PART II

POLICIES AND PROCEDURES FOR

EMERGENCY AMBULANCE



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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Part II Policies and Procedures Manual for Emergency Ambulance Services
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REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**-Added **D**-Deleted **M**-Modified	CITATION (Revision required by Regulation, Legislation, etc.)
01/01/22		No update for first quarter		
04/01/22	Chapter 1000 Section 1004, B,b.i.	Updated section to add that ACR surveys will be completed every two years instead of twice a year.	A	CMS-Approved SPA
04/01/22	Chapter 1000 Section 1004, B. b.ii.	Updated section to add that the State will apply a Statewide median average for providers not able to provide at least three commercial payer rates.	A	CMS-Approved SPA
04/01/22	Chapter 1000 Section 1004, B.b.iii.	Updated section to add that the supplemental payment will be issued on an annual basis	A	CMS-Approved SPA
07/01/22		No update for this quarter		

PART II - POLICIES AND PROCEDURES FOR EMERGENCY AMBULANCE SERVICES

TABLE OF CONTENTS

CHAPTER 600	**SPECIAL CONDITIONS OR PARTICIPATION**	**1**
CHAPTER 700	**SPECIAL ELIGIBILITY CONDITIONS**	**3**
CHAPTER 800	**PRIOR APPROVAL**	**4**
801	OBTAINING PROIR APPROVAL	
802	PREPAYMENT REVIEW	
803	RETROACTIVE ELIGIBILITY	
CHAPTER 900	**COVERED SERVICES**	**7**
901	LOCAL TRANSPORTATION FOR APPROPRIATE FACILITIES	
902	MEDICAL SUPPLIES	
903	LIMITATIONS ON COVERED SERVICES	
904	NON-COVERED SERVICES	
CHAPTER 1000	**BASIS FOR REIMBURSEMENT**	**17**
1001	GROUND AMBULANCE	
1002	AIR AMBULANCE	
1003	TELEMEDICINE	
1004	UPPER PAYMENT LIMIT	
APPENDIX A	**AMBULANCE REIMBURSEMENT**	
APPENDIX B	**CLAIM FORMS & BILLING INSTRUCTIONS**	**19**
APPENDIX C	**MODIFIER**	**30**
APPENDIX D	**CONDITION CODES**	**32**
APPENDIX E	**GEORGIA FAMILIES**	**37**
APPENDIX F	**GEORGIA FAMILIES 360°**	**42**
APPENDIX G	**PROVIDER CONTACT**	**49**

CHAPTER 600
SPECIAL CONDITIONS OF PARTICIPATION

601. In addition to the general conditions of participation identified in Part I, Section 106, providers of Ambulance Services must:

601.1 Maintain a current license, permit, or certification as required by all levels of government in Georgia for operation of an ambulance vehicle; and, comply with all state and local laws governing licensing and certification of an emergency transportation vehicle. Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies. This includes a vehicle license, driver's license, and business license when appropriate.

601.2 Maintain all State required insurance coverage.

601.3 Bill only for covered ambulance services rendered to Medicaid members when transportation is provided to a health care facility to obtain emergency treatment (refer to Chapter 900).

601.4 Accept the amount paid by the Division for transportation services as payment in full for covered services.

601.5 Bill the Division their usual and customary fee for services rendered. "Usual and customary" is defined as the fee charged to private paying patients for the same service during the same period of time.

601.6 Agree to maintain for each service a patient care report or trip sheet signed and dated by the person completing the report (including their credentials) ***and*** an additional document that details the patient's medical necessity for the transport. The additional documentation can be an Emergency Room record, Certificate of Medical Necessity or another document used by the treating facility or physician. This document must also be signed and dated by the physician with credentials listed. Both documents must be kept on file with the provider's copy of the claims.

Rev. 07/02

601.7 Agree to maintain, for a minimum of five (5) years, such records as are necessary to fully disclose the extent of services provided and to furnish the Division with information regarding payment of claims when requested. Records must contain at a minimum the information listed below:

a) Member's name, address, and Medicaid number;
b) Date of ambulance transportation;

c) Member's point of origin and destination;
d) Number of miles traveled with member in the ambulance; and,
e) A copy of a valid (DMA-80) prior approval form when required.

Rev. 10/02
Rev. 01/03
Rev. 04/16

601.8 Agree not to seek or accept any payment whatsoever for covered services from the member or other interested party when the member was accepted as a Medicaid or Medicare/Medicaid member. (Refer to Part I, Chapter 100, Section 104.1)

CHAPTER 700
SPECIAL ELIGIBILITY CONDITIONS

No special eligibility conditions are required for member participation in the Ambulance Program except those listed in Part I, Section 107.

The Benefit Defined

The ambulance benefit is defined in title XVIII of the Social Security Act (the Act) in §1861(s)(7): “ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations.”

This statutory definition incorporates by reference the regulations there under, which are those at 42 CFR §410.40 (Coverage of ambulance services) as well as the regulations at 42 CFR §410.41 (Requirements for ambulance suppliers) which are, themselves, incorporated into §410.40 by reference in §410.40(a) (1). Thus, in effect, §1861(s) (7) of the Act together with 42 CFR §§ 410.40-410.41 comprise the ambulance benefit definition.

CHAPTER 800
PRIOR APPROVAL

800. Prior Approval

Rev. 10/18

As a condition of reimbursement, the Division requires that certain services be approved prior to the services being rendered. Prior approval from the Divisions medical review agent, the Alliant Health Solutions (AHS), pertains to medical necessity only. The patient must be Medicaid eligible at the time the service is rendered. The Division requires prior approval for:

a) Ambulance transportation of more than 150 miles one way from institution to institution (e.g. hospital to nursing home or hospital to hospital);

b) All ambulance transportation of more than 50 miles beyond the borders of the Georgia state line (out of state).

c) **Air** ambulance transportation for all members, procedure codes A0430 and A0431 must be utilized to report air transport.

Rev. 07/13

d) Non-Emergency Ambulance Transportation must be prior approved. Non-emergency is defined as ambulance transportation not of an emergent nature, but the member requires services that can only be provided by a licensed EMT-B or higher as defined by the scope of practice set by the Georgia's regulatory authority. Examples include but are not limited to; initiating or maintaining IV fluids establishing/maintaining airway or suctioning, monitoring or regulating oxygen therapy that cannot be self-administered, or a member which requires restraints en route.

The Division may require approval of all, or certain procedures performed by a specified ambulance provider. This decision may be based on findings or recommendations of the Division and/or its authorized representatives or agents, the Secretary of the U.S. Department of Health and Human Services or the applicable state licensing authority. This action may be invoked by the Commissioner as an administrative recourse in lieu of or in conjunction with an adverse action described in Chapter 400 of the Part 1 Policies and Procedures Medicaid/PeachCare for Kids provider manual (available at www.mmis.georgia.gov).

801. Obtaining Prior Approval

Certain medical circumstances may require planned transportation by an ambulance. Request for planned transportation by ambulance must be submitted prior to the time of transportation.

Request for prior approval must contain the following information:

a) Name, provider number and address of the ambulance provider
b) Name, Medicaid ID number and address of the member

c) Age or date of birth of the member
d) Name of attending physician
e) Name and address of point of pickup (name of institution).
f) Name and address of destination (facility patient is being transported to)
g) Date of Service; and
h) Medical certification signed by the physician (or designee) that includes the medical diagnosis and the member's physical condition that necessitates emergency ambulance transportation.

Incomplete requests will not be processed until all necessary information has been received by AHS. Decisions will be rendered within 5 business days of the receipt of a completed case. Once a decision has been rendered, AHS will notify the provider, in writing, with an approval or denial. Upon receipt of an approval Providers must list the twelve (12) digit prior approval number on the CMS-1500 claim form. The claim will not be reimbursed if the prior approval number is not included on the claim.

Request can be received via the web portal at www.mmis.georgia.gov.

Telephone request will **not** be granted. Questions regarding PA request should be directed to AHS at 800.766.4456.

801.1 Post Approval

In the event that medically necessary *ground* transportation services cannot be prior approved the provider must request post-approval from AHS within ***30 calendar days*** of the medically necessary transport. In order to receive post-approval for the ambulance transport documentation must provide evidence that the transport was medically necessary, not planned and prior approval could not be obtained.

In the event that medically necessary *air* transportation services cannot be prior approved the provider must request post-approval from AHS within ***30 calendar days*** of the medically necessary transport. In order to receive post-approval for the ambulance transport documentation must provide evidence that the transport was medically necessary, not planned and prior approval could not be obtained.

Emergency air ambulance providers transporting members (who meet the criteria listed in appendix D) must also request post-approval from the Division. The post approval request must be requested from AHS within ***30 calendar days*** of the medically necessary transport.

All post-approval request may be submitted via the web portal www.mmis.georgia.gov.

802. Prepayment Review

Ambulance transportation service is medically necessary ground or air transport for a Medicaid eligible member to receive immediate and prompt medical services arising in an emergency situation (e.g., accidents, acute illness, and injuries). Documentation to

substantiate medical necessity may be requested in a prepayment or post payment review by the Division. Lack of appropriate medical justification may be cause for denial, reduction, or
recoupment of reimbursement.

Prepayment review means review of documentation prior to payment of a claim. The following procedure codes have been placed on prepayment review:

A0430 – Fix Wing (Airplane) for adult
A0431-- Rotary Wing (Helicopter) for adult
A0433 – Advance Life Support
A0434 – Specialty Care Transport

Repeated use of the aforementioned codes with unfounded medical necessity may result in adverse action by the Division. Detailed documentation of medical necessity to support the use of these types of transports is required. To facilitate the review process, the ambulance trip report may be submitted with the claim as an attachment via the web portal at www.mmis.georgia.gov.

803 Retroactive Eligibility

Conditions may exist wherein an individual's Medicaid is granted retroactively. In these instances, for services that require prior approval, please follow the guidelines in section 801.1 (Post Approval). It is the provider's responsibility to submit a copy of the retroactive eligibility determination, and a request for post authorization to the medical review agent for processing.

The provider has six (6) months after the date in which the determination of retroactive eligibility was made to obtain post approval. Please review to the Part I Policies and Procedures for Medicaid/PeachCare for Kids provider manual, Chapter 200, Section 202.2C for the retroactive eligibility policy.

PART II - CHAPTER 900
SCOPE OF SERVICES

900 **Covered Services**

The Medicaid ambulance benefit is an emergency transportation benefit and without a transport there is no payable service. Services covered under the Medicaid Ambulance Services Program include Basic Life Support (BLS) and Advanced Life Support (ALS) ambulance services which are certified as medically necessary by a physician, provided to appropriate local health facilities and provided to eligible members whose conditions require life sustaining equipment and personnel en-route. As a general rule only mileage to the nearest appropriate facility equipped to treat the patient is covered. See Section 903 for limitations on covered services. When medically necessary, the following are covered services:

Rev.10/02
Rev.10/05 A.) **Basic Life Support (BLS)**: Transportation by a ground ambulance vehicle which is equipped with the necessary supplies and services as defined by the State of Georgia. BLS ambulances must be staffed by at least two people, at least one of whom must be certified as an emergency medical technician (EMT) by the State or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. BLS services should be billed utilizing HCPCS codes A0429 (BLS- Emergency) *or* A0428 (BLS- Non-emergency).

Rev.10/05 B.) **Advanced Life Support (ALS)**: An assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. ALS vehicles must be staffed by at least two people, one of whom must be certified by the State or local authority as an EMT-Intermediate or an EMT-Paramedic.

1.) ALS coverage is determined by the medically necessary level of service required to treat the patient and/or the reported condition of the member at the time of dispatch. Ambulance staffing or local ALS mandate alone do not justify an ALS level of service. When reporting the ALS code, your documentation must reflect an ALS vehicle was dispatched, medical justification for sending an ALS vehicle and details of specialized services.
2.) ALS services should be billed utilizing HCPCS codes A0433 (ALS, Level 2-Emergency), A0427 (ALS, Level 1, Emergency) *or* A0426 (ALS- Non-emergency).

Rev. 07/06 C.) **Advanced Life Support, Level 1(ALS 1)**: When medically necessary, it is the transportation by a ground ambulance vehicle which is equipped with the necessary supplies and services as defined by the State of Georgia and, includes the provision of an ALS assessment or at least one ALS intervention. An ALS intervention is a procedure that is medically necessary and required to be done by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic and must be medically necessary.

Rev.01/06

D.) **Advanced Life Support, Level 2(ALS 2)**: When medically necessary it is the transportation by a ground ambulance vehicle which is equipped with the necessary supplies and services as defined by the State of Georgia and, includes:

1.) At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or

Rev. 10/16

2.) The provision of at least one of the ALS2 procedures listed below:
   a.) manual defibrillation/cardioversion
   b.) endotracheal intubation (ET); monitoring and maintenance, also includes coverage of ET tube previously inserted prior to transport
   c.) central venous line
   d.) cardiac pacing
   e.) chest decompression
   f.) surgical airway; or
   g.) intraosseous line

Rev.01/06
Rev.07/07

E.) **Specialty Care Transport (SCT)**: When medically necessary, SCT is the inter-facility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services at a level of service beyond the scope of the EMT paramedic. SCT is necessary when a patient's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (e.g., emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training). In Georgia, this training should be beyond the scope of pre-hospital emergencies, and specifically address the clinical needs of patients being transferred between hospitals for a higher level of care not available at the sending hospital, and training to operate and monitor equipment not normally used in the standard EMS operation. **NOTE**: Georgia Medicaid does not cover facility to facility transport within the *same* hospital network or institution. These intra-facility transports are non-covered. SCT services should be billed utilizing HCPCS code A0434.

Rev. 10/05
Rev. 07/06

Emergency ambulance services are covered when the services are medically necessary, meet the destination limits of closest facilities, and are provided by an ambulance service that is licensed appropriate by the state. Emergency means services provided after the sudden onset of a medical condition, manifesting itself by acute signs or symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in the following: placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

900.1 Certification of Medical Necessity

Medical necessity exists when the patient's physical condition prohibits use of any method of transportation except ambulance service. No payment will be made for ambulance service if another means of transportation could be used without

endangering the member's health. The emergency room record, certificate of medical necessity (CMN) or another document used by the treating facility or physician must be obtained for each ambulance service and kept on file with the provider's copy of the claim. This document must also be signed and dated by the physician with credentials listed. A copy of the ambulance trip report or patient care report is also required by the Department. This policy is applicable when billing claims in which Medicaid is the primary payer. Claims where Medicare is the primary payer (crossover claims) are exempt from the policy regarding medical necessity documentation. Failure to produce the above required documents (CMN or ER Record and trip report or patient care report) can result in adverse action by the Division (refer to Part I, Chapter 400, Section 405). The physician's certification of medical necessity indicates one of the following was met:

Rev.10/05

a) The member's condition required medically necessary transportation by an ambulance service and other means of transportation would be inappropriate and could further endanger the members health.

b) The member is moved from a skilled nursing facility to a hospital or from a hospital to a skilled nursing facility, and other means of transportation would be inappropriate. The pickup point and destination must be within the service area "locality". Refer to Section 901 for definition of "locality".

c) The member is transported from hospital to hospital, or from one skilled nursing home to another skilled nursing home and other means of transportation is inappropriate. Payment would be made when the first institution was not an "appropriate facility" and the patient must be admitted to the nearest "appropriate facility". **NOTE**: Georgia Medicaid will allow facility to facility transport within the same hospital network or institution **only for higher level of care or physician specialty. These intra-facility transports must be submitted with supporting documentation**. Refer to Section 901 for definition of "appropriate facility".

d) The member is transported from a hospital or skilled nursing home to the member's residence and the residence is within the institution's service area or locality and other means of transportation are inappropriate. A member may be transported outside the institution's locality only if the institution is the nearest one with "appropriate facilities"; or

Rev.10/05

e) The member's condition does not conform to any of the above circumstances, but the member requires a medically necessary ambulance, or the use of life sustaining equipment provided in the ambulance. The claim form and the physician's written certification of medical necessity must be sent to:

Rev.04/16

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

Rev.10/05

Payment will only be made in cases in which the service is reviewed by the Departments' Medical Review Agent, the Alliant Health Solutions (AHS), and determined to be medically necessary.

Rev. 10/18 **900.2 EMS Ambulance Treat Without Transport**

EMS Ambulance Treat without Transport is defined as the assessment and treatment inclusive of pharmaceutical intervention by advanced level EMS personnel within a 911 response resulting in improved patient condition, but refusal by the patient to be transported to a health care facility for continuation of care.

The purpose of this proposal is to establish a mechanism for ambulance providers to recover a portion of the expense related to a patient's refusal of transport to a medical facility for evaluation after pharmaceutical intervention has been provided. It is the intent of this proposal for EMS providers to continue to provide appropriate care and treatment, and encourage patients to be transported to a medical facility following medication administration. This proposal is not designed to incentivize medics to provide prehospital treatment inclusive of pharmaceuticals without encouraging transport to a health care facility for follow up evaluation.

Program Participation Parameters

1. Ambulance service must be licensed by the Georgia Department of Public Health.

2. Ambulance Service has an actively engaged Medical Director compliant with Georgia Department of Public Health Rules and Regulations Chapter 511.

3. Ambulance response was generated through a call for assistance by dialing “911", or other designated local emergency response telephone number, resulting in an immediate response to the patient.

4. Members must be at least 18 years of age, regardless of the presence of a legal guardian.

5. Assessment and treatment provided on scene to patient must be compliant with approved ambulance service protocols.

6. Documentation of the patient encounter must be thorough and include details specific to the patient's mental status, assessment, treatment, and pharmaceuticals provided to the patient.

7. A signed and witnessed Refusal of Care form compliant with approved ambulance service protocols must accompany the patient care report. This form must be kept with patient files, and provided in case of an audit.

This is to be billed on the CMS- 1500 form HCPCs code A0998 with modifier ET (Emergency Services) to attest that the call originated from a “911" call, or other designated local emergency response telephone number. Only one unit per member per day is reimbursable. Mileage will not be reimbursed with A0998. Do not attach the Refusal of Care form to the claim; the signed form must be kept with EMS files, and provided on request.

901 <u>Local Transportation to Appropriate Facilities</u>

Only local transportation by ambulance is covered, and therefore, only mileage to the nearest and appropriate facility equipped to treat the patient is covered. In instances where multiple facilities meet the destination requirement can treat the patient appropriately, and the locality of each facility encompasses the place where the ambulance transportation of the patient began, the full mileage to the *closest* facility to which the patient is taken is covered.

a) **Locality:** The service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services.

b) **Appropriate Facility:** The institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. It also means that a physician or physician specialist is available to provide the necessary care required to treat the patient’s condition. The fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

Example: Mr. “A” becomes ill at home and requires ambulance service to the hospital. The hospital servicing the community in which he lives is capable of providing general hospital care. However, Mr. “A” requires immediate kidney dialysis and the community hospital do not have a dialysis machine. Ambulance service would be covered to the nearest hospital with a kidney dialysis machine (appropriate facility), although the trip was beyond the locality of the community hospital.

If a member is transported to an institution that is found to have inadequate facilities for treatment and the member must be transported to another institution with adequate facilities, both trips will be covered. Occasionally, a member may have to be transported to an institution outside the local area due to the lack of bed availability at the local institution. It will be presumed that there are beds available at the local institution unless the provider

furnishes information that proves otherwise.

Documentation must be supplied to support the medically necessary transportation to an institution or facility. Georgia Medicaid will allow facility to facility transport within the *same* hospital network or institution **only for higher level of care or physician specialty. These intra-facility transports must be submitted with supporting documentation**.

Rev. 7/19 **901.1 Transport to Alternate Destination**

Emergency Ambulance Transportation to Alternate Destination is define as an option for EMTs and EMS, under the direct supervision of a physician, to transport a member to an appropriate destination other than an emergency department to transport low-acuity, properly screened patients for continuation of care.

- Ambulanceservices have traditionally been directed to evaluate/stabilize on scene and transport patients to a full-service emergency department for continuation of care. This model appropriately safeguards the status of those most critically ill or injured.

- EMTs and EMS providers can competently evaluate a patient to differentiate between urgent and non-urgent conditions but have no alternatives to an emergency department for patient transport.

- Member may opt out and choose transportation to the emergency department.

This proposal is intended to match patients with minor medical conditions with local definitive care resources having expertise in an ambulatory clinic setting.

Program Participation Parameters

1. Licensed by the Georgia Department of Public Health, and the designated 911 zone provider for the location of the response;

2. The EMTs or EMS doing the transport have an actively engaged Medical Director compliant with DPH rules and regulations;

3. Ambulance response was generated through a call for assistance 911, or other designated local emergency response telephone number, resulting in an immediate response to the patient;

4. Patients must be at least 18 years of age;

5. Approved protocol for patient evaluation and transport to an alternate destination must be on file and signed by the Medical Director for the responding ambulance service;

6. Assessment and treatment provided on-scene to patient must be compliant with approved ambulance service protocols;

7. Documentation of the patient encounter must be thorough and include details specific to the patient's mental status, assessment, and explanation of the option for transport to an alternate destination;

8. A signed and witnessed Refusal of Care form compliant with approved ambulance service protocols must accompany the patient care report;

Verification of Alternate Destination Transport Agreement with the receiving facility must be on file and available for review id requested.

Please bill using usual and customary processed. Use modifier ET (Emergency Services) to attest that the call originated from a "911" call, or other local emergency response telephone number.

Only one bill per member per day is reimbursable.

Use the following HCPCs codes:

- A0425 Mileage
- A0428 Basic Life Support

The ET modifier must be billed as the modifier to indicate alternative destinations.

Use the following Origination sites:

- **R** Residence
- **S** Scene

Use the following Destination sites:

- **P** Physician office, Urgent Care, Independent Clinic, Federally Qualified Health Center, Rural Health Clinic, Community Mental Health Center, Intermediate Care Facility, Military Treatment Facility, Public Health Clinic and Rural Health Clinic

- **H** Outpatient Hospital, Ambulatory Surgical Center, Birthing Center, Inpatient Psychiatric Facility, Psychiatric Facility, Psychiatric Residential Treatment Center, Comprehensive Inpatient Rehabilitation Center, Comprehensive Outpatient Rehabilitation Center

902. Medical Supplies

Rev.10/05

Intravenous (I.V.) solutions, splints, backboards, ace bandages, oxygen, dressings or any other supplies used to provide emergency care en route is included in the base rate and will not be reimbursed as a separate item.

903. Limitations on Covered Services

Rev.04/05

903.1 Institution to institution transportation in excess of one hundred and fifty (150) miles one-way is not covered unless approved prior to the transport. Refer to Chapter 800 for Prior Approval procedures.

903.2 Georgia Medicaid will allow facility to facility transport within the same hospital network or institution **only for higher level of care or physician specialty. These intra-facility transports must be submitted with supporting documentation.**

903.3 Transport of patients from one hospital to another is generally considered non-emergent. Stabilized patients being transported by ambulance to another facility for a higher level of care or for services not available at the originating facility require ***prior approval***. The Prior Approval form should be included in the documentation submitted for review.

903.4 No payment will be made for ambulance transportation if the member was pronounced dead by a licensed physician before the ambulance was called. If the member was pronounced dead after the ambulance was called, but before pickup, the service to the point of pickup is covered. If the ambulance service was furnished to a member pronounced dead en route, the entire trip is covered.

903.5 Transportation for childbirth that occurred in the home or en route is covered.

903.6 Only two (2) (***one*** round trip) transports are allowed per member per date of service.

Rev.10/01
Rev.07/07

903.7 The Georgia Medicaid ambulance benefit is a transportation benefit and without a transport there is no payable service. Only loaded miles are payable; and, ambulance providers will not be reimbursed for miles when there is no patient being transported.

Ground transportation of ten (10) miles or less is included in the base rate. Total loaded miles will be reimbursed less these 10 miles. **Mileage will not be reimbursed if there is no claim or payment for the base rate**.

Rev.10/02

903.8 An ambulance may transport more than one patient at a time. This may happen at the scene of a traffic accident or transfer of multiple birth high risk neonates. In this case, reimbursement will be based on half of the ambulance fee schedule amount for the level of medically appropriate services furnished to each patient.

904. Non-Covered Services

The following services are not covered in the ER Ambulance program:

Rev.10/05 a.) Non-emergency ambulance transportation in which the member is ambulatory;

b.) The member's condition does not require movement by stretcher;

c.) The ambulance was used because other means of transportation were unavailable;

d.) ALS services when the member has a Do Not Resuscitate (DNR) status and is being transferred from one facility to another or home. (in this instance BLS services *may* be considered);

e.) The member was transferred from facility to facility solely at the request of the member;

f.) The member requested transportation to a more distant hospital or health care facility to receive the services of a specific physician of the member's choice;

g.) Transportation for routine labor and delivery in a hospital, birthing center or a similar type setting;

h.) Transportation of a member pronounced dead at the scene before the ambulance was called;

Rev.01/99 i.) Non-emergency ambulance transportation of a convalescent type. In
Rev.07/00 order to receive this type of reimbursement the provider must be under contract with a Non-Emergency Medical Transportation (NEMT) Broker. Providers must contact the Broker in the region where they want to provide transportation services. Please refer to the NEMT Broker Services policy manual for additional information;
Rev.10/1/19

j.) Transportation of a member that does not require the services of an EMT or higher;

Rev.10/02 k.) Service to a member who refuses treatment or refuses to be transported to an appropriate facility;

Rev.04/08 l.) Inter-facility transport of members to a facility that provides the same level of care and not for a higher level of care; and

m.) Ambulance services certified by a physician as medically necessary, but not included as a covered service, may be covered for members less than twenty-one (21) years of age when such services are prior approved by the Division and/or its authorized representative, Alliant Health Solutions (AHS).

CHAPTER 1000
BASIS FOR REIMBURSEMENT

1000. Reimbursement

Rev.01/12 Payment will not be made when other transportation could be utilized without endangering the patient's health, whether such means of transportation is actually available.

The maximum allowable amount is derived from Medicare's maximum allowable reimbursement rates for non-hospital-based ambulance services. The maximum rates are 90% of the CY2002 Medicare fee schedule for Locality 01 for Medicaid covered procedure codes in the Emergency Ambulances (EAS) program. Fee schedule rates for public and private providers of ambulance services are the same and the state does not subdivide, or sub classify its payment rates based on whether the provider is a public or private entity/provider. Annual or periodic adjustments will be made, and such adjustments will be reflected in the fee schedule that is made available to the providers and public.

Rev.10/02 ### 1001. Ground Ambulance

Reimbursement is approved based on the level of service provided, not the vehicle used. If a local government requires an ALS response for all calls, Medicaid pays only for the service medically necessary. (Refer to Section 801.1)

Rev.07/07 ### 1002. Reimbursement Methodology for Air Ambulance

Only medically appropriate air ambulance transportation will be covered. The member's emergency medical condition must require immediate and rapid ambulance transportation that could not have been provided by land ambulance in order for the department to consider reimbursement. **NOTE**: Georgia Medicaid will allow facility to facility transport within the same hospital network or institution **only for higher level of care or physician specialty.** These intra-facility transports must be submitted with supporting documentation.

Emergency air ambulance providers will be reimbursed on an established calculated rate. This calculated rate includes ground transport to/from the air ambulance landing site (site of transfer) to/from the facility. The reimbursement rate has been determined by obtaining three estimates from air ambulance providers. The Division will then pay the lower of the transporting providers charge or the amount estimated for the air ambulance service.

Rev.10/02 a) Fixed Wing Air ambulance (FW)-airplane is furnished when the member's medical condition is such that transport by ground ambulance, in whole or in part, is not

appropriate. Generally, transport by fixed wing air ambulance may be necessary because the member's condition requires rapid transport to a treatment facility, and either great distances or other obstacles (e.g., heavy traffic), precludes such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance may also be necessary because the member is inaccessible by a ground ambulance vehicle.

b) Rotary Wing Air ambulance (RW) –helicopter is furnished when the member's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the member's condition requires rapid transport to a treatment facility, and either great distances or other obstacles (e.g., heavy traffic), preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may be necessary because the member is inaccessible by ground ambulance vehicle.

1. Effective July 1, 2014, the Department began providing emergency air ambulance services to adults 21 years of age and older by rotary wing (helicopter) air ambulance at the ground ambulance rate. Coverage is limited to one emergent event (1 leg) with major trauma of any sort to a level 1, 2, or 3 trauma center, stroke center or burn center by a fully medically equipped and licensed ALS helicopter (this includes Georgia Medicaid trauma, stroke and burn centers within 50 miles of the Georgia border).

Rev.04/16 2. Effective July 1, 2015, the Department of Community Health received approval from CMS to provide emergency air ambulance services to adults 21 years of age and older by rotary wing (helicopter) air ambulance at the negotiated rate. Coverage is limited to one emergent event (1 leg) with major trauma of any sort to a level 1, 2, or 3 trauma center, stroke center or burn center by a fully medically equipped and licensed ALS helicopter (this includes Georgia Medicaid trauma, stroke and burn centers within 50 miles of the Georgia border).

Rev.07/16 The air rotary reimbursement rate has been predetermined by CMS' approval using three estimates received from air rotary providers. The DCH will pay the lower of the transporting providers' charge or the amount estimated for the rotary air ambulance service using one (1) of the following three (3) predetermined rates for rotary air transport and choosing the lessor comprise of:

1. The provider's submitted charge, or
2. The Loaded miles x $16.00 = Sum + $2,573.00 or
3. The $3,300.00 fixed rate.

Rev. 10/16 **1003. <u>Telemedicine Reimbursement for Ambulance Providers</u>**

Effective April 22, 2016, the Centers for Medicare & Medicaid Services (CMS) approved Georgia Department of Community Health (DCH), Medicaid Division State Plan

Amendment (SPA) for Ambulance as telemedicine sites. Emergency Ambulances may serve as a telemedicine origination site and the ambulance may bill a separate origination site fee. Emergency Ambulance may not serve as a distant site. The following are the definitions for Telemedicine Based Services:

A. Originating Sites (HCPCs Q3014): Originating site means the location of an eligible Medicaid beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites are reimbursed at 84.645% of the 2012 Medicare fee schedule.

B. Distant Site Practitioners: Distant site means the site at which the physician or delivering the service is located at the time the service is provided via a telecommunications system. Distant Site Practitioners shall be reimbursed according to the same methodology as if the visit occurred in person. Ambulances are not authorized to provide distant site services.

Please review the information below to obtain a better understanding of what the telemedicine billing entails. The prior approval requirements, non-covered, and covered services requirements have not changed. The Telemedicine originating fee (Q3014) cannot be billed in combination with other rendered EMS services.

- Emergency ambulance transportation of more than 150 miles one way from an institution to an institution.
- Emergency transportation services certified by a physician as medically necessary, but not included as a covered service, may be covered for recipients under twenty-one years of age when such services are prior approved by the department.
- All ambulance transportation of more than 50 miles beyond the boundaries of the Georgia state line (out-of-state).
- Transportation that is not of an emergency nature, but the recipient requires services of an EMT and the life sustaining equipment provided in the emergency ambulance.
- All ambulance transportation by air ambulance except for recipients 0 to twelve months of age who meet certain criteria listed in the policies and procedures manual.

Limitation: Emergency ambulance services are reimbursable only when medically necessary. The recipient's physical condition must prohibit use of any method of transportation except emergency for a trip to be covered.

1004. Fee-For-Service Ground Ambulance Upper Payment Limit (UPL)

Supplemental Payment Program

Effective with dates of service beginning on January 1, 2020 and thereafter, the Fee-for-Service Ground Ambulance UPL program will provide supplemental payments for in-state government-owned (hospital affiliated or free-standing) ground ambulance providers.

A. Eligibility for Ground Ambulance Providers

Participation in the program is voluntary and dependent upon the ambulance provider securing a commitment from a unit of government or a healthcare provider that is owned by a unit of government to make an inter-governmental transfer (IGT) of funds

Rev.04/22

B. Participation Requirements

a. Ambulance providers must complete the Department of Community Health Average Commercial Rate Survey due on or before July 31st and January 31st of each year.
b. Effective with calculations on or after August 13, 2021, the following changes will apply:
    i. Ground ambulance providers to submit commercial payer rates every two years.
    ii. A statewide median average for those providers who are unable to provide a minimum of three commercial payer rates will be calculated (using claims with dates of service starting on or after January 1,2021).
    iii. The supplemental payment will be issued annually.
c. Providers are required to provide the rates paid by commercial insurers for the following HCPCS codes:
    1. A0425 - Mileage
    2. A0426 - Advanced Life Support (ALS, Non-Emergency)
    3. A0427 - Advanced Life Support (ALS, Level 1, Emergency)
    4. A0428 - Basic Life Support (BLS, Non-Emergency)
    5. A0429 - Basic Life Support (BLS, Emergency)
    6. A0433 - Advanced Life Support, Level 2 (ALS Level 2, Emergency)
    7. A0434 - Specialty Care Transport
d. Documentation supporting the commercial payment rates reported in the survey.
e. A completed and signed Government Ownership Checklist form.
f. Submit a transfer of public funds (ITG) from a unit of government (county, city, other municipality, or a state agency) to the state Medicaid agency.

C. Calculation of Payment

The first supplemental payment will be based on Medicaid FFS ambulance claim dates of service from January 1, 2020 through June 30, 2020. The second supplemental payment will be based on Medicaid FFS ambulance claim dates of service from July 1, 2020 through December 31, 2020. Each calculation will be based on Average Commercial Rate (ACR) data corresponding to the same period as the Medicaid claims data.

Provider ACR X Medicaid Fee-For-Service (FFS) Utilization = UPL

APPENDIX A
AMBULANCE REIMBURSEMENT

All codes are paid at Base Rate One Way **HCPCS Code**		**Description**		**Max Allow**
Rev.10/06	A0425	Mileage		$ 4.92
Rev.10/06	A0426	Advanced Life Support (ALS, Non-Emergency)	Prior Approval Required	$ 255.72
Rev.10/06 Rev. 07/16	A0427	Advanced Life Support (ALS, Level 1, Emergency)	Base Rate One-Way	$ 324.93
Rev.10/06	A0428	Basic Life Support (BLS, Non-Emergency)	Prior Approval Required	$159.82
Rev.01/06	A0429	Basic Life Support (BLS, Emergency)	Base Rate One-Way	$ 255.72
Rev.07/03	A0430	Base Rate – Fixed Wing (Airplane)	Prior Approval Required/Adult Prepayment Review	Calculated
Rev.07/06	A0431	Base – Rotary Wing (Helicopter)	Prior Approval Required/Adult Prepayment	Calculated
Rev.07/06 Rev.10/19	A0433	Advanced Life Support, Level 2 (ALS Level 2, Emergency)	Prepayment Review	$ 439.52
Rev.07/06	A0434	Specialty Care Transport	Prepayment Review	$ 303.67
Rev.07/16	A0436	Rotary Wing Air Mileage		$ 0.00
Rev.10/18	A0998	Treat Without Transport		$ 30.00

APPENDIX B

CLAIM FORM & BILLING INSTRUCTIONS

Rev.04/05

All enrolled provider for the Emergency Ambulance Services must use the CMS 1500 (02/12) form.

All claims for services rendered must be submitted within six (6) months from the date of service. Claims with third party resources must be submitted within twelve (12) months from the date of service.

Medicaid/Medicare Crossover

Rev.01/05

A special crossover claim form is no longer required when billing Medicaid/Medicare crossover. Claim(s) must be submitted in the same format as they are submitted to Medicare. If a hospital ambulance company submits a claim to Medicare on the UB-04 claim form; that form must also be used when submitting to Medicaid. The Medicare Explanation of Medicare Benefits (EOMB) *must* accompany the Medicaid claim in order to be considered for reimbursement. Claim(s) must be submitted within twelve (12) months from the date of service. Please review the Medicare Secondary Claims User Guide for additional information.

For specific Medicare crossover claims instructions and tips for submitting crossover claims, ambulance providers should refer to the “Medicaid Secondary Claims User Guide”.

NOTE: Medicare crossover claims are reimbursed in accordance with Part I, Chapter 300, Section 302 of the Policies and Procedures for Medicaid/PeachCare for Kids manual.

Rev.07/06

Non Hospice Related Transports

Non hospice related transports must be billed with the Hospice Referral Form for Non Hospice Related Services (DMA 521) attached. This form should be obtained from the hospice provider. The DMA 521 is located at **www.mmis.georgia.gov** under Documents and Forms.

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

The following table outlines the updated and revised changes to the new CMS 1500 claim (shown above) form (version 02/12):

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

	accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/HP:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering - DK; Referring - DN or Supervising - DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/HP:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes - value 9; or ICD -10 diagnoses (CM) codes - value 0. **(Do not bill ICD 10 code sets before October 1, 2015.)**
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. **FOR DCH/HP**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

This section provides *specific* instructions for completing the Health Insurance Claim Form CMS-1500 (02/12). A sample invoice is included for your reference.

Item 1 Health Insurance Coverage

Check Medicaid box for the patient's coverage.

Item 1a Insured's I.D. Number

Enter the member's Medicaid identification number exactly as it appears on the member's current Medical Assistance Eligibility Certification.

Item 2 Patient's Name

Enter the patient's name exactly as it appears on the patient's current Medical Assistance Eligibility Certification (last name first).

Item 3 Patient's Date of Birth and Sex

Enter the patient's 8-digit birth date (MM/DD/YYYY) and gender.

Item 5 Patient's Address

Enter the patient's street number and name, city, state and zip code.

Item 9 Other Insured's Name

As a general rule Medicaid/PeachCare for Kids is the "payor of last resort", meaning other available third party resources must be exhausted before Medicaid/PeachCare for Kids pays for the medical care of a member.

When a liable third party carrier is identified within the Medicaid Management Information System (MMIS), the services billed to Medicaid will be denied. The information necessary to bill the third party carrier will be provided as part of the Remittance Advice on the Third Party Carrier Page. A reasonable effort must be made to collect all benefits from other third party coverage (Please refer to Chapter 300 of the Part 1 Policies and Procedures Manual).

If the member has other third party coverage for these services item nine (9) must be completed with the name of the policyholder. If no third party coverage is involved leave the entire section blank. Medicare is not considered third party.

Item 9a Other Insured's Policy or Group Number

If there is other third party coverage enter the policy or group number.

Item 9d Insurance Plan Name or Program Name

Enter the insurance plan name or the program name and carrier code. (*Carrier codes are located in the Third Party Insurance Carrier Listing.)

Item 10-10c Is the Patient's Condition Related To:

Check all the appropriate boxes.

Item 14 Date of Current

Enter the exact or approximate date of the illness (first symptom), injury (accident), or pregnancy (last menstrual period).

Item 18 Hospitalization Dates Related to Current Services

Enter the dates of admission and/or discharge from an inpatient facility in month, date, year, (MM/DD/YYYY) format if applicable.

Item 19 Reserved for Local Use

Enter the 'From' and 'To' zip codes. 'From' refers to the point of pickup zip code and 'To' refers to the discharge point zip code.

Item 21 Diagnosis or Nature of Illness or Injury

Enter the valid ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) diagnosis code(s) related to the service(s) being rendered. All diagnosis codes must be written on the claim form using the identical format (excluding the decimal point) as shown in the ICD-10-CM book.

Item 22 Medicaid Resubmission Code

Enter the control number of the previous denied claim you are resubmitting.

Item 23 Prior Authorization Number

For services that require prior approval, enter the twelve digit prior approval number. If no prior approval is required leave blank.

Item 24a Date(s) of Service

Enter the date of service that the loaded ambulance vehicle departs the point of pickup (in MM/DD/YY format).

Item 24b Place of Service

Valid POS codes are:
41 – for Ground Ambulance
42 – for Air Ambulance

Item 24d Procedures, Services, or Supplies

Enter the appropriate procedure code for the type of transportation services provided. A list ambulance codes reimbursable by GA Medicaid is available in Appendix

Modifier

Rev.01/06 Modifiers are required on all valid ambulance codes. The approved modifiers are listed in Appendix C:

Rev.04/16

Item 24e Diagnosis Pointer

Enter the relevant number (1, 2, 3 or 4) linked to the ICD-10 CM diagnosis code entered in Item 21.

Item 24f Charges

Enter your "usual and customary" charge(s) for the transportation services provided.

Item 24g Days or Units

Enter total loaded miles traveled. Miles 0-10 are included in the base rate. If 0-10 units are billed no mileage will be reimbursed. If the provider bills for mileage over 10 miles (units), the MMIS will automatically deduct the 10 miles and only reimburse for mileage over 10. If mileage is required for more than one trip on the same date, all mileage should be added in item 24(g). The base rate should be billed on one line as two (2) units (if procedures are the same). If the base rate procedures are different, then they both must be billed on the same claim with 1 unit each.

Item 25 Federal Tax ID Number

Enter the tax ID

Item 26 Patient's Account No.

Enter the patient's account number. This is a number used internally by the provider. If no such number exists, leave blank.

Item 28 Total Charge

Enter the total of all charges listed in 24 (lines 1-6).

Item 29 Amount Paid

Enter the amount received from third party. If not applicable, leave blank.

Item 30 Balance Due

Enter the total charge (item 28) less any third party payment (item 29).

Item 31 Signature of Physician or Supplier Including Degrees or Credentials

The provider must sign or signature stamp each claim for services rendered and enter the date. Unsigned invoice forms will not be accepted.

Item 33 Billing Provider Info & PH#

Enter the provider's name, address, and phone number. Providers must notify the HP Enterprise Services Provider Enrollment Unit in writing of address changes.

Item 33a NPI

Enter the providers NPI number in field 33A.

Item 33b Enter the identifying Medicaid provider number assigned to you in field 33B.

APPENDIX C

Rev. 04/17
Rev. 10/18
Rev. 7/19

DD = Diagnosis or therapeutic site other than P or H When these are use as origin code; to Diagnosis or therapeutic site other than P or H When these are use as origin code;
DE = Diagnosis or therapeutic site other than P or H When these are use as origin code; to Residential, domiciliary, custodial facility (other than 1819 facility
DG = Diagnosis or therapeutic site other than P or H When these are use as origin code; to Hospital based ESRD facility;
DH = Diagnosis or therapeutic site other than P or H When these are use as origin code; to Hospital
DJ = Diagnosis or therapeutic site other than P or H When these are use as origin code; to Freestanding ESRD facility;
DN = Diagnosis or therapeutic site other than P or H When these are use as origin code; to Skilled nursing facility
DP = Diagnosis or therapeutic site other than P or H When these are use as origin code; to Physician's office;
DR = Diagnosis or therapeutic site other than P or H When these are use as origin code; to Residence
ED = Residential, domiciliary, custodial facility (other than 1819 facility); to Diagnosis or therapeutic site other than P or H When these are use as origin code;
EG = Residential, domiciliary, custodial facility (other than 1819 facility); to Hospital based ESRD facility
EH = Residential, domiciliary, custodial facility (other than 1819 facility); to Hospital
EN = Residential, domiciliary, custodial facility (other than 1819 facility); to Skilled nursing facility
ER = Residential, domiciliary, custodial facility (other than 1819 facility); to Residence
ET = Treatment without transport/Transport to Alternate Destination
GD = Hospital based ESRD facility; to Diagnosis or therapeutic site other than P or H When these are use as origin code;
GM = Multiple patients on one ambulance trip
GN = Hospital based ESRD facility; to Skilled nursing facility
GP = Hospital based ESRD facility; to Physician's office;
GR = Hospital based ESRD facility, to Residence
HH = Hospital to Hospital
HI = Hospital; to Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport
HN = Hospital; to Skilled nursing facility
HR = Hospital; to Residence
IH = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport; to Hospital
JD = Freestanding ESRD facility; to Diagnosis or therapeutic site other than P or H When these are use as origin code;
JE = Freestanding ESRD facility; to Residential, domiciliary, custodial facility (other than 1819 facility);
JG = Freestanding ESRD facility; to Hospital based ESRD facility
JH = Freestanding ESRD facility; to Hospital

JJ = Freestanding ESRD facility; to Freestanding ESRD facility;
JN = Freestanding ESRD facility; to Skilled nursing facility
JP = Freestanding ESRD facility; to Physician's office;
JR = Freestanding ESRD facility; to Residence
ND = Skilled nursing facility; to Diagnosis or therapeutic site other than P or H When these are use as origin code;
NE = Skilled nursing facility; to Residential, domiciliary, custodial facility (other than 1819 facility)
NG = Skilled nursing facility; to Hospital based ESRD facility
NH = Skilled nursing facility; to Hospital
NJ = Skilled nursing facility; to Freestanding ESRD facility
NN = Skilled nursing facility; to Skilled nursing facility
NP = Skilled nursing facility; to Physician's office
NR = Skilled nursing facility; to Residence
PD = Physician's office; to Diagnosis or therapeutic site other than P or H When these are use as origin code;
PE = Physician's office; to Residential, domiciliary, custodial facility (other than 1819 facility);
PH = Physician's office; to Hospital
PJ = Physician's office; to Freestanding ESRD facility;
PN = Physician's office; to Skilled nursing facility
PP = Physician's office; to Physician's office
PR = Physician's office; to Residence
QL = Patient pronounced dead after ambulance called
RD = Residence; to Diagnosis or therapeutic site other than P or H When these are use as origin code
RE = Residence; to Residential, domiciliary, custodial facility (other than 1819 facility)
RG = Residence; to Hospital based ESRD facility
RH = Residence; to Hospital
RI = Residence; to Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport
RJ = Residence; to Freestanding ESRD facility
RN = Residence; to Skilled nursing facility
RP = Residence; to Physician
SH = Scene of accident or acute event; to Hospital
SI = Scene of accident or acute event; to Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;
SN = Scene of accident or acute event; to Skilled nursing facility
SP = Scene of accident or acute event; to Physician's office
SR = Scene of accident or acute event; to Residence

APPENDIX D

CONDITION CODES

Georgia Medicaid requires the use of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes for all claims submitted for reimbursement. We have attached a list of Medical Condition Codes as an ***educational guide***. The attached list was most recently updated by CMS Transmittal 1185, Change Request 5542 issued February 23, 2007. It is a tool to assist ambulance providers and suppliers to communicate the patient's condition to Medicaid. Use of the Medical Condition Code list does not guarantee payment of the claim or payment for a certain level of service. Ambulance providers must maintain adequate documentation of dispatch instructions, patient's condition, other on-scene information, and details of the transport (e.g., medications administered, changes in patient's condition, and miles traveled), all of which may be subject to medical review by the Department.

ICD-10-CM codes are required on all FFS claims submitted to Georgia Medicaid for reimbursement, they are not required (per Health Insurance Portability and Accountability Act (HIPAA)) on most Medicare crossover claims and generally do not trigger a payment or denial of a claim.

While the medical conditions/ICD-10-CM code list is intended to be comprehensive, there are circumstances that warrant the need for ambulance services using ICD-10-CM codes not on this list. Because it is critical to accurately communicate the condition of the patient during the ambulance transport, claims should contain only the ICD-10-CM code that most closely informs the Department why the patient required the ambulance transport. This code is intended to correspond to the description of the patient's symptoms and condition once the ambulance personnel are at the patient's side. The Medical Conditions List is set up with an initial column of primary ICD-10-CM codes, followed by an alternative column of ICD-10-CM codes. The primary ICD-10-CM code column contains general ICD-10-CM codes that fit the transport conditions as described in the subsequent columns.

AMERICAN AMBULANCE ASSOCIATION
CONDITION CODE LIST
ICD-10 CROSSWALK VERSION

EMERGENCY NON-TRAUMATIC CONDITION CODES							
Condition-General	**Existing ICD-9 Primary Code**	**Proposed ICD-10 Code**	**ICD-10 Condition-General**	**Specific Condition**	**Level of Service**	**Comments**	**HCPCS**
Severe abdominal	535.50	R10.0	Acute Abdominal Pain	With other signs or symptoms.	ALS	Nausea, vomiting, fainting, pulsatile mass, distenstion, rigid, tenderness on exam, guarding.	A0427/A0433
Abdominal pain	789.00	R10.9	Unspecified Abdominal Pain	Without other signs or symptoms.	BLS		A0429
Abnormal cardiac	427.9	I49.9	Cardiac Arrhythmia, Unspecified	Potentially life threatening.	ALS	Bradycardia, junctional and ventricular blocks, non-sinus tachycardia, PVC's >6, bi and trigeminy, ventricular tachycardia, ventricular fibrillation, atrial flutter, pEA, asystole, AICD/AED fired.	A0427/A0433
Abnormal skin signs	780.8	R23.8	Other Skin Changes		ALS	Disphorhesis, cyanosis, delayed cap refill, poor tugor, mottled. Poor turgor, mottled.	A0427/A0433
Allergic Reaction	995.0	T78.2XXA	Anaphylatic shock, unspecified, initial encounter	Potentially life threatening.	ALS	Other emergency conditions, rapid progression of symptoms, prior history of anaphylaxis, wheezing difficulty swallowing, or symptoms.	A0427/A0433
Allergic Reaction	692.9	T78.40XA	Alergy, unspecified, initial encounter	Other	BLS	Hives, itching, rash, slow onset, local swelling, reddness, erythema.	A0429
Blood glucose	790.21	R73.09	Other abnormal glucose	Abnormal <80 or >250 with symptoms.	ALS	Altered mental status, vomiting, signs of dehydration.	A0427/A0433
Abnormal Vital signs {includes abnormal pulse}	796.4	R68.89	Other general symptoms and signs	With or without symptoms	ALS		A0427/A0433
Respiratory Arrest	799.1	R09.2	Respiratory Arrest		ALS	Apnea, hypoventilation requiring ventilatory assistance and airway management.	A0427/A0433
Difficulty breathing	786.05	R06.02	Shortness of Breath		ALS		A0427/A0433
Cardiac arrest -resucitation in progress	427.5	I46.9	Cardiac arrest, cause unspecified		ALS		A0427/A0433
Chest pain [non-traumatic]	786.50	R07.9	Chest pain, unspecified		ALS	Dull, severe, crushing, substernal, epigastric, left sided chest pain associated with pain of the jaw, left arm, neck, back and nausea, vomitting, palpitations, pallor, disphoresis, decreased LOC.	A0427/A0433
Choking episode	784.99	R09.89	Other specified symptoms and signs involving the circulatory and respiratory systems	Airway obstructed or partially obstructed.	ALS		A0427/A0433
Cold exposure	991.6	T68.XXXA	Hypothermia, initial encounter	Potentially life or limb threatening.	ALS	Temperature of 95°F, deep frost bite, and other emergency conditions.	A0427/A0433
Cold exposure	991.9	T69.9XXA	Effect of reduced temperature, unspecified intinal encounter	With symptoms.	BLS	Shivering, superficial frost bite, and other emergency conditions.	A0429
Altered level of consciousness (nontraumatic)	780.97	R41.82	Altered mental status, unspecified		ALS	Acute conditon with Glascow Coma Scale < 15.	A0427/A0433
Convulsions/seizures	780.39	R56.9	Unspecified convulsions	Seizing, immediate post seizure; postictal, or at risk of seizure & requires medical monitoring/observation.	ALS		A0427/A0433
Eye symptoms [non-traumatic]	379.90	H57.9	Unspecified disorder of eye and adnexa	Acute vision loss and/or severe pain.	BLS		A0429
Non-traumatic headache	437.9	G44.89	Other headache syndrome	With neurologic distress conditions or or sudden onset.	ALS		A0427/A0433
Cardiac symptoms other than chest pain	785.1	R00.2	Palpitations	Palpitations, skipped beats.	ALS		A0427/A0433
Cardiac symptoms other than chest pain	536.2	R07.9	Chest Pain, unspecified	Atypical pain or other symptoms.	ALS	Persistant nausea and vomiting, weakness, hiccups, pleurtic pain, feeling of impending doom and other emergency conditions.	A0427/A0433

AMERICAN AMBULANCE ASSOCIATION
CONDITION CODE LIST
ICD-10 CROSSWALK VERSION

Condition-General	Existing ICD-9 Primary Code	Proposed ICD-10 Code	ICD-10 Condition-General	Specific Condition	Level of Service	Comments	HCPCS
Heat exposure	992.5	T67.5XXA	Heat exhaustion, unspecified, intial encounter	Potentially life-threatening.	ALS	Hot and dry skin. Temp>105, neurologic distress of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions.	A0427/A0433
Heat exposure	992.2	T67.2XXA	Heat cramp, unspecified, intial encounter	With symptoms.	BLS	Muscle cramps, profuse sweating, fatigue.	A0429
Hemorrhage	459.0	R58	Hemorrhage, not elsewhere classified	Severe [quantity] and potentially life theatening.	ALS	Uncontrolled or significant signs of shock or other emergency conditions. Severe, active vaginal or rectal bleeding, hematemesis, hemoptysis, epistaxis, active post-surgical bleeding.	A0427/A0433
Infectious diseases requiring isolation procedures/public health risk	038.9	B99.9	Unspecified infectious disease		BLS		A0429
Hazmat Exposure	987.9	T59.891A	Toxic effect of other specified gases, fumes and vapors, accidental (unintentional), initial encounter		ALS	Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation.	A0427/A0433
Medical Device Failure	995.00	T82.519A	Breakdown (mechanical) of unspecified cardiac and vascular devices and implants, initial encounter	Life or limb threatening malfunction, failure, or complication.	ALS	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted durg therapy device.	A0427/A0433
Medical Device Failure	996.30	Y82.8	Other medical devices associated with adverse incidents	Health maintenance device failures that cannot be resolved on location.	BLS	Oxygen system supply malfunction, orthopedic device failure.	A0429
Neurologic Distress	436	R41.89	Other symptoms and signs involving congnitive functions and awareness	Facial drooping, loss of vision, aphasia, difficulty swallowing, numbness, tingling, extremity, stupor, delirium, confusion, hallucinations, paralysis, paresis [focal weakness], abnormal movements, vertigo, unsteady gait/balance, slurred speech, or unable to speak.	ALS		A0427/A0433
Pain, severe not otherwise specified	780.96	R52	Pain, unspecified	Acute onset, unable to ambulate or sit due to intensity of pain.	ALS	Pain is the reason for the transport. Use severity scale (7-10 for severe pain) or patient receiving pharmalogic intervention.	A0427/A0433
Back pain - non-traumatic [T and/ or LS]	724.5 or 724.9	M54.9	Dorsalgia, unspecified	Suspect cardiac or vascular etiology or sudden onset of new neurological symptoms.	ALS	Other emergency conditions, absence of/or decreased leg pulses, pulsatile abdominal mass, severe tearing abdominal pain or neurolgoical distress.	A0427/A0433
Poisions, ingested, injected, inhaled, abdorbed.	977.9	T50.904A	Poisoning by unspecified drugs, medicaments and biological substances, undetermined, initial encounter	Adverse drug reaction, poison exposure by inhalation, injection or absorption.	ALS		A0427/A0433
Alcohol intoxication or drug overdose [suspected]	305.00	T88.7XXA	Unspecified adverse effect of drug or medicament	Unable to care for self and unable to ambulate, airway not compromised.	BLS		A0429
Severe alcohol intoxication	977.3	F10.929	Alcohol use, unspecified with intoxication, unspecified	Airway may or may not be at risk. Pharmacological intervention or cardiac monitoring may be needed. Decreased LOC resulting or potentially resulting in airway compromise.	ALS		A0427/A0433
Post-operative procedure complication	998.9	T81.89XA	Other complicatios of procedures NOS	Major wound dehiscence, eviseration, or requires special handling for transport.	BLS	Non-life threatening.	A0429
Pregnancy complication/child birth/labor	650	O26.90	Pregnancy related condtions, uspecified, unspecified trimester		ALS		A0427/A0433
Psychiatric/behavioral	292.9	F19.939	Other psychoactive substance use, unspecified with withdrawal, unspecified	Abnormal mental status; drug withdrawl.	ALS	Disoriented, DT's, withdrawal symptoms.	A0427/A0433

AMERICAN AMBULANCE ASSOCIATION
CONDITION CODE LIST
ICD-10 CROSSWALK VERSION

Condition-General	Existing ICD-9 Primary Code	Proposed ICD-10 Code	ICD-10 Condition-General	Specific Condition	Level of Service	Comments	HCPCS
Psychiatric/behavioral	298.9	R45.89	Other symptoms and signs involving emotional state	Threat to self or others, acute episode or exacerbation of paranoia, or disruptive behavior.	BLS	Suicidal, homicidal or violent.	A0429
Sick person - fever	036.0	R50.9	Fever, unspecified	Fever with associated symptoms [headache, stiff neck, etc.] Neurological changes.	BLS	Suspected spinal meningitis.	A0429
Severe dehydration	787.01	E86.9	Volume Depletion Unspecified	Nausea and vomiting, diarrhea, severe and incapacitating resulting in severe side effects of dehydration.	ALS		A0427
Unconscious, fainting, syncope, weakness, or dizziness	780.02	R55	Syncope	Transient unconscious episode or found unconscious. Acute episode or exacerbation.	ALS		A0427/A0433
EMERGENCY TRAUMA CONDTITION CODES							
Condition-General	**Existing ICD-9 Primary Code**	**Proposed ICD-10 Code**	**ICD-10 Condition-General**	**Specific Condition**	**Level of Service**	**Comments**	**HCPCS**
Major trauma	959.8, 995.83, 879.8, or 995.80	T07	Unspecified multiple injuries	As defined by ACS Field Triage Decision Scheme. Trauma with one of the following: GC>14; systolic BP < 90; RR <10 or >29; all penetrating injuries to head, neck, torso, extremitites proximal to elbow or knee, chest, combination of trauma and burns, pelvic fractures, open or depressed skull fracture, paralysis, severe mechanism of injury, including: ejection, death of another passenger in same patient compartment, falls >20", '20 deformity in vehicle or 12" deformity of patient compartment, auto pedestrian/bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle or sexual assault with major and minor injuries.	ALS/BLS	See "Condition (specific) column	A0427/A0433
Acute Respiratory Failure, following Trauma or Surgery	518.51	J96.00	Acute Respiratory failure, unspecified whether with hypoxia or hypercapnia	Need to Monitor or maintain airway. Decreased LOC, bleeding into airway, trauma to head face or neck.	ALS		A0427/A0433
Open and Closed Trauma's, Animal Bites	887.4, 897.4,869.0,869.1,989.5, 829.0, 880.00,886.0, or 895.0	T14.8	Other injury of unspecified body part	Open and closed traumas, amputations, wounds,and animal bites with local pain, swelling or special handling, or potentianally life threatening.	ALS/BLS		A0427/A0433
Other trauma	958.2	R58	Hemorrahge not elsewhere classified	Major bleeding.	ALS	Uncontrolled or significant bleeding.	A0427/A0433
Lightning	994.0	T75.00XA	Unspecified effects of lightning, initial encounter		ALS		A0427/A0433
Electrocution	994.8	T75.4XXA	Electrocution, initial encounter		ALS		A0427/A0433
Near Drowning	994.1	T75.1XXA	Unspecified effects of drowning and nonfatal submersion, initial encounter	Airway compromised during near drowning.	ALS		A0427/A0433
Burns	949.2, 949.3	T30.0	Burns of unspecifed body region, unspecifed degree	Major or minor burns.	ALS		A0427/A0433
Eye injuries	921.9	S05.90XA	Unspecified injury of unspecified eye and orbit, initial encounter	Acute vision loss or blurring, severe pain or chemical exposure, penetrating sever lid lacerations.	BLS		A0429
NON-EMERGENCY CONDITION CODES							
Condition-General	**Existing ICD-9 Primary Code**	**Proposed ICD-10 Code**	**ICD-10 Condition-General**	**Specific Condition**	**Level of Service**	**Comments**	**HCPCS**
Cardiac/hemodynamic monitoring in route	428.9	Y71.0	Diagnostic and monitoring cardiovascular devices associated with adverse events		ALS	Expectation monitoring is needed before and after transport.	A0426

Advanced airway maagement	518.81 or 518.89	J98.4	Other disorders of the lungs		ALS	Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning.	A0426/A0433
Chemical restraints	293.0	F06.8	Other specified mental disorders due to known physiological condition		ALS	Medication administered for the explicit purpose of reducing an individual's functional capacity where there is dange to physicial safety of self or others.	A0426
Condition-General	**Existing ICD-9 Primary Code**	**Proposed ICD-10 Code**	**ICD-10 Condition-General**	**Specific Condition**	**Level of Service**	**Comments**	**HCPCS**
Suctioning required enroute, need for titrated O2 therapy or IV fluid management	496	Z99.89	Dependance on other enabling machines		BLS	Per transfer instructions.	A0428
Airway control/positioning required enroute	786.09	R06.89	Other abnormalities of breathing		BLS	Per transfer instructions.	A0428
Third party assistance attendant required to apply, adminster or regulate or adjust oxygen enroute	492.8	Z99.81	Adminstor Supplemental Oxygen		BLS	Does not apply to patient capable of self-administration of portable or home O2. Patient must require oxygen therapy and be so frail as to require assitance.	A0428
Patient safety: Danger to self or others in restratints, monitoring or seclusion	293.1 or 298.8 or 298.9	R45.89	Other symptoms and signs involving emotional state	Patient safety-danger to self or others-threat to self or others, acute episode.	BLS	Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely. Refer to 42 CFR Section 482.13 (f) for definition.	A0429
NON-EMERGENCY CONDITION CODES							
Condition-General	**Existing ICD-9 Primary Code**	**Proposed ICD-10 Code**	**ICD-10 Condition-General**	**Specific Condition**	**Level of Service**	**Comments**	**HCPCS**
Patient safety - risk of of falling off wheelchair or stretcher while in motion. (not related to obesity)	781.3	Z91.81	Risk of Falling		BLS	Patient's physical condition is such that patient risks injury during vehicle movement despite restraints.	A0428
Special handling -en route-isolation	041.9	B96.89	Other specified baterial agents as the cause of diseases classifed elsewhere.		BLS	Includes patients with communicable diseases or hazardous material exposure who must be isolated from public whose medical condition must be protected from public exposure; surgical drainage complications.	A0428
Special handling, positioning required.	907. 2 or 719.45 or 719.49	G89.29	Other Chronic pain		BLS	Requires special handling to avoid further injury.	A0428
Bed Confined	NEW	Z74.01	Bed Confied Status	Limited to patients that are: (1) unable to get up from bed without assistance, (2) unable to ambulate, and (3) unable to sit in a chair or wheelchair. All three conditions must be present for this condition to apply.	BLS	Refer to 42 CFR Section 410.40 (d)(1) for definition.	A0428

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Rev 07/21

Appendix F

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 three 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 three licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	CareSource 1-855-202-1058 www.caresource.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 three CMOs are State-wide.**

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

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

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
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/Georgia Medicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.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.

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 recredentialing 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 recredentialing 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 recredentialing 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 recredentialing decision. The credentialing decision is provided to the CMOs.

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES for assistance with credentialing and recredentialing 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
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.

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan
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	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.

	due to moral or religious objections • PCP moves, retires, etc.	

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
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.

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
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

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 #	GROUP #	Helpdesk
Amerigroup Community Care	IngenioRx	020107	HL	WKJA	1-833-235-2031
CareSource	Express Scripts (ESI)	003858	MA	RXINN01	1-800-416-3630
Peach State Health Plan	CVS	004336	MCAIDADV	RX5439	1-844-297-0513

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
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes

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
1 (800) 454-3730	1 (855) 202-1058 1 (866) 930-0019 (fax)	1 (866) 399-0929

APPENDIX G

GEORGIA HEALTH PARTNERSHIP (GHP)

Provider Correspondence GEORGIA HEALTH PARTNERSHIP (GHP)

Gainwell Technologies
Provider and Member Services
P.O. Box 105200
Tucker, GA 30085-5200

Provider Enrollment
Access on-line at www.mmis.georgia.gov

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

- - Asynchronous
  - Web Portal
  - Physical Media
  - Network Data Mover
  - Systems Network Architecture
  - Protocol (TCP/IP)

Provider Inquiry Numbers:

800-766-4456 (Toll free)

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