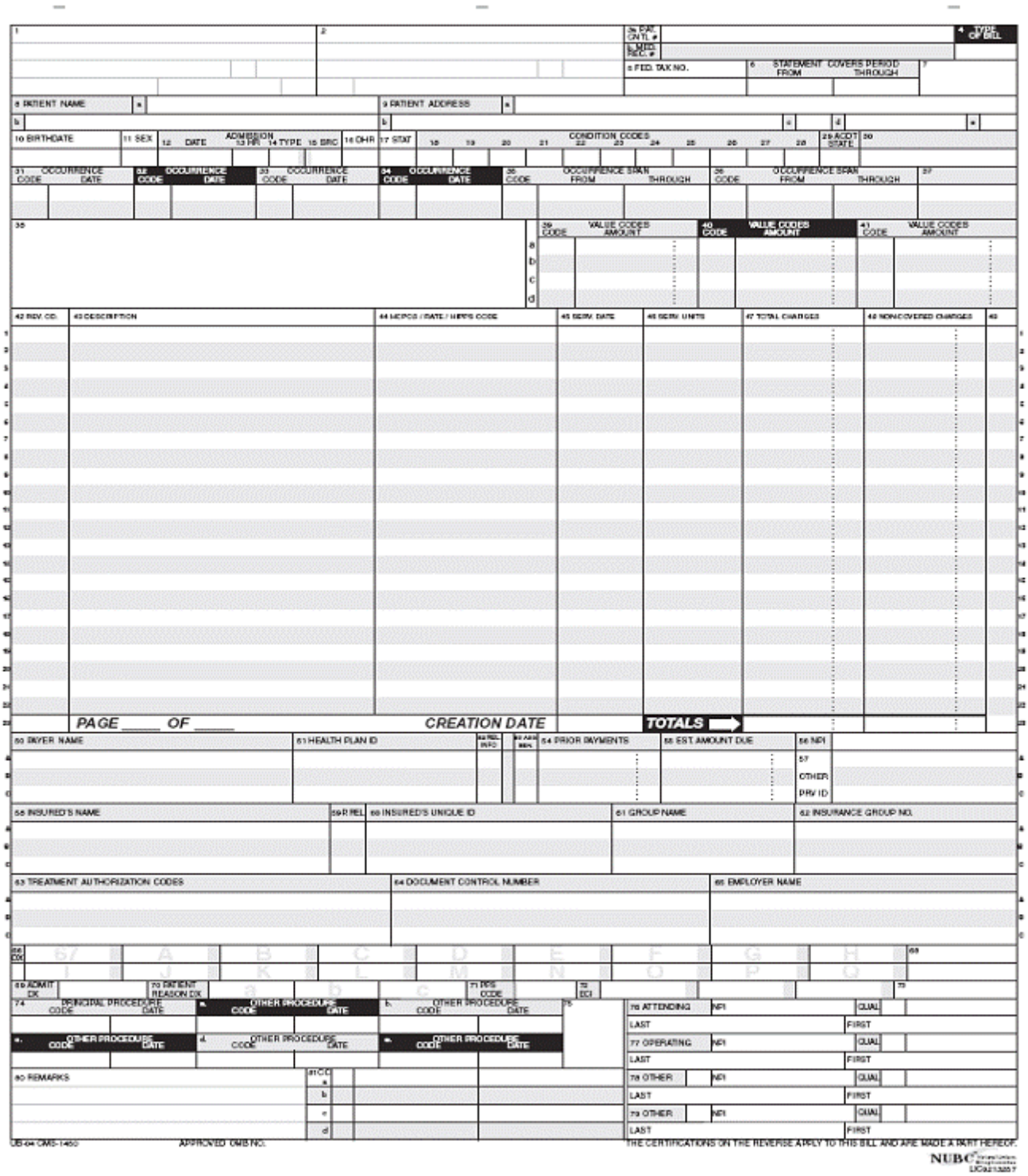
The web contact address is http://www.mmis.georgia.gov

Rev. 07/15

APPENDIX G

Rev. 10/07

NATIONAL UNIFORM BILLING CLAIM FORM (UB-04)



COMPLETION OF THE NATIONAL UNIFORM BILLING CLAIM FORM (UB-04)

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

FL 1 Provider Name, Mailing Address, and Telephone Number
Enter the name of the provider submitting the bill, the complete mailing address, and telephone number.

Rev. 10/07

FL 2 Pay-to Name, Pay-to Address, Pay-to city, State
Enter the name of the provider, the complete mailing address and telephone number for Pay-to information.

FL 3A Patient Control Number
Enter the patient's unique alpha-numeric number assigned by the provider to facilitate retrieval of individual case records and posting of payment.

FL3B Medical Record Number
Enter the number assigned to the patient's medical/health record by the provider.

NOTE:
The medical/health record number is typically used in auditing the history of Treatment and can expedite the processing of claims when medical records are required. It should not be submitted for the Patient Control Number (FL3A) which is assigned by the provider to facilitate retrieval of the individual financial record.

FL 4 Type of Bill
Enter 813 or 823 as the type of bill (e.g. interim, final)

FL5 Federal Tax Number
Enter the provider's federal identification number.

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

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

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

FL 10 Patient Birth date
Record date of birth exactly as it appears on the Medicaid card. An unknown birth date is not acceptable. If the date on the Medicaid card is incorrect, the member or

the member's representative should contact the DFCS to have it corrected immediately

FL 11 Patient Sex

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

Rev. 07/11

FL 12 Admission Date

The admission date or hour is no longer permitted on Hospice outpatient claims when submitted electronically via Web Portal, EDI 837 I (institutional claims) 5010 version, and Provider Electronic Solution (Gainwell Technologies 's electronic claim submission software) 5010 version.

FL 14 Type of Admission

Enter the appropriate code to indicate the priority of this admission.
(3) Elective-the patient's condition permits adequate time to schedule the availability a stable accommodation.

FL 15 Source of Admission

Enter the appropriate code to indicate the source of this admission. Enter code structure (for Emergency, Elective, or Other Type of Admission).

1 - Physician Referral
2 - Clinic Referral
3 - HMO Referral
4 - Transfer from a Hospital
5 - Transfer from a Skilled Nursing Home
6 - Transfer from Another Health Facility
7 - Emergency Room
8 - Court/Law Enforcement
9 - Information Not Available

FL 17 Patient Discharge Status

Enter a code indicating patient status as of the "Statement covers thru date". Effective for claims with a Date of Service (DOS) on or after 9/1/2016, ***Patient Discharge Status 20 (expired) is no longer accepted*** for Hospice SIA claims with DOS on or after 9/1/2016. Only PDS 40, 41, or 42, may be used for SIA claims.

Use the applicable code from the list below:

01 Discharged to home or self-care (routine discharge)
02 Discharged/transferred to another short-term general hospital
03 Discharged/transferred to skilled nursing facility (SNF)
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution
06 Discharged/transferred to home under care of organized home health service organization
07 Left against medical advice
30 Still patient

40 Expired at home
41 Expired in a medical facility(e.g., hospital, SNF, ICF, or freestanding hospice)
42 Expired- place unknown

FL 39-41 Value Code

Rev. 07/13

It is necessary to fill in the Value Code Section on all *hospice* claims *except for claims for* ***Revenue Code 659****-- hospice nursing facility room and board*, On the paper UB04 Form this is field #s 39-41.

Regional Codes:
In the Value Code field enter 61 as the Value code. In the Amount field next to the value code enter the Regional Code followed by a decimal and two zeros (i.e., 3.00). The following is a list of Regional Codes that are associated with your Region.

Rural GA counties not listed in the regions shown below will be covered under GA Rural Region 8. (see Appendix A, pgs. A-1 and A-2)

Rural AL counties not listed in the regions shown below will be covered under AL Rural Region 12. (see Appendix A)

REGIONAL CODES EFFECTIVE DATES 10/01/06	REGIONS
ALBANY, GA	1
ATHENS-CLARK COUNTY, GA	2
ATLANTA-SANDY SPRINGS-MARIETTA, GA	3
AUGUSTA-RICHMOND COUNTY, GA-SC	4
MACON, GA	5
SAVANNAH, GA	6
COLUMBUS, GA	7
GA RURAL AREA	8
CHATTANOOGA, TN	9
DOTHAN, AL	10
GREENVILLE, SC	11
AL RURAL AREA	12
GAINESVILLE-HALL, GA	20
VALDOSTA, BROOKS, ECHOLS, LANIER, LOWDES, GA	21
BRUNSWICK, BANTLEY, GLYNN, MCINTOSH, GA	25
DALTON, MURRAY, WHITFIELD, GA	26
SPARTANBURG, SC	28

HINESVILLE-FORT STEWART, GA	**31**
WARNER ROBINS, GA	**32**
ROME, GA	**34**

Rev. 04/11

Covered Days:

Rev. 07/13

In the Value Code field enter 80. In the Amount field next to the value code enter the number of days in whole numbers to the left of the dotted line.

Rev. 04/15

Non-Covered Days:

In the Value Code field enter 81. In the Amount field next to the value code enter the number of days in whole numbers to the left of the dotted line.

FL 42 Revenue Code

Enter the appropriate Revenue Code from the list below. When billing the following **Hospice Revenue Codes**, providers must select the most appropriate CPT code, and a valid CPT code, as indicated below, must be present for the claim to adjudicate successfully.

651 Routine Home Care RTN Home

When billing for revenue code 651, procedure codes (Q5001-Q5010) must be present.

652 Continuous Home Care CTNS Home (a minimum of 8 hours not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is routine home care for reimbursement purposes. A portion of an hour is 1 hour). 1 unit is billed for each hour.

When billing for revenue code 652, procedure codes (Q5001-Q5003, Q5009-Q5010) must be present.

655 Inpatient Respite Care IP Respite

When billing for revenue code 655, procedure codes (Q5003-Q5009) must be present.

656 General Inpatient Care GNL IP

When billing for revenue code 656, procedure codes (Q5004-Q5009) must be present.

657 Physician Services PHY SVCS (CPT Code required)
Note: If Revenue Code 657 is billed, attending Physician ID in Field 76 must be completed on the UB04.

659 Nursing Home *Other /NH RB (use of this revenue code requires Room & Board that field 83 includes Medicaid Provider number of the nursing

facility). Additionally, field 84 should have the Nursing Facility's name and address listed.

*Note: Month-to-month span billing is not allowed. Claims that cross span months or years will deny and will not adjudicate successfully due to the span billing.

Rev. 01/08

Effective January 1, 2008, all payment rates (routine home care, continuous home care, inpatient respite and general inpatient care) will be adjusted by the geographic wage index value of the area where hospice services are provided. In other words, the wage component of each payment rate is multiplied by the wage index value applicable to the location in which the hospice services are provided. Hospice providers will be required to indicate on hospice claims, the Core Based Statistical Area (CBSA) for the location where hospice care is provided.

001 Total Charge TTL CHG

FL 43 Revenue Description

Enter a narrative description or standard abbreviation for each Revenue code shown in column 51 on the adjacent line in column 42. The information assists clerical bill review. The description and abbreviations should correspond with the revenue codes as defined in the l992 Georgia Uniform Billing Manual.

FL 44 CPT/HCPCS/Rates

When billing for revenue code 657 a valid CPT-4 code must be entered.

FL 45 Service Date

Enter the line item service date.

FL 45 Creation Date (Line 23)

FL 46 Units of Service

Enter the units of service or number of days associated with Revenue Codes in FL 42.

FL 47 Total Charges (by Revenue Category)

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

FL 50 Payer

A, B, C Hospice providers must enter the letter '**D'** in this field.

A reasonable effort must be made to collect all benefits from other third-party coverage. Federal regulations require that Medicaid be the payer of last resort. (See Chapter 300 of the Policies and Procedures Manual applicable to all Medicaid providers.) When a liable third-party carrier is identified on the card, the provider must bill the third party.

NOTE:
Lines A, B, and C are used for FL 50 through 65 to indicate primary (A), secondary (B) and tertiary (c) payers. For examples: If Medicaid is the primary payer listed on line A of FL 50, Medicaid information must be listed on line A through FL 65.

FL 51 A, B, C — Health Plan ID
Enter provider number for each payer listed in 50.

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

FL 55 A, B, C — Estimate Amount Due
Enter the estimated amount due from Medicaid, generally equals the patient liability.

FL 56 — National Provider ID
Enter the National Provider ID of the Provider.

FL 57 A, B, C — Other Provider ID
Enter other provider identifiers as assigned by the health plan as indicated in FL 50 A, B, C

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

A number or other indicator which designates that the treatment covered by this bill has been authorized by the DMA. Enter the 6-digit authorization number as required for inpatient hospital admissions and selected outpatient procedures, if applicable.

FL 59 A, B, C — Patient's Relationship to Insured
Enter relationship of the patient to the identified insurer, if applicable, for each payer listed in Field Locator 50.

FL 60 A, B, C — Insured's Unique ID
Enter Medicaid member's identification number on the Medicaid card or the approval letter (for the member being treated) to the line associated with Medicaid in field locator box 50. Enter appropriate ID numbers for any other payers identified in field locator box 50.

FL 61 — Insurance Group Name

A, B, C Enter other payer's group/employer name.

FL 62 Insurance Group Number
A, B, C Enter group number, if applicable, for each coverage listed in Field Locator 50

FL 65 Employer Name
Enter name, if applicable, for each payer listed in Field Locator 50.

Rev. 04/14

FL 66 Diagnosis and Procedure Code Qualifier (ICD Version Indicator)
Enter the version of International Classification of Diseases (ICD) reported. Effective 10/1/2015, GA Medicaid will only accept ICD-10 codes.

Rev. 04/15

FL 67 Principal Diagnosis Code
Enter the ICD-10 CM code for the *principal* diagnosis appearing in FL76. Effective 10/1/2015, enter the ICD-10 CM code. Codes prefixed in 'E' or 'M' are not accepted by the Division. A limited number of 'V' Codes are accepted.

FL 69 Admitting Diagnosis
Enter the ICD-10 CM diagnosis code provided at the time of admission as stated by the physician. Effective 10/1/2015, enter the ICD-10 CM code.

FL 76 Attending Physician ID
Enter the name or number assigned by Medicaid (or the state license number) to the physician attending the patient. This is the physician primarily responsible for the care of the patient. Note: If Revenue Code 657 is billed, this field must be completed on the UB04.

FL 78 Other Provider Identifiers NPI)
Enter the name and ID number of the individual corresponding to the provider type qualifiers: **DN: Referring Provider; ZZ: Other Operating MD; and 82: Rendering Provider. Secondary ID qualifiers: OB: State License number; 1G: Provider UPIN; and G2: Provider Commercial number**, if applicable. Hospice must use field 78. (Do not enter any information in field 79).

* Note: Revenue Code 657
Is used on FL 42 to indicate the physician's or nurse practitioner's hands-on visit to the Medicaid member. The hospice provider submits the UB-04 claim using Revenue Code 657 on the line item for the professional service of the hospice physician/nurse practitioner, the appropriate HCPCS code for the applicable time spent (one [1] unit allowed) and the date of the service.

Non-hospice physicians, e.g. consultants, should bill on the CMS-1500 for the member's professional services that are not related to the terminal illness.

The allowed procedure codes for use with Hospice Revenue Code 657:

99212
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- A problem focused history;
- A problem focused examination;
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self -limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family

99213
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- An expanded problem focused history;
- An expanded problem focused examination;
- Medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- A detailed history;
- A detailed examination;
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Hospice providers (Provider Contract, COS 690) who have experienced these claims denials will be able to submit new claims to replace those that denied using the correct procedure code(s). Hospice Providers will have thirty (30) days from the posting date of this notice to do so. Following the thirty (30) day period of resubmission, Georgia Medicaid will perform a Mass Adjustment to reprocess the new claims to override timely filing only. Only those claims submitted cleanly and which only deny for timely filing only will successfully adjudicate in this one-time mass adjustment to allow hospice claims for physician services.
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NOTE:
For electronic claim submission, the nursing facility provider number should be entered in Field 78. Placement of the nursing facility provider number in any other field will result in claim denial for exception 4106 – Rate Record Not Found.

APPENDIX H

ADVANCE DIRECTIVES LETTER OF AGREEMENT

The Patient Self Determination Act as enacted by the Omnibus Budget Reconciliation Act of 1990 (Sections 4206 and 4751) mandates that effective December 1, 1991, Medicare and Medicaid certified hospitals, nursing facilities, hospices, and providers of home health care or personal care services give adult patients information about their right to make decisions concerning medical care. This includes the right to formulate advance directives such as a living will or durable power of attorney for health care.

Definitions:

"Advance Directive" means written instruction, such as a durable power of attorney for health care, or a living will, recognized under applicable state law, and relating to the provision of health care to an individual when the individual is no longer able to make such decisions.

"Durable Power of Attorney" means an advance directive, recognized under applicable state law, by which an individual designates and the person to make medical care decisions about his or her treatment in the event the individual is no longer able to make such decisions.

"Living Will" means an advance directive, recognized under applicable state law, by which individual expresses, in advance, his or her wishes regarding medical treatment in the event the individual is no longer able to make such decisions.

Agreement:

As a condition of participation in the Georgia Medical Assistance (Medicaid) program, _____, agrees to:

- Provide written information to all adult individuals (ages 18 years and older) about their rights under Georgia State law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives. The written information required by the law must be given out by hospitals at the time of the individual's admission as an inpatient; by nursing facilities when the individual is admitted as a resident; by a provider of home health or personal care services in advance of the adult individual receiving care; and by hospices at the time if initial receipt of hospice care.

- Maintain written policies and procedures with respect to advance directives and provide written information to patients and residents about the facility's policy on implementing advance directives.

- Document in the individual's medical record whether the individual has executed an advance directive. If the individual has executed a document for advance directives, a

copy of the document of the advance directive must be included in the individual's medical record.

- Not discriminate against an individual based on whether that individual has executed an advance directive.
- Ensure compliance with requirements of Georgia State law.
- Provide for educating staff and the community on advance directives. (As long as education campaigns are conducted, this requirement is met. This can be accomplished by newsletters, articles in the local newspapers, local news reports, or commercials.)
- Provide appropriate forms to members, residents or clients upon request.
- Communicate advance directives verbally and in writing in case of the transfer of the individual within or between agencies/facilities, or between the individual's home and agencies/facilities.

_____
Signature of Authorized Official

_____
Print or Type Name

_____
Title

_____
Name of Provider

_____
Date Signed

Rev: 07/15

Rev. 04/14
Rev. 07/17

APPENDIX I

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	CareSource 1-855-202-1058 www.caresource.com
Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe

Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All four CMOs are State-wide.**

The Department of Community Health has contracted with four CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan
- WellCare of Georgia

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women

171	RSM Child
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
245	Women's Health Medicaid
471	RSM Child
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 < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult

125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional 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
227	Disabled Adult Child - Aged
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	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
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
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
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
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

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com	866-231-1821 www.wellcare.com

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for

Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:
Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.
You may also contact Gainwell Technologies at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Members Admitted to Hospice from CMO:
Members enrolled in Medicaid managed care (CMO) at the time of the hospice election date will remain in CMO until the end of the election month. CMO's receive a monthly member reimbursement, coordinate all medical services and pay provider claims through the month during which the member is enrolled in CMO.
Hospice providers will contact the CMO immediately upon member election of hospice services to notify the CMO and facilitate coordination of care. Additionally, hospice providers must submit the DMA-579 for transfer to fee-for-service Medicaid within three (3) business days of member election to prevent the member's continued enrollment in Medicaid managed care.

Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. Gainwell Technologies will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:
Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:
For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to Gainwell Technologies in error:
Gainwell Technologies will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing:
Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and re-credentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.
This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.
The CVO's one-source application process:

- •Saves time
- •Increases efficiency
- •Eliminates duplication of data needed for multiple CMOs
- •Shortens the time period for providers to receive credentialing and re-credentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and re-credentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or re-credentialing decision. The credentialing decision is provided to the CMOs.
HP provider reps will provide training and assistance as needed. Providers may contact HP for assistance with credentialing and re-credentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:
Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:
For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to Gainwell Technologies in error:
Gainwell Technologies will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:
Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:
Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**

Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.	WellCare runs claims payment cycles up to six (6) times each week for **clean** claims. For further information, please refer to the WellCare website, the WellCare provider manual, or contact Customer Service at 866-231-1821

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.	Members can change PCPs for any reason within the first 90 days of their enrollment. After the first 90 days, members may change PCPs once every six months.

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.	PCP changes made between the 1st and 10th of the month will go into effect right away. Changes made after the 10th of the month will take effect at the beginning of the next month

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including

prior approval requirements.
To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com	866-300-1141 ProspectiveProviderGA@WellCare.com or https://www.wellcare.com/en/Georgia/Become-a-Provider

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	**PBM**	**BIN #**	**PCN**
Amerigroup Community Care	ESI	003858	MA
CareSource	CVS Caremark	004336	MCAIDADV Group: RX0835
Peach State Health Plan	US Script (PBM) Caremark (Claims Processor)	004336	MCAIDADV
WellCare of Georgia	Caremark	004336	MCAIDADV

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through Gainwell Technologies by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. Gainwell Technologies will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes	Yes, you may also use the WellCare subscriber ID

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates: Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?
No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
1 (800) 454-3730	1 (855) 202-1058 1(866) 930-0019 (fax)	1 (866) 399-0929	1 (866) 231-1821 1 (866) 455-6558 (fax)

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APPENDIX J

CO-PAYMENT

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

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

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

- Emergency services, and
- Family Planning services
- Waiver services
- Dialysis

The provider may not deny services to any eligible Medicaid member because of the member's inability to pay the co-payment.

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

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

P	=	Pregnant
S	=	Nursing Facility Members
H	=	Hospice
E	=	Emergency Services

PeachCare for Kids® Co-payments: 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.

Rev. 07/12

APPENDIX K

Non-Emergency Transportation Program

People enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid recipients to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?

If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, **you must contact the NET Broker serving the county you live in** to ask for non-emergency transportation. See the chart below to determine which broker serves your county and call the broker's telephone number for that region.

What if I have problems with a NET broker?

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, **call the Member CIC at 866-211-0950**.

Region	Broker / Phone number	Counties served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb and Gwinnett
Central	LogistiCare Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	LogistiCare Toll free 1-888-224-7988	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	LogistiCare Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

APPENDIX L

PROVIDER PREVENTABLE CONDITIONS, NEVER EVENTS, and HOSPITAL ACQUIRED CONDITIONS

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

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

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

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

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

July 1, 2012

APPENDIX M

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

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

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

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

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

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

April 1, 2014

APPENDIX N



Information for Providers Serving Medicaid Members
in the Georgia Families 360^{0} SM Program

Rev. 07/18

Georgia Families 360° SM, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible through its provider network for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360^{0}SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360^{0} SM Every member in Georgia Families 360^{0} is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov

APPENDIX O

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APPENDIX P

Radiological Services

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

A. Professional Component: (26 modifier)

Radiology services should be billed as professional component when:

1. The physician provides only the professional service for the procedure; or
2. The service is provided in a hospital; or
3. The technical portion of the service is performed by someone other than the physician's salaried employee.

B. Technical Component: (TC modifier)

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

C. Radiology Component (FX modifier)

D. Complete Procedure

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

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

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

E. Computerized Tomography - (CAT SCANS)

The Division reimburses for medically necessary CAT scans.

F. Low Osmolar Contrast Media

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

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

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

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

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

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

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

G. Magnetic Resonance Imaging (MRI)

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

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

H. Portable X-Ray and CT Scan

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

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

GA Medicaid does not reimburse for technical components for these services as a separate part of the service. Providers billing for these services must bill a full component only. GA Medicaid will not reimburse for set-up fee of the equipment (Level II HCPCS code Q0092).
Transportation of portable x-ray equipment is reimbursable only when the equipment used is transported to the location where x-ray services are provided. GA Medicaid will not reimburse for the transportation of the portable x-ray equipment when the x-ray equipment is stored at a facility for use as needed.

GA Medicaid will only pay for single transportation payments per trip to a facility or location for a single date of service. Therefore, providers should make every effort to schedule all members at a single location during a single trip to that location. If more than one member at the same location is x-rayed, the portable X-ray transportation fee is allocated among the members who receive portable X-ray services in a single trip.
GA Medicaid reimburses procedure code R0075 (Transportation of portable X-ray equipment), per trip to facility or location for portable X-ray providers, more than one member seen. The Division also reimburse procedure code R0070 (Transportation of portable X-ray equipment), per trip to facility or location, one member seen.

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

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

• R0075 Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one member seen, per trip to facility or location. The following modifiers are to be billed with R0075:

Modifiers:
(no modifier if one patient served)
UN - Two patients served
UP - Three patients served

UQ - Four patients served
UR - Five Patients served
US - Six or more patients served

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

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

Note: GA Medicaid will only pay for a single transportation payment per trip to a facility or location for a single date of service. Therefore, providers should make every effort to schedule all members at a single location during a single trip to that location.
All providers, including their staff, contracted staff and volunteers must comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements.
The portable x-ray provider is responsible for determining that a member is Medicaid eligible on the date of service.

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

• A copy of the written, signed and dated order by the member's physician,
• The date of the x-ray examination,
• The name of the physician who performed the professional interpretation of the procedure, and
• The date the radiograph was sent to the physician.

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

• Procedures involving fluoroscopy,
• Procedures involving the use of contrast media,
• Procedures requiring the administration of a substance to the member, the injection of a substance, or the spinal manipulation of the member,
• Procedures requiring special technical competency and/or special equipment or materials,
• Routine screening procedures such as annual physicals,
• Procedures which are not of a diagnostic nature, e.g., therapeutic x-ray treatments, and
• Annual x-rays.

Fee Schedule

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

H. Mammography

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

Office of Regulatory Services
Health Care Services
Georgia Department of Community Health
2 Peachtree Street, N.W., 19th Floor
Atlanta, Georgia 30303
(404) 657-5407

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

Prior Authorization & Pre-Certification
AHS
PO Box 105329 Atlanta, Georgia 30348
800-766-4456 (Toll free)

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