PART II

POLICIES AND PROCEDURES
For
HOSPITAL SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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Part II Policies and Procedures Manual for Hospital Services

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PART II - POLICIES AND PROCEDURES
FOR
HOSPITAL SERVICES

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PART II - CHAPTER 600

SPECIAL CONDITIONS OF PARTICIPATION AND INITIAL ENROLLMENT

601. Special Conditions of Participation

In addition to the general conditions of participation which apply to all providers in the
Medicaid Program as outlined in Part I, the following conditions apply to hospitals:

601.1 The Hospital must be currently licensed under the provisions of state law and must not be operated primarily for the care and treatment of patients with mental disease or special disorders such as, but not limited to, alcoholism or drug abuse.

601.2 The Hospital must meet Title XVIII Standards for Medicare participation as currently determined or be certified as eligible for participation.

601.3 The Hospital must operate a utilization review program in compliance with a Utilization Review Plan approved by the state.

601.4 When a Hospital provides medical treatment to a member for injury, disability, disease or sickness resulting from accidents or other possible tortuous conduct, the Division must be notified. Please refer to Section 303.5 of Part I Policies and Procedures for Medicaid/PeachCare for Kids.

Third Party Administration
Division of Medical Assistance Plans
P. O. Box 38439
Atlanta, Georgia 30334

601.5 "Hill-Burton" Hospitals are required to comply with Hill-Burton regulations.

601.6 The Hospital must develop written policies and procedures on advance directives in compliance with Section 1902 (a) (57) of the Social Security Act. (See Section 901)

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601.7 In accordance with the Mammography Quality Standards Act (MQSA) of 1992, P.L. 102-539, when a hospital provides mammography services, the facility is required to submit a copy of the Food and Drug Administration (FDA) letter of certification that identifies the mammography certification number. The hospital must notify the Division of any change in certification status. Notification should be mailed to:

Gainwell Technology
Provider Enrollment
Post Office Box 105200
Tucker, Georgia 30085-5201

The Hospital must timely and accurately report to the Georgia Comprehensive Cancer Registry certain information on cancer patients who receive hospital services at the hospital in accordance with the Georgia Comprehensive Registry Policy and Procedure Manual (Cancer Registry Manual).

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

602. Initial Enrollment

In addition to the completion of a Statement of Participation and a Request for Taxpayer Identification Number and Certification (IRS Form W-9), a hospital also must submit the following information:

A) A letter from the state licensing unit showing the bed capacity, permit number and effective date of the permit.

B) A document from the state licensing unit showing that the hospital has been recommended for certification or that it meets the requirements for the Medicare program.

C) Written evidence that the hospital is in compliance with Title VI, Civil Rights Act of 1964, as amended.

D) A copy of the written notification to the hospital from the Medicare fiscal intermediary showing the fiscal year end and Medicare provider number.

E) The hospital's most common semi-private room rate.

F) A copy of the hospital's current Utilization Review Plan.

G) Advance Directives Letter of Agreement.

H) When the hospital provides mammography services, a copy of the letter of certification that identifies the mammography certification number.

I) A copy of the CMS-1513 form, Disclosure of Ownership and Control Interest Statement.

Rev. 1/15 603. Change of Ownership or Legal Status

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

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

1) Effectively became a different legal entity through incorporation, re-incorporation, merger, joint venture, dissolution, creation of a partnership, or reorganization,
2) Took over more than fifty percent (50%) of the predecessor's assets, Medicaid/PeachCare for Kids clients, or Medicaid/PeachCare for Kids billings,
3) Or has substituted for the predecessor in the program, as evidenced by all attendant circumstances.

Reimbursement for services rendered prior to the effective date of enrollment of a successor provider (including any adjustments for underpayments made by the Division) shall be made to the provider of record at the time the payment is made or to that provider's payee as properly designated on the appropriate form(s) required by the Division. Any dispute or conflict legal or otherwise, arising between the currently enrolled provider and the predecessor provider concerning either apportionment of liability for any overpayment previously made by the Division or the right to additional reimbursement for any underpayments previously made by the Division shall be the sole responsibility of such parties and shall not include the Division.

B) Upon completion of the change of ownership or legal status enrollment application, the predecessor's provider number will be the same base nine-digit provider number as the successors with a unique suffix identifying the service location, e.g. 123456789B. The Department shall authorize this only in situations in which the predecessor and successor's category of service are the same.

1) Should the predecessor and successor's category of service not be the same, the new owner applying for enrollment may not request a change of the predecessor's provider number without the express consent of the Chief of the Division of Medical Assistance.

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

PART II- CHAPTER 700
SPECIAL ELIGIBILITY CONDITIONS

No special member eligibility conditions, other than those listed in Part I, Section 106, are required for utilization of services in the Hospital Program.

PART II - CHAPTER 800

PRECERTIFICATION PROCEDURES

801. Services That Require Precertification

As a condition of Reimbursement, the Division requires that Inpatient Hospital admissions and certain outpatient procedures be prior approved or pre-certified. Precertification pertains to medical necessity and appropriateness of setting only; the patient must be eligible at the time the service is rendered. The purpose of the program is to ensure that medically necessary quality health-care services be provided to eligible Medicaid members in the most cost effective setting. Precertification does not guarantee reimbursement. The medical record must substantiate the medical necessity including the appropriateness of the setting for the services provided and billed to the Division.

All services regardless of certification are subject to review for medical necessity. (See Part I, Sections 106.12 and 204.)

Deliveries, Newborns (birth), and members who have Medicare Part A are not subject to precertification. Once a newborn has been discharged from the initial birth hospital stay, Precertification is required for all subsequent admissions.

Newborns remaining hospitalized more than 30 days continuously from the date of birth require precertification beginning the 31st day of that hospital stay.

For dates of service October 1, 1993 through June 30, 1995, cesarean section deliveries at certain hospitals will be exempt from precertification requirements. To qualify for this exemption, the hospital must perform at least one hundred Medicaid paid deliveries in the calendar year. Additionally, the number of Medicaid paid cesarean section deliveries must have been no more than twenty percent of the hospital's total Medicaid paid deliveries for the previous calendar year.

As a condition of reimbursement, emergency admissions must be certified within thirty calendar days after admission (see Section 903.6). Inpatient hospital admissions for post delivery services must be pre-certified when a delivery procedure cannot be coded on the hospital claim form; e.g., delivery at home, delivery enroute to the hospital, etc.

Appendix D provides detailed information regarding specific outpatient procedures that must be certified prior to the time they are performed. Emergency outpatient services and Urgent outpatient procedures performed as a result of a condition which, if not treated within 48 hours, would result in significant alteration in the member's health status, must be certified within thirty (30) calendar days of the date of the procedure.

NOTE: FAILURE TO OBTAIN THE REQUIRED CERTIFICATION WILL RESULT IN DENIAL OF REIMBURSEMENT.

802. Procedures for Obtaining Precertification for All Medical Services except Dental Services and Transplants

The attending physician is responsible for obtaining precertification for the services identified in Section 801 and for providing the precertification number to each Medicaid provider associated with the case; i.e., assistant physician, hospital, etc. The physician's failure to obtain the correct precertification number will be imputed to the hospital and result in denial of payment. If the attending physician is not currently enrolled as a Medicaid provider or the patient has Medicare Part B only, the hospital then is responsible for obtaining the precertification number and making it available to each provider associated with the case.

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Requests should be initiated at least one (1) week prior to the planned admission or procedure. Approval is valid for ninety (90) days from the date of approval. Hospital admissions exceeding ninety (90) days require recertification within three (3) calendar days prior to the ninetieth (90th) day of the continued stay. Failure to obtain recertification within the three calendar days of the ninetieth day will result in denial of the continued stay. No recertification will be granted for any part of the continuous stay if the request for recertification is received after the ninetieth (90th) day. Precertification and recertification may be requested by contacting the Gainwell Technology PA/UM online via the web portal at www.mmis.georgia.gov or by calling

Telephone: 1-800-766-4456 (Provider Call Center)

Rev. 10/09

Sections 202.2 of Part 1 addresses timely submission of claims when conditions exist that are beyond the control of the provider. In accordance with Section 202.2, when an individual is made retroactively eligible, requests for certification must be received within six (6) months from the month of determination of retroactive eligibility. Additionally, when members are eligible for both Medicare and Medicaid, and Medicare benefits are exhausted, requests for certification must be received within three (3) months of the month of notification of exhaustion of benefits.

In a case in which it is unknown if Medicaid will be the primary payer, you should call the Gainwell Technology PA/UM Call Center. Medicaid patients with Medicare Part A and B coverage do not require precertification from Medicaid.

Medicaid patients with Part B only coverage should be precertified. Members with private insurance and Medicaid should be precertified.

When precertification is not required or has been obtained for an outpatient procedure and during the procedure, it is determined that additional or a different procedure is necessary (for determining timeliness or precertification update requests), the additional or different procedure will be considered an urgent procedure. The hospital's request for an update of the precertification file will be considered timely if received within thirty days of the date of the procedure.

When precertification is not required or has been obtained for an outpatient procedure and after the procedure has been performed, it is determined that inpatient services are necessary (for determining timeliness of precertification update requests), the admission

should be considered an emergency. The hospital's request for an update of the precertification file should be considered timely if received within thirty days of the beginning date of the episode of care.

Requests for updates to the precertification file and retroactive certification of inpatient admissions following a procedure or service clearly requiring an inpatient level of care that should have been anticipated will not be considered timely and will be denied.

An outpatient observation status becomes inpatient when the determination is made that inpatient services are medically necessary (if the length of stay is less than 48 hours) or the length of stay is no more than 48 hours. In these cases, the request for certification of the inpatient admission must be received within thirty (30) days of the beginning date of the episode of care (see Section 903.6).

803. Procedures for Obtaining Precertification for Dental Services Requiring Hospitalization

Dental services requiring inpatient or outpatient hospitalization must be Prior Approved and/or Pre-certified for Medicaid members regardless of age and service being performed. It is the responsibility of the attending dentist to obtain prior approval and/or precertification. The attending dentist must provide the precertification number to the hospital. The dentist failure to obtain the correct precertification number will be imputed to the hospital and result in denial of payment.

The hospital must submit Dental charges using the appropriate Current Dental Terminology (CDT) procedure code for the services provided.

All dentists' requests must be submitted on the American Dental Association (ADA) 1999, Version 2000 Dental claim form. The dentist's requests for surgical and medical services identified in Part II of the Dental Services manual must be submitted on the all precertifications should be submitted via the Web Portal.

804. Procedures for Obtaining Precertification for Covered Transplants

Refer to Section 903.3 for additional information regarding transplant services. Requests for approval of coverage of all transplant services, on the all precertifications should be submitted via the Web Portal.

The request sent to GMCF for review prior to performance of the transplant should include current medical records. These records should include medical history, pertinent laboratory findings, x-ray and scan reports, social history, and test results that exclude viremia.

Transplant procedures and related services must be approved prior to the time that services are rendered, regardless of age. These services cannot be approved retroactively. The member must be eligible at the time services are provided.

If approval is given for the transplant procedure a twelve-digit precertification number will be assigned.

PART II - CHAPTER 900

SCOPE OF SERVICES

901. General

The Hospital Program provides reimbursement for medical services rendered in an inpatient or outpatient hospital setting. Covered services for eligible program members are those primarily for treatment indicated in the management of acute illness, injury, or impairment, or for maternity care.

Federal regulations require that the Division establish reimbursement limitations to ensure medical necessity of services and utilization control.

In accordance with Federal regulations, non-covered medically necessary services provided to children less than twenty-one (21) years of age may be reimbursable if prior approved by the Division. All services provided to members twenty-one years (21) of age and older are subject to the reimbursement limitations described in this manual regardless of the diagnosis, type of illness or condition.

Coverage is provided for preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished under the direction of a doctor or by an institution which is licensed or formally approved as a hospital by an officially designated state standard-setting authority and is qualified to participate under Title XVIII (Medicare) of the Social Security Act, or is determined currently to meet the requirements for such participation, and which is enrolled in the Medicaid program.

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

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

- Provide written information to individuals regarding the institutions or program's written policies respecting the implementation of the right to formulate advance directives.

- Document in the patient's medical record whether or not an advance directive has been executed.

- Comply with all requirements of State law respecting advance directives.

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

- Not condition the provision of care or otherwise discriminate against an individual who has executed an advance directive.

901.1 An "inpatient" is defined as a patient who has been admitted to a participating hospital on recommendation of a licensed doctor and is receiving room, board, and professional services in the hospital on a continuous twenty-four hour a day

basis. A length of stay less than twenty-four hours may be considered inpatient if the service can only be provided on an inpatient basis. (See Section 904.7) Transfers between units within the hospital are not considered new admissions.

Rev. 12/12

901.2 An "outpatient" is a patient who is receiving professional services at a participating hospital. (See Section 903.6 regarding observation services.)

Free standing (satellite) clinics, which are not operated as part of a hospital, are considered doctors' offices. Services provided in these clinics and other away- from-hospital settings are not covered in the Hospital Program.

902. Documentation and Coding Requirements

Written records must be maintained which fully disclose the extent, medical necessity and appropriateness of setting for those services provided. The information must identify the patient, support the diagnosis, justify the treatment, and document the course and results accurately. See section 903.14.

902.1 All Medical Records must contain the information listed below:

A) Identification of the patient.

B) Medical history of the patient.

C) Report of relevant physical xamination.

D) Diagnostic and therapeutic orders.

E) Evidence of appropriate informed consent.

F) Clinical observations, including the results of therapy.

G) Reports and results of procedures and tests.

H) Conclusions at termination of hospitalization, evaluation or treatment.

I) Condition of the patient upon discharge and instructions given to the patient and family.

J) Signature and date for each entry.

902.2 Inpatient Medical Records must contain at least the following:

A) Identification data including the patient's name, address, date of birth, next of kin, and a number that identifies the patient and the patient's medical record.

B) Medical history completed within twenty-four of admission, including the chief complaint, details of the present illness, relevant past, social and family histories, and an inventory by body systems.

C) Relevant obstetrical records and prenatal information.

D) Report of the physical examination, completed within twenty-four of admission;

E) A statement of conclusions or impressions drawn from the admission history and physical examination.

F) A statement of the course of action planned for the patient while in the hospital including a periodic review of the planned course of action, as appropriate.

G) Diagnostic and therapeutic orders written by medical staff members. Verbal orders must be authenticated in the manner established by the Rules and Regulations for Hospitals, Chapter 290-9-7-.18(2) (6) (1).

H) Appropriate informed consent;

I) Clinical observations.

J) Progress notes by the medical staff which give a chronological report of the patient's course in the hospital and reflect changes in condition and the results of treatment.

K) Consultation reports that contain the consultant's written opinion and reflect, when appropriate, an actual examination of the patient and the patient's medical record.

L) Nursing notes and entries by non-physicians that contain medically relevant observations and information.

M) Reports of procedures, tests and their results.

N) A preoperative diagnosis recorded prior to surgery by the individual responsible for the patient.

O) Operative report dictated or written on the medical record immediately after surgery containing a description of the findings, the technical

procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary surgeon and any assistants.

P) Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedures.

Q) Clinical summary at termination of hospitalization which recapitulates the reason for hospitalization, the significant findings, and the procedures performed and treatment rendered the condition of the patient upon discharge, and any significant instructions given to the patient and family.

R) In teaching hospitals, the medical record must make it clear that the attending physician is providing professional services independently of the student or resident and that the notes of the student or resident only reflect his role as student or resident. At a minimum, the medical record must contain signed or countersigned notes which clearly specify that the physician personally reviewed the history, gave a physical examination, and confirmed or revised the diagnosis and prescribed treatment. The attending physician must be recognized by the member as the member's personal physician.

902.3 In addition, Physicians' Current Procedural Terminology, Fourth Edition (CPT-4) coding and/or HCPCS is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. Certain codes from these schemes are not accepted by the Division.

Hospitals are required to code all relevant diagnoses and all surgical and obstetrical procedures on all inpatient and outpatient claims submitted to the Division.

The hospital must select the code(s) that most nearly describe(s) the diagnosis (es) and procedure(s) performed. When a single code is available for reporting multiple tests of procedures, that code must be utilized rather than reporting the tests or procedures individually.

ICD-10-CM and CPT Coding Books may be ordered from:

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

Order Department OP054192
American Medical Association
P. O. Box 10950
Chicago, Illinois 60610

902.4 The claim form required by the Division for billing (inpatient and outpatient hospital services is the National Uniform Billing Form (UB-04). See the Billing Instructions Appendix O) for the required information to file a claim for hospital services.

903. Hospital Services

The Division will reimburse enrolled hospital providers for the services and procedures.

903.1 Hospital Based Physicians, Certified Registered Nurse Anesthetists, and Nurse Practitioners

Prior to July 1, 1991, hospital providers were given the option of billing for hospital-based physicians' professional services on the hospital claim form. Effective with dates of service July 1, 1991, and after, all hospital-based physicians must be enrolled in the Physician Services. Program and all inpatient and outpatient professional services must be billed on the physician's claim form.

Prior to July 1, 1993, services provided by certified registered nurse anesthetists, (CRNAs), nurse practitioners and physician's assistant anesthesiologist's assistants (PAAAs) could be billed on the hospital claim form. Effective with dates of service July 1, 1993, and after, all CRNAs, pediatric nurse practitioners, obstetrical nurse practitioners, family nurse practitioners and PAAAs must enroll in the appropriate practitioner program within the Division of Professional Services.

Effective with dates of service January 1, 1994, and after, adult and gerontological nurse practitioners must enroll in the appropriate practitioner program within the Division of Professional Services. All inpatient and outpatient services must be billed in accordance with the policies and procedures for the specific program.

Hospital-based physicians, CRNAs, specified nurse practitioners and PAAAs may designate the hospital as payee by agreement. The hospital must maintain each agreement authorizing such payments on file and submit a copy to the Provider Enrollment Unit at the address included in Part I, Section 105.

Services rendered to eligible members by hospital-based physicians, CRNAs, designated nurse practitioners and PAAAs will be covered both on an inpatient and outpatient basis as long as the services are medically necessary and within the contractual or financial agreement with the hospital. These services are subject to retrospective review by the Division or its authorized agents.

903.2 Services Available Through Contractual Shared Agreement

When covered services are not available or provided in the hospital where the member is an inpatient or outpatient, the services must be furnished by another enrolled hospital through a contractual agreement. The original hospital where the member is an inpatient or outpatient must bill the Medicaid program for the shared services or procedures along with the other charges incurred during that course of treatment or inpatient confinement. The Medicaid program should only be billed by the original hospital for all of the charges incurred. Services furnished "under arrangement" with outside

suppliers, including other providers, are subject to CMS-15, Provider Reimbursement Manual, principles of reimbursement.

Rev. 01/09

A) Hospital Back Transfers

The department may approve transfers from a higher level of care facility to the originating lower level of care facility for continuation of a lower level of care, provided the:

1. Higher level of care is no longer warranted,

2. Level of care continues to meet the criteria for inpatient confinement, and

3. Transfer back does not compromise patient care.

This is intended to provide a mechanism for Georgia Medicaid members to receive medically necessary level of care in the most appropriate setting and does not serve to replace or otherwise circumvent the terms and conditions outlined in Section 903.2: *Shared Available Through Contractual Shared Agreement.* This policy is not meant to allow transfers to lower level of care facilities to alleviate bed overcrowding or for patient convenience. All transfers are subject to precertification in accordance with Section 800.

See Section 1013 for transfer cases for reimbursement of Hospital Back Transfers.

903.3 Transplant Services

Rev. 07/08

Services and supplies related to covered transplant services may be billed to the Division as long as the individual receiving the transplant is eligible for Medicaid. For Medicaid members under age twenty-one (21) years of age, all recognized, non-experimental organ transplants are covered if medical necessity is properly documented and precertification/prior approval is obtained. For Medicaid members twenty-one (21) years of age and over, the only transplants covered are kidney, liver, bone marrow and cornea. Non-covered transplant services are not covered if Medicaid did not pre-certify the transplant, then any subsequent charges or follow-up care is non-covered per Medicaid Policy.

See Chapter 800 for precertification requirements.

Hospital services in connection with the acquisition of tissue or an organ from a living donor for transplant in an eligible member are considered as services for the treatment of the member and are covered as such, although the donor may or may not be Medicaid eligible.

903.4 Dialysis

Hospital-based dialysis facilities must be separately enrolled in the Dialysis Services Program to receive reimbursement for maintenance dialysis services provided to members with End Stage Renal Disease (ESRD). Routine maintenance dialysis services are not covered in the Hospital Program.

ESRD services that are required when the member's regular dialysis facility is closed must be billed directly to the facility normally providing these services.
To receive reimbursement, the hospital must have an agreement with the dialysis facility to provide these services if the facility is closed.

Inpatient dialysis services are covered for acute renal failure. If a certified dialysis facility performs ESRD services for the patient while admitted to the hospital, the dialysis facility must bill Medicaid for services rendered. If an ESRD patient is provided emergency services as an outpatient because the
dialysis facility is closed, the hospital must bill the patient's usual dialysis facility for services provided.

Only revenue codes 801, 802, 803, 804, 880 and 881 will be covered in the Hospital Program. Reimbursement for maintenance dialysis to hospitals that do not have a hospital based dialysis facility and for dialysis services provided in cases of acute renal failure will be included in the Diagnosis Related Grouping (DRG) reimbursement rate.

Inpatient maintenance dialysis services provided by hospitals with a hospital- based dialysis facility must be billed to the Dialysis Services Program. Reimbursement will be pro-rated at 1/30th of the allowed composite rate for each day of service.

903.5 Rehabilitation Services

Rehabilitation as defined by federal regulation is not covered in the Hospital program. However, short-term rehabilitation services, i.e., Physical therapy, Occupational therapy and Speech therapy are covered immediately following and in treatment of **acute** illness, injury or impairment when the conditions listed below are met.

A. Services must be furnished under a written treatment plan established and signed and dated by the Physician, NP or PA. This plan must identify the rehabilitation potential, set realistic goals and measure progress. The plan must contain the type of modalities and procedures that will be used, frequency of visits, estimated duration, diagnosis, functional goals and recovery potential.

B. The physician must initially certify the plan of care (POC). The initial plan of care can cover up to 3 calendar months or 12 weeks. Treatment units for 1 discipline per PA to cover up to 3 calendar months can be submitted with each request. Prior authorizations will only accept 3 calendar months and 1 discipline modifier.

Any requests beyond the 3 calendar months will require an updated plan of care with recertification by the physician, NP or PA and must be submitted in a new prior

authorization request. Recertification must include an estimate of how much longer the service will be needed and the diagnosis and date of onset of the acute illness, injury or impairment that is being treated. All requests will be reviewed for medical necessity and acuity.

C. The services must be of such a level of complexity and sophistication or the member's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified therapist in a hospital based setting versus a community-based setting.

D. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state.

E. The amount, frequency and duration of the services must be reasonable under accepted standards of practice.

F. Physical therapy, occupational therapy, and speech therapy billed to the Division by the *individual* practitioner are not covered in the Hospital program.

Submitting for Prior Authorization through the Hospital Outpatient therapy (HOT) Program

Services through the HOT program require prior authorization. This includes both evaluations and treatments. Providers must submit ***separate*** prior authorizations for Evaluation codes vs. Treatment codes.

Prior Authorization for EVALUATIONS:

- Request for evaluations through the Hospital Outpatient Therapy program should be for ACUTE conditions only. Clinical and ICD 10 codes should reflect that the member has an "ACUTE" condition. *Exceptions include: DME evaluations for wheelchairs and equipment, some swallowing studies and some hearing evaluations.*
- Evaluation codes will populate for approval for a 90 day date span. This will allow flexibility of scheduling and prevent the need for date changes.
- Modifiers are not required for evaluation codes.
- Backdating is defined as an "effective" date prior to the "request" date on the PA. Back dating is ONLY allowed in the case of RETRO eligibility, OR under Emergent/Urgent circumstances i.e. ED evaluation, Observation stay**,** or under circumstances of an urgent evaluation done after surgery when there was no time to request prior authorization. Backdating is NOT allowed for failure to plan or provider error. Provider should enter a statement in the Comment/messages section if request is for OBSERVATION stay, RETRO, or evaluations performed in Emergency Department.
- Urgent/ Emergent relates to those cases where member has retro eligibility for the date of service and/or patient suffered an urgent medical condition requiring immediate therapy care. Requests submitted on or after request date should be submitted as elective.
- Providers should answer ALL questions on the Prior authorization. Questions relate to policy and answers indicate adherence to policy.

- **Family of Codes: PT and OT** Evaluation codes are part of a "family of codes". This indicates that you will only need to enter one of the codes in the family of codes. At the time claims are billed, the most appropriate code in the family should be selected. There is no family of codes for Speech evaluation codes as these evaluations are based on specific diagnostic issues and not based on time to complete. Please only select the appropriate speech evaluation codes for patient's needs. Other, unnecessary evaluation codes will be denied.

PT evaluation family of codes include:

97161 Physical therapy evaluation: low complexity (20 minutes)
97162 Physical therapy evaluation: moderate complexity (30 minutes)
97163 Physical therapy evaluation: high complexity (45+ minutes)

OT evaluation family of codes include:

97165 Occupational therapy: low complexity (30 minutes)
97166 Occupational therapy: moderate complexity (45 minutes)
97167 Occupational therapy: high complexity (60 minutes)

- Evaluation Prior Approvals do not require an attachment**.** However, if there is no attachment, providers must provide specific documentation in the body of the PA of the ACUTE condition requiring treatment. Please be specific as to the DATE of onset of the illness, injury or surgery. A clear sentence of patient's age, illness, injury or surgery and the EXACT date it occurred in the comments/messages section will expedite processing of your request. This statement must support that condition is ACUTE.
- In the case of DME evaluations, provider should be specific in answering the questions as to the type of equipment being requested by choosing the appropriate equipment in the drop down menu. **97542** – Wheelchair management code can be requested with an equipment evaluation. This code can be used for "delivery" of equipment requested. At this time, it is the only code that can be submitted as both an "evaluation code" and a "treatment code".
- Providers will answer an attestation question regarding "orders". By answering YES to this question the provider is attesting that they have written and signed orders from the Physician, NP, or PA.
- Chronic conditions with acute exacerbations are NOT covered. If there is a chronic condition with a superimposed new and acute injury such as chronic back pain with a new strain as a result of a recent motor vehicle accident or fall, it will be reviewed for acuity and medical necessity. It is imperative that you are specific with details and date of onset.

    - For example:
      Chronic condition: Low back pain. **Acute exacerbation**: Member was in a car accident (date of accident) and sustained a new injury.
      Chronic condition: Lymphedema. **Acute exacerbation**: Lymphedema with new open wounds (provide details and date of onset of new wounds).

Prior Authorization for TREATMENT:

- All requests for treatment units should be for an "ACUTE" condition, injury, illness or surgery. This information and DATE of onset should be readily available in the documentation submitted.
- Treatment PA's require an attachment. **You must attach a copy of your PLAN OF CARE to all requests for treatment units.** If there is no attachment, your PA will be automatically system denied. The plan of care must be signed and dated by the physician, PA or NP within 30 days of starting treatment. By answering YES to the question regarding the plan of care, provider attests they will have the plan of care signed and dated within 30 days of starting treatment. By allowing the plan of care to be signed within 30 days of starting treatment, this will prevent delays in initiating patient care.
- Provider must answer all questions on the PA. Failure to adhere to policy will result in system denials.
- Treatment units can be requested for a max of 3 calendar months.
- Each line must have an effective and expiration date within the same calendar month. The effective to expiration date should not span over more than one calendar month. Example: effective: 5/1/2021- expiration: 5/31/2021. Incorrect would be: effective: 5/1/2021- expiration: 7/30/2021. Dates spanning over more than one calendar month will cause edit errors to your PA and issues with payment in claims.
- EFFECTIVE date for elective care must be on or AFTER the REQUEST date on the prior authorization. Urgent/Emergent OR documented Retro-eligibility for the dates being requested can have effective date prior to REQUEST date. Documentation should clearly reflect RETRO eligibility or the EXACT date of illness, injury or surgery and valid reason for urgent/emergent request. Failure to plan is not urgent/ emergency and will be denied for untimely.
- All requests for treatment codes require use of a modifier in the Mod 1 column only. GP for Physical therapy. GO for Occupational therapy. GN for Speech therapy. Only 1 discipline can be submitted per prior authorization request. Please note, all PAs for therapy codes that do not use modifiers or use two different modifiers on the same PA will be denied and provider will be asked to enter a new PA with the correct modifier. Reviewers are unable to make this correction. Claims submitted without a modifier will be denied.
- There are 3 "family of codes" for treatment units; **Speech therapy**: 92507 and 92526 **Physical and Occupational therapy**: 97110, 97112, 97116, 97530, 97535. These codes are part of a FAMILY OF CODES. When you are approved for 1, you may bill any of the other codes within the same family to claims. When requesting these codes, you should request the total number of units needed. Use of the appropriate modifier will identify your code to the correct discipline. Without a modifier, it will appear to the system as a duplication. A treatment prior approval submitted without a modifier, will result in the case being denied as the modifier cannot be added by reviewer. Audiology codes 92651, 92652, and 92653 do not require prior authorization.
- Units should be calculated appropriately by the provider. Therapy sessions should not exceed one hour and should be calculated based on 4 units per session when using 15 min timed codes or 1 unit per session when using an untimed codes (ex: 92507 or 92526). Units are submitted based on the TOTAL number of units needed for the calendar month. 2x weekly would be 8 units per week or 32-40 TOTAL units per month. 3x weekly would be 12 units per week or 48-

60 TOTAL units per month. Max number of units should be divided over the CPT codes submitted.

- The Plan of care approved by the Physician, PA, or NP must contain at minimum the components listed below. The POC at a minimum must be submitted for the Medicaid member as documentation of medical necessity.

    a. Member's name and member ID number
    b. Date of Birth
    c. Acute Diagnosis and/or condition requiring treatment with clearly documented date of onset.
    d. Modalities
    e. Procedures (i.e., description of the services requested)
    f. Evaluation and date the evaluation was conducted
    g. POC completion date (this must be on or after the evaluation date)
    h. Effective POC start and end dates along with the frequency and duration of services.
    i. Location of services
    j. Team members that are treating the patient (i.e., OT, SLP, PT, etc.)
    k. Current level of function
    l. Patient's progress to date
    m. Functional outcomes (potential for rehabilitation, long term goals of therapy)
    n. Goals to be achieved as well as time lines to reach projected goals
    o. Any other relevant medical information.
    p. The therapist that develops the POC must sign and date the document on the date completed.

- At the time the claims are billed, the most appropriate code in the family of codes should be billed. The modifiers approved on the PA should be in agreement with the modifiers submitted on the claim or the claim may deny.

903.6 Observation

The purpose of observation is to treat patients expected to be stabilized and released within twenty-four (24) hours, determine the need for further treatment or for inpatient admission. Thus a patient in observation may improve and be released or admitted as an inpatient. Outpatient observation services Begin and End with a physician's order.

Rev. 12/12 Observation services are those services furnished by a hospital, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Appropriateness of observation services is determined using qualifying criteria such as those published by a "nationally recognized criteria", severity of illness/intensity of services (SI/IS), and medical necessity reviewed by peer reviewers.

Observation services usually do not exceed twenty-four (24) hours and the physician's decision to admit or discharge is typically determined within this time. Orders for "observation" and "inpatient admission" can only be written by those physicians

authorized by the hospital's medical staff bylaws to admit patients or order outpatient observation.

Some patients, however, may require more than twenty-four (24) hours of outpatient observation services. In only rare and exceptional cases, outpatient observation services span more than 24 hours. If a patient is retained on observation status for more than 24 hours without being admitted as an inpatient, further observation services will be denied as not reasonable and necessary for the diagnosis or treatment of a physical or mental health condition. (See Part I Policies and Procedures Manual, Definitions, definition 48 Medical necessity.). Count as the first hour the time of admission to an observation status. Claims submitted with more than 24-hour observation will be denied. If the 24-hour observation limit is exceeded and the patient does not meet the acute criteria for inpatient admission, the claim and medical justification should be submitted to Medical Review.

If the patient's medical condition meets medical necessity and using acute inpatient-qualifying criteria published by a "nationally recognized criteria", inpatient admission is appropriate, and the patient must remain hospitalized until concurrent review performed by the hospital indicates discharge is necessary. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests and when provided in compliance with all policies and procedures described in this manual.

A person is considered a hospital inpatient if formally admitted and acute inpatient qualifying criteria designated by the Division, from a "nationally recognized criteria" are met. When a hospital places a patient under observation, but has not formally admitted them as an inpatient, the patient is considered an outpatient.

Observation is generally covered as an outpatient service. Observing the patient for up to 24 hours should be adequate in most cases. A hospital, which believes that exceptional circumstances in a particular case justify approval of more than 24 hours in an outpatient observation setting, may submit a claim by hard copy with documentation of the exceptional circumstances. The claim may include the total number of observation units. The claims will pend for medical review. If, after medical review, the determination is made that continued observation beyond 24 hours was medically necessary, an observation status ***may*** be approved. However, any services provided beyond the medically necessary time
are non-covered.

If medical review determines that observation beyond 24 hours was not medically necessary, payment will be made for the hours determined to be medically appropriate, up to 24 hours. When the patient's condition does not meet inpatient criteria and the hospital does not wish to file an appeal for the observation beyond 24 hours, all charges past the 24-hour period are non- covered. The provider should then bill the department for only those hours considered medically appropriate.

When medical necessity dictates an inpatient admission of a patient in observation, this should be billed under revenue code 762, as referred to in the billing instructions, (form locator 42) which reflects this transaction. Observation is a covered revenue code on an inpatient claim.

Outpatient observation is not covered in the following situations: complex cases requiring inpatient care, post-operative monitoring during the standard recovery period; routine preparation services furnished prior to diagnostic testing in the hospital outpatient department and the recovery afterwards; and the observation billed concurrently with therapeutic services such as chemotherapy, physical therapy, etc.

The outpatient status becomes inpatient when the determination is made that inpatient services are medically necessary. Inpatient services must be certified as explained in Chapter 800. Certification must be obtained within thirty calendar days of the beginning date of this episode of care. In order to receive certification for the admission, documentation must be provided evidencing that the criteria admission is medically necessary and appropriate.

The date of the inpatient admission will be the actual date the patient is formally admitted as an inpatient and will count as the first inpatient day. When a patient is admitted to the hospital from outpatient observation, all observation charges must be combined and billed with the inpatient charges. Elective procedures where the anticipated stay is 24 hours or less are typically considered an observation stay, primarily if the primary reason for the stay is to monitor for potential complications. Services, such as complex surgery, clearly requiring inpatient care may not be billed as outpatient.

Request for updates to the precertification file and retroactive certification of inpatient admissions following a procedure or service clearly indicating an inpatient level of care that should have been anticipated will not be considered timely and will be denied.

Failure to obtain the required certification will result in denial of reimbursement of ALL services provided.

Rev. 12/12

The Division only covers services that are medically appropriate and necessary. The services provided in the setting must be appropriate to the specific medical needs of the member. (See Part I Policies and Procedures Manual, Definitions, 19 Medical Necessity.) The medical record must substantiate the medical necessity and appropriateness including appropriateness of the setting. When the outpatient observation setting is non-covered, all services provided in the outpatient observation setting are also non-covered. Services that are not reasonable or necessary for the diagnosis or treatment of the patient but are provided for the convenience of the patient or a physician are not covered. (See Part I Policies and Procedures Manual, Definitions, 19 Medical Necessity.)

Level of care and setting determination are based on patient assessment, medical condition and anticipated or actual treatment as documented in the request for approval. Peer review, in conjunction with inpatient/outpatient qualifying criteria from a "nationally recognized criteria" may be used by PA/UM contractors to assess the patient's medical condition and to substantiate medical necessity for inpatient or outpatient status. The process is the standard for providers, DCH, Gainwell, PA/UM and any other Division Contractors. Hospitals will be required to conduct concurrent review and will be required to keep the hospitalized patient until the same criteria indicates hospitalization is no longer necessary. DMA will notify providers in writing at least 30 days prior to the date of any changes in the criteria or version of criteria being used to certify inpatient admissions. Written notice

would be provided on banner messages, on remittances, and on the Gainwell Technology web site (www.mmis.georgia.gov). The same version of criteria will be used for any retrospective medical reviews as were used prospectively or concurrently.

NOTE: Hospitals should not substitute outpatient observation services for medically appropriate inpatient admissions. An inpatient is not considered to have been discharged if placed in observation status after an inpatient admission. The availability of outpatient observation does not mean that services, for which an inpatient stay is anticipated, may be performed and billed to the Division on an outpatient basis. Services such as complex surgery clearly requiring inpatient care and pre-certification may not be billed as Outpatient.

903.7 Delivery and Care of Newborn Infants

Effective with dates of admission July 1, 1998 and greater, charges for the mother and baby must be billed separately. Please refer to the Newborn Medicaid Eligibility Certification (DMA-550) in the Billing Manual for Hospital Services and Appendix H of Part II - Policies and Procedures for Hospital Services.

Effective with dates of admission July 1, 2000 and greater newborn screening tests are covered in the hospital. Revenue code 479 should be used when billing for the newborn hearing-screening test. Please refer to the Billing Instructions for Hospital Services, Form Locator 42.

Rev. 01/18

Effective January 1, 2007, Georgia law (OCGA 31-12-6 & 31-12-7) and Rules and Regulations (Chapter 290-5-24) require that every live born infant have an adequate blood testing for 28 disorders. Effective January 1, 2007, the Department of Community Health will increase Georgia Medicaid payments to hospitals by $40 per newborn, when a newborn screening is performed. This payment is once per newborn member per lifetime. Effective July 1, 2010 the newborn screening add-on to hospitals increased from $50 to $63 for screening performed on or after October 1, 2016.

In order for the hospital to receive the additional $40 payment, the provider must include condition code “A1” on the newborn claim in field 18-28 on the UB-04. The $40 payment is an add-on to the DRG payments and does not impact the adjudication of a claim, nor the payment methodology currently used by the department. This is an add-on payment meant to increase the DRG payment by $40 for newborn claims when a newborn screening has been performed.

Rev. 01/19

Effective for dates of service including and after July 1, 2018, a $1000 add-on payment for newborn delivery in rural counties with populations of less than 35,000.

903.8 Magnetic Resonance Imaging (MRI)

Medically necessary MRIs are covered by the Division when CT scans or SPECT procedures are not definitive or appropriate. Only one MRI per day will be paid without submission of documentation for medical necessity. Please note that only enrolled Medicaid providers may be reimbursed for MRI procedures.

903.9 Non-coverage of medically necessary services for members under twenty- one (21) years of age may be appealed to:

Medical Policy Unit-Hospital Service
Division of Medicaid, 37th Floor
2 Peachtree Street, N.W.
Atlanta, Georgia 30334-3159

903.10 Hospital-Based Rural Health Clinics

Hospitals providing primary care services through the Rural Health Clinic Program must be certified by the Department of Health and Human Services (HHS) and appropriately enrolled by the Division as a Hospital-Based Rural Health Clinic. Please refer to the conditions of participation in Chapter 600 of the Policies and Procedures for Rural Health Services manual.

903.11 Mammography Services

Screening and diagnostic mammography services are covered. Reimbursement for mammography services is limited to one procedure per member, per year (July 1 - June 30) unless medical documentation is provided which justifies additional services.

In accordance with the MQSA of 1992, mammography services are reimbursed only when provided by a facility that has been certified by the FDA for mammography services. Effective with dates of service October 1, 1994, and after, a facility that has not been certified, has been denied certification or whose accreditation has been revoked will not be reimbursed for these services. Effective
Rev. 10/11 November 1, 2011, a facility's Mammography Certificate is to be sent to Gainwell Provider Enrollment Unit for placement in their provider enrollment file.

903.12 HIV Education and Counseling

The Division, in support of the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG), strongly suggests that HIV education and counseling be made part of the routine standard of care for Medicaid eligible pregnant women.

903.13 Partial Hospitalization Program - Psychiatric

A Partial Hospitalization Program (PHP) for Medicaid purposes is defined as a comprehensive structured program that uses a multidisciplinary team to provide comprehensive coordinated services within an individual treatment plan for individuals diagnosed with one or more psychiatric disorders.

It is a service in a continuum of care designed to prevent hospitalization or to facilitate the movement of the acute psychiatric client to status in which the client is capable of functioning within the community with less frequent contact with the psychiatric health care provider.

Partial Hospitalization is a time limited, ambulatory, active psychiatric and/or substance abuse treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic milieu. Partial Hospitalization Programs (PHP) may be provided on a day and/or evening schedule. Such programs employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. Programs are

designed to serve individuals with significant mental health impairments resulting from a psychiatric emotional behavioral, and/or substance abuse disorder, and further serve to avert hospitalization and/or increase a member's level of independent functioning.

In order for partial hospitalization to be covered, the services must be:

A) Certified on admission by the physician that the individual would require short-term acute inpatient psychiatric treatment in the absence of partial hospitalization.

B) Incident to physician's services. The services must be furnished while the individual is under the care of a physician. The services must be prescribed by a physician under an individualized plan of treatment. The plan of treatment must be established and periodically reviewed by a physician in consultation with the appropriate staff.

C) A plan of treatment must be established within the first 7 days of a patient's participation in the program; reviews and updates to the plan should be performed at least every 31 calendar days, and must include documentation supporting the need for continued acute care services.

D) The services must be reasonable and necessary for the diagnosis or active treatment of the individual's condition.

E) There is a reasonable expectation that the treatment will improve or maintain the patient's condition and functional level and prevent relapse and/or acute care hospitalization.

Reimbursement for partial hospitalization services is dependent on two critical points: 1) the initial decision as to the medical appropriateness of entrance into the program for treatment; and 2) the decision concerning discharge. Both determinations should take into account both the diagnosis and the individual's treatment needs.

The partial hospitalization program is designed to treat patients who exhibit severe or disabling conditions related to an acute psychiatric/psychological condition or an acute exacerbation of a severe and persistent mental disorder. The partial hospitalization may occur in lieu of an admission to an inpatient hospital or a continued inpatient hospitalization. The following clinical information must be submitted that supports the emergent nature of the services provided. Only the following documents should be submitted to Georgia Medical Care Foundation (GMCF) for review:

- **History and Physical**
- **Discharge Summary**
- **Physician Progress Notes**

Medicaid eligible members may attend PHPs for a minimum of one (1) to a maximum of five (5) days per week. A treatment day requires a minimum of four (4) hours of scheduled programming inclusive of at least one therapy session (individual, group, or family therapy) per day. The daily programming usually includes a combination of treatment and therapeutic activities. Examples of treatment include, but are not limited to: individual psychotherapy; group psychotherapy; family therapy / medication reviews; on-going assessments; expressive therapy, such as, dance, art, or psychodrama; theme specific (psycho- educational) groups, such as, communication skills, assertiveness training, stress management, symptom recognition, problem solving, relaxation training, and groups which focus on substance abuse issues. Appropriate adjunctive therapeutic activities include cooking, budgeting, personal hygiene skills, recreation, and social activities designed to incorporate family involvement. Adjunctive therapeutic activities are not counted toward fulfilling the four-hour minimum treatment day requirement.

Members may **not attend PHP and a Methadone clinic**. Only one of these services will be reimbursed.

Mandatory Services:

Psychiatric partial hospitalization programs must provide the following mandatory services and at least two of the following optional services. Payment for both mandatory services and optional services is included in the rate for day treatment. Providers shall not make any additional charges to the Georgia Division of Medical Assistance or to the member.

A) **Medically Necessary Psychotherapy Services:** These services must demonstrate active treatment of a patient with a psychiatric condition. These services are subject to program limitations and must be provided by professionals operating within the appropriate scope of practice.

1) Individual Psychotherapy;

2) Group Psychotherapy;

3) Family Psychotherapy; and

4) Family Assessment if appropriate.

B) **Medically Necessary Nursing Services:** Medical services directed by a Registered Nurse who evaluates the particular medical nursing needs of each client and provides for the medical care and treatment approved by the supervising practitioner.

C) **Medically Necessary Psychological Diagnostic Services:** Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. A Licensed Psychologist may perform testing and evaluation services. If testing and evaluation services are provided by a specially licensed psychologist or approved Master's level person, the services must be ordered by a supervising practitioner. The supervising practitioner must document medical necessity.

D) **Medically Necessary Pharmaceutical Services:** If medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse, or licensed practical nurse.

E) **Medically Necessary Dietary Services:** If a day treatment program provides meals, services must be supervised by a registered dietitian, based on the client's individualized needs. The program may contract for these services through an outside licensed certified facility.

Optional Services:

The member must have a need for the services, a supervising practitioner must order the services, and the services must be a part of the member's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy. In appropriate circumstances, occupational therapy may be covered if prescribed as an activities therapy in a psychiatric program:

A) Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the program may contract for these services from a licensed/certified professional as listed below:

1) Recreational Therapy

2) Speech Therapy

3) Occupational Therapy

4) Vocational Skills Therapy

5) Self-Care Services: Services supervised by a registered nurse or occupational therapist that is oriented toward activities of daily living and personal hygiene. This includes toileting, bathing, grooming, etc.

B) Social Work provided by a bachelor's level social worker: Social services to assist with personal, family and adjustment problems which may interfere with effective use of treatment, i.e., case management type services.

C) Social Skills Building

D) Life Survival Skills

Documentation Requirements:

The physician certification must include:

- The individual would require hospitalization in the absence of partial hospitalization.
- The individual is under his/her care.
- The services were furnished under a written individualized plan of care. The treatment plan must include, but is not limited to:

- Physician's diagnosis
- Treatment goals
- Type of service used to achieve the goals
- Amount, frequency and duration of the modalities used to treat the problems identified.

Treatment Goals:

Treatment goals are used to measure:

- The patient's response to therapy
- Impact of treatment
- Coverage of services

The physician determines the frequency and duration of the services taking into account accepted norms of medical practice and a reasonable expectation of improvement in the patient's condition or maintenance of an appropriate functional level.

If a therapy (group or otherwise) is not indicated in the plan of care, it cannot be covered as medically necessary.

Progress Notes:

- Progress notes for each service must be present and relate to the patient's condition and the treatment plan.
- Progress notes should reflect the patient's response to the therapy.

- Notes may be made on a weekly basis but should be comprehensive and indicate the specific dates and group sessions or other services rendered for the time period. (Example: Attended individual sessions on April 5, 7, and 9.)

Non-Covered Services:

Services which are considered non-covered and should not be included in the day care charge:

- Meals and transportation.
- Activity therapies, group therapies, or other services and programs, which are primarily recreational or divisional in nature.
- Day treatment or geriatric day care programs that consist of
- Activity therapies providing social and recreational activities to individuals who need some supervision during the day while family members are away from home.
- Psychosocial programs or community support groups in non-medical settings for chronically mentally ill persons for the purpose of social interaction.
- Vocational and pre-vocational assessment and training. Services related to employment opportunities, work skills or work settings are not covered.
- Drugs and biological items that can be self-administered.
- General education programs or education of the general public.
- Any service that does not have a specific treatment goal and is not outlined in the individualized treatment plan.
- Any services not documented in the medical records and identified in the itemized statement.
- Services to members who:

1) Refuse or cannot participate with the treatment.
2) Are suicidal, homicidal or severely demented individuals.
3) Demonstrated inadequate impulse control.
4) Require social, custodial, and recreational or respite care.
5) Have multiple unexcused absences or is non-compliant with the program

903.14 Genetic Counseling

Perinatal genetic counseling will be covered when provided by an employee/contracted agent of a hospital. These services must be performed by a master's prepared certified genetic counselor in conjunction with a physician who is board certified in Genetic medicine.

Genetic counseling services provided are to be non-directive, outcome planning related and used to factually inform both the physician and parents of possible genetic impacts and anomalies.

Services will be limited to three (3) counseling sessions within an eleven-month period for an eligible Medicaid member. This is to include one (1) initial screening interview and up to two (2) follow-up sessions for discussion and clarification of issues.

Billing for Perinatal genetic counseling should occur using the revenue code 561 and the UB-04 claim form, bill type 131.

904. Limited Inpatient Services

With the exception of the limitation described in 904.6, there is no limit on the number of medically necessary inpatient hospital days a Medicaid member is allowed. Readmission for the same or related problem within three (3) days of discharge is considered the same admission. Medical justification is the only criterion for hospitalization for eligible members. Documentation to substantiate medical necessity and appropriateness of setting 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.

Inpatient emergency medical services are defined as those services that are medically necessary as a result of a sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily part or death of the individual.

904.1 Admission for diagnostic purposes is covered only when the diagnostic services cannot be performed on an outpatient basis.

904.2 Chest X-rays and other diagnostic procedures performed as part of the admitting procedure will be covered only when:

A) The test is specifically ordered by a physician responsible for the patient's care;

B) The test is medically necessary for the diagnosis or treatment of the individual patient's condition;

C) The test does not unnecessarily duplicate the same test done on an outpatient basis before admission, or done in connection with a recent admission; and

D) The test is billed with the admission.

904.3 Certain services may only be reimbursed when performed on an outpatient basis unless medical necessity for an inpatient admission is documented and pre- certified (see Sections 802 and 903.6).

In some cases, the hospital determines that an outpatient hospital setting was appropriate to the specific medical needs of the member after the services were provided on an inpatient basis. A physician's order must document the patient's status at the time of admission, and any changes in the patient's status during the hospital stay should be documented with a physician's order. Changes made to the patient's status must be made on the basis of medical review and not due to any specific insurance criteria for billing and reimbursement.

Outpatient services billed as inpatients that are identified for recoupment after review for medical necessity by the Division or its authorized representatives cannot be re-billed as outpatient.

904.4 See Section 911 for limits to abortion, sterilization and hysterectomy coverage.

904.5 Certain services are not reimbursable without precertification. Refer to Chapter 800 for precertification requirements.

904.6 Reimbursement for psychiatric services is limited to short term acute care. The maximum length of stay considered for reimbursement by the Division is 30 days. Psychiatric admissions, which have a length of stay in excess of 30 days, will post an edit for medical review. Prior Authorization is required for additional days in excess of the 30 allowed days with clinical justification and review of the member's medical records for medical necessity.

904.7 Inpatient admissions of less than twenty-four hour's duration are subject to review for medical necessity of admission. A length of stay less than twenty-four hours may be considered inpatient if the services can be provided only on an inpatient basis. Outpatient services billed as inpatient are subject to recoupment after review for medical necessity and cannot be re-billed as outpatient.

904.8 Co-payments

Effective with dates of service July 1, 1993, and after, the Division is implementing a $3.00 member co-payment on all non-emergency outpatient hospital visits. Outpatient hospital visits include those to clinics o w n e d and operated by a hospital (including satellite clinics), hospital outpatient departments or hospital emergency rooms.

Effective with dates of service July 1, 1994, and after, the Division is implementing a $12.50 member co-payment on all non-emergency inpatient hospital admissions.

For dates of service July 1, 1994, and after, pregnant women, members under 21 years of age, nursing facility residents, community care members, dialysis members, hospice care participants and persons who have both Medicare and Medicaid coverage are not subject to the co-payment. Family planning services are also not subject to the co-payment. Beginning with dates of service January 1, 1995, co-payments apply to the following groups of members who were previously exempt

from participation in co-payments. The three groups affected are dialysis members, Medicare/Medicaid dually eligible members, and members in waivered services programs. These groups are required to co-pay beginning with dates of service January 1, 1995, and after, for those services designated as co-pay services.

Maintenance dialysis services for end stage renal disease are not designated as co-pay services. No co-pay is required for those services.

Members who may be subject to the co-payment may be identified by checking member eligibility via the web or telephone.

On each outpatient visit, the hospital must verify that the member is subject to the co-payment.

Services may not be denied because of the member's inability to pay the co-payment. The co-payment is limited to non-emergency admissions.

905. Non-Covered Inpatient Services

The services and procedures listed below are non-covered by the Medicaid Division in the Hospital Program. Services related to, required in preparation for, or as a result of non-covered services are not covered. Medicaid members enrolled after receiving care that is, or would not have been covered by Georgia Medicaid do not have coverage for care related to, or as a result of the non-covered services done prior to member enrollment. Adverse action may be taken against hospitals that willfully continue to bill the Division for non-covered services identified in this manual.

A) Services and supplies which are inappropriate or medically unnecessary as determined by the Division, the Division's peer review organization, or other authorized agent.

B) Private rooms. Conditions that require an isolation room or special care unit ICU, CCU) are reimbursable. All other accommodations are reimbursed at the semiprivate room rate on file with the Division for the date of service.

Patients should be notified upon admission that the Division will only cover the semi-private room rate. Members who request a private room after being informed of the Division's policy will be responsible for the difference between the hospital's semi-private and private room rates.

The member cannot be billed for the difference between the amount paid by Medicaid and the private room rate when the hospital has only private rooms, has only private rooms available, or the patient has a condition which requires an isolation room or special care unit.

C) Intermediate care; i.e., step-down units are reimbursable at the semi-private room rate;

D) Late charges - defined as a portion of the charges for a given service omitted from the original billing which included some of the charges for that given service. If the total charges for a given service were omitted from the original billing, a positive adjustment may be requested. Providers who repeatedly use the incorrect billing code generating the need for a positive adjustment may be subject to adverse action by the Division. Late Charges to previously paid revenue codes/claims are not allowed to be changed once the previously claim is paid.

E) Take-home prescription drugs, medical supplies, durable medical equipment, and artificial limbs and appliances.

F) Nursing service. This includes services traditionally accepted as nursing care even though provided by other ancillary departments; e.g. blood glucose testing, dressing changes, and labs drawn by nursing (i.e. STAT), tracheostomy care, oral care, etc.

G) Private duty nurses, sitters or companions.

H) Ambulance or other transportation, including air ambulance.

I) Services which are not medically necessary to the patient's well-being; e.g., television, telephone, combs, brushes, guest meals, cots, etc.

J) Non-consumable multiple supply items; e.g., bath basins, admission kits, disposable pillows, etc.

K) Service charges for individual areas within the hospital; e.g., pharmacy dispensing fee, IV admixture fee (except for hyper alimentation), cover charge for central supply, charges for handling and distribution of supplies, transportation within the hospital, equipment installation, thawing/splitting/pulling, specimen collection, venipuncture, standby equipment, staff time and evaluations, etc.

L) Resuscitation, code, CPR (cardio-pulmonary resuscitation), etc. Supplies associated with this service will be reimbursed.

M) Leave of absence.

N) Clinic services while the member is an inpatient.

O) Patient or family education or supplies.

P) Utilization review.

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Q) Differential service charges; e.g., "STAT" or priority, after-hours or "call-back" fees. Only those hospitals that do not provide twenty-four hour emergency service may bill for the after hour and call-back differential fee.

R) Services provided free-of-charge to the public by the hospital or county health departments, state laboratory or other state agencies; i.e., immunizations, metabolic screens for members under one year of age, etc.; see Appendix E.

S) Services mandated to be performed only on an outpatient basis.

T) Investigational items and experimental services, drugs or procedures or those not recognized by the Federal Drug Administration, Medicare and the Division's contracted peer review organization as universally accepted treatment; including but not limited to, dual photon absorptiometry, etc.

U) Any services or items furnished for which the hospital does not normally charge.

V) Refer to Section 911 for non-covered situations concerning abortions, sterilizations and hysterectomies.

W) Services or procedures performed which are not in compliance with the policies and procedures contained in this manual.

X) Tubal re-anastomosis procedures pertaining to sterilizations and vasectomies.

Y) Services provided by an institution for mental disease or special disorders.

Z) Separately billed equipment and supplies which are integral parts of hospital care and the area in which care is being provided; e.g., cardiac monitor in ICU, light source in OR, call system, blood pressure cuffs and monitors, specimen collection devices and containers, ABG kits, IV bottles/bags, IV administration kits, nutritional supplements, dressings, blankets, oxygen sensors, pumps, under pads, depends/diapers, restraints, gait belt, etc.

AA) Preventive health care. Members under age twenty-one (21) may receive this care through the EPSDT screening process.

BB) Miscellaneous and non-specific charges.

CC) Non-acute levels of care.

DD) Infertility procedures and related services.

EE) Never Events or HAC Conditions and any HCPCS/CPT Procedure to Procedure (PTP) co- pairs in billing Outpatient Hospital Services per CMS' directive in the NCCI/MUE regulations.

FF) Services with a corresponding charge of zero. No zero-dollar charges should be listed on the itemization checklist submitted to GMCF of review. Additionally, do not white out the item, or strike through the item.

GG) Please use the Procedure Search panel for covered codes

906. Limited Emergency Room and Outpatient Services

A) Emergency medical services are defined as those services that are medically necessary as a result of a sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily part or death of the individual. Emergency room visits that cannot be documented as true medical emergencies or potential medical emergencies will be reimbursed at an all- inclusive flat rate of $60 for (Urban hospital setting and OOS Counties) and $70 for rural hospital setting. This rate is for all in-state and out of state emergency medical services. This rate will cover all ancillary services rendered as well as the fee for use of the emergency room. It is for the medical screening and stabilization services provided in the emergency room without regard to prior authorization. The rates will not be subject to the hospital's reimbursement rate.

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B) Accurate coding is critical to ensure proper reimbursement. Coding of certain diagnoses that represent diseases and conditions that are recognized as medical emergency situations on a claim will result in the claims being treated as an emergency service. If the medical record supports the existence of an accurate emergency situation, but the diagnosis is not identified as an emergency, the claim must be submitted to GMCF along with documentation. The claim will suspend for medical review. If, after medical review, the determination is made that an emergency or potential emergency did in fact exist, the services will be reimbursed at the hospital's specific outpatient rate.

In non-emergency situations where the provider may be able to identify a chronic abuser of the Emergency Room, the provider may exercise its right to advise the member that they will not be accepted as a Medicaid member. Should the member choose to receive services, they will be responsible for all charges incurred.

All hospitals should consider the following alternatives in the event a member is not accepted and treated as a Medicaid member:

A) Refer the member to a specific alternate health care setting where he or she can obtain the same level of care that day or the next day.

B) Advise the member on conditions that necessitate visits to the emergency room and explain the appropriate settings for treatment.

C) There is no limit imposed on the number of visits allowed per day per member in true medical emergencies.

D) More than one non-emergency visit by the same member in one day is subject to review for medical necessity and possible denial depending on the individual situation.

E) See Chapter 800 for precertification requirements. Without precertification certain outpatient services are not reimbursable.

F) Reimbursement for psychiatric services is limited to short-term acute care.

G) One series of birthing and parenting classes provided to pregnant members will be reimbursed per twelve-month period. This service is reimbursed under revenue code 942. Policies and Procedures can be found in Part II of the Policies and Procedures for Childbirth Education Program manual.

H) Services provided within three (3) days of inpatient admission or discharge for the same or related diagnosis is considered part of the admission.

The three (3) day payment window policy applies to services furnished by the hospital (or an entity it wholly owns or operates) and includes laboratory and radiology services.

An entity wholly owned or operated by the hospital is: if a hospital has direct ownership or control over another's entity's operations, services provided by that entity are subject to the DRG payment window; if a third organization owns or operates both the hospital and the entity the payment window does not apply.

907. Non-Covered Emergency Room and Outpatient Services

The services or procedures listed below are non-covered by the Division in the outpatient Hospital Program. Services related to and required in preparation or as a result of non- covered services are also non-covered. Adverse action may be taken against hospitals that willfully continue to bill the Division for non-covered services identified in this manual.

A) Services and supplies which are inappropriate or medically unnecessary as determined by the Division, by the Division's peer review organization, or other authorized agent.

B) Late charges - defined as a portion of the charges for a given service omitted from the original billing which included some of the charges for that given service.

C) If the total charges for a given service were omitted from the original billing, a positive adjustment may be requested. Providers who repeatedly use the incorrect billing code generating the need for a positive adjustment may be subject to adverse action by the Division.

D) Take-home medical supplies and appliances, durable medical

equipment. E) Take-home prescription drugs.

F) Routine physical examinations.

G) Ambulance or other transportation services including air ambulance.

H) Any services or items furnished for which the hospital does not normally charge.

I) Services provided free-of-charge to the public by the hospital, County Health Departments, State Laboratory or other state agencies; i.e., immunizations, metabolic screens for members under one year of age, etc. See Appendix E

.J) Resuscitation, code, CPR (cardiopulmonary resuscitation), etc.; only the supplies associated with this service will be reimbursed.

K) Differential service charges; e.g., "STAT" or priority, after-hours or "call-back" fees. Only those hospitals that do not provide twenty-four hour emergency service may bill for the after hour and call-back differential fee.

L) Cosmetic surgery or mammoplasties for aesthetic purposes.

M) Service charges for individual areas within the hospital; e.g., pharmacy dispensing fee, IV admixture fee (except for hyper alimentation), cover charge for central supply, charges for handling and distribution of supplies, transportation within the hospital, equipment installation, specimen collection, venipuncture, standby equipment, staff time, and evaluations.

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N) Investigational items and experimental services, drugs or procedures or those not recognized by the Federal Drug Administration, Medicare and the Division's contracted peer review organization as universally accepted treatment.

O) Services or procedures performed which are not in compliance with the policies and procedures contained in this manual.

P) Refer to Section 911 for non-covered situations concerning abortions, sterilizations and hysterectomies.

Q) All applicable procedures, codes, and charges listed in Section 905.

R) Preventive Health care. Members under age twenty-one may receive this care through the EPSDT screening program.

S) Tubal re-anastomosis procedures pertaining to sterilizations and vasectomies.

T) Nursing service. This includes services traditionally accepted as nursing care even though provided by other ancillary departments.

U) Services non-covered or denied by the Division because they were provided on an inpatient basis (see Section 903.6).

V) Services provided by an institution for mental disease or special disorders.

W) Separately billed equipment and supplies which are integral parts of hospital care and the area in which care is being provided, e.g., cardiac

monitor in ICU, light source in OR, call system, blood pressure cuffs and monitors, specimen collection devices and containers, etc.

X) Patient or family education or supplies (except as described in Section 906). Y) Miscellaneous and non-specific charges.

Z) Non-acute levels of care.

AA) Infertility procedures and related services.

BB) Unlisted or Non-Specified Procedures

CC) Physical Therapy, Occupational Therapy, and Speech Therapy that are not immediately following and in treatment of acute illness, injury or impairment are not covered in the outpatient hospital setting. Medicaid Programs such as CIS (Children Intervention Services) and CISS (Children Intervention School Services) cover members under 21 years of age who require therapy not related to an acute illness, injury, or impairment. Please refer the Part II Policies and Procedures for CIS and CISS.

908. Other Hospital Related Services

In order to receive reimbursement for the services listed below, the hospital must be separately enrolled as a provider of these services. A Policies and Procedures manual is provided for each specific program. These services will not be reimbursed from a hospital claim form.

A) Emergency Ambulance Ground Transportation-Prior Approval is required for ground transportation over 150 miles (institution to institution);

B) Air Ambulance Transportation-Prior Approval is required for all air ambulance transportation;

C) Nonemergency Ambulance Transportation (NET);

D) Durable Medical Equipment (DME);

E) Orthotics and Prosthetics O & P);

F) Pharmacy

G) Early Periodic Screening Diagnosis and Treatment;

H) Pregnancy Related Services;

I) Perinatal Case Management;

J) Children's Intervention Services;

K) Rural Health Clinic; and

L) End Stage Renal Disease Routine Maintenance Dialysis.

909. Out-of-State Providers and Service Limitations

Out-of-state hospital providers not enrolled in the Georgia Medicaid program as participating providers will be reimbursed for covered services provided to eligible. Georgia members while out-of-state if the claim is received within twelve months from the month of service, and if at least one of the following conditions is met:

A) The service was prior authorized by the Division; or

B) The service was provided as a result of an emergency or life-endangering situation occurring out of state. (If the out-of-state provider believes the medical record supports the existence of an emergency situation but the diagnosis does not justify an emergency, the claim must be submitted with a copy of the medical record.)

C) Out-of-state providers located within 50 miles of the boundary of the State of Georgia will be permitted to enroll for Medicaid and/or Medicare on a participating basis, provided all other enrollment criteria are met. *These are referred to as Border Providers.*

D) Emergency medical services are defined as those services that are medically necessary as a result of a sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily part or death of the individual. Emergency room visits that cannot be documented as true medical emergencies or potential medical emergencies will be reimbursed at an all-inclusive flat rate of $60. This rate is for all urban and out of state emergency medical services. This rate will cover all ancillary services rendered as well as the fee for use of the emergency room. It is for the medical screening and stabilization services provided in the emergency room without regard to prior authorization. The $60 flat rate will not be subject to the hospital's reimbursement rate.

E) Georgia Medicaid does not cover services provided in foreign countries. The Department will reimburse providers in the 50 states, the District of Columbia, the Northern Mariana Islands, American Samoa, Guam, Puerto Rico, and the Virgin Islands for services provided in an emergency situation or when prior authorization was obtained from the Department before the service is provided. Out-of-state providers must be licensed in the United States and/or its territories. Out-of-State providers are required to be licensed in their own state of practice and enrolled in their own state's Medicaid program. No payment can be made unless the patient meets Georgia Medicaid eligibility criteria. Out-of-State providers must complete the enrollment process prior to any commitment of payment. The Department will not reimburse providers in foreign countries.

F) Routine health care or elective surgery provided by out-of-state providers is not covered unless prior authorization is obtained.

G) Members should be transferred to another in-state Georgia facility before transferring the member out-of-state for emergent care. The medical record should document why the member was not transferred to another Georgia facility.

H) The referring in-state provider is required to request prior approval by documenting inwriting the medical necessity of obtaining services out-of- state and providing the name and address of the out-of-state medical provider.

I) The out-of-state provider cannot obtain a prior authorization request.

J) Reimbursement and coverage of out-of-state services are determined in accordance with current policies and procedures of the Georgia Division of Medical Assistance and are contingent upon the patient's eligibility at the time services are provided.

K) Contractual agreements will not apply to in-state facility to an out of -state facility due to the different reimbursement types.

Out-of-state providers will be reimbursed in accordance with the policy described in Subsection 1001.4. Requests for prior approval or questions regarding out-of-state services must be directed to the following:

Prior Authorization & Pre-Certification
Alliant Health Solutions
PO Box 105200
Atlanta, Georgia 30348
800-766-4456 (Toll free)

Out-of-state claims submitted for reimbursement must have a copy of the authorization letter attached if services were prior authorized or medical justification if the services were due to an emergency or life-endangering situation.

910. Medicaid/Medicare

A) Medicare Part B Only Services: Many Medicaid members also are eligible for Medicare. Hospital claims submitted to the Division for members with Medicare "**Part B only**" will be reimbursed at the Per Case Rate. Inpatient hospital admissions for "Part B Only" members must be pre-certified. See Chapter 800 for precertification requirements.

Providers should bill Medicare for all Part B reimbursable ancillary services (i.e.…lab, radiology, pharmacy, supplies, etc.). **Medicare Part B** services will cross over to Medicaid and adjudicate as a crossover claim. Providers may then bill Medicaid for the Part A inpatient hospital services. Do not use bill classification 121 for these claims; bill classification 111 should be used. Enter "Medicare Part B" as the Primary payer on Line A of Field Locator 50 and the total amount paid by Medicare under Part B for the Part B ancillary charges entered as a prior payment in Field Locator 54A with a Claim Filing indicator of MB (Medicare Part B). Enter the Claim Filing indicator of MC (Medicaid) in Field Locator 54B and the total amount paid by Medicaid under Part B for the Part B ancillary charges entered as a prior payment. Attach a copy of the EOMB from Medicare and the Remittance Advice from Medicaid showing the amount paid for the Part B ancillary charges to the claim:

All claims are to be submitted electronically through EDI or on the web portal at www.mmis.georgia.gov.

For more detail billing instructions; please review the Medicaid Secondary Claims User Guide.

B) Exhaustion of Medicare Lifetime Reserve Days

When the total Medicare Lifetime Reserve Days are exhausted, the Division may be billed for charges incurred by Medicaid members.

The claims for these charges must be filed on the UB-04 claim form with the Report of Eligibility or Explanation of Medicare Benefits attached. The attachment must state that the patient's total Lifetime Reserve Days are exhausted and include the last date of Medicare entitlement. When filing the UB-04, Medicaid liability begins with charges incurred after Medicare benefits were exhausted.

Please refer to Part I, Chapter 300 for more details regarding Medicare/Medicaid policies and procedures.

C) Partial Medicare Eligibility:

When a Medicaid member's Medicare eligibility begins during the course of an inpatient hospitalization, but after the admission date, the Division may be billed for the dates the patient was Medicaid only and as a secondary payer for the dates the member became Medicare Primary.

911. Limits to Abortion, Sterilization and Hysterectomy Coverage

Medicaid funds are unavailable for sterilization, hysterectomies, or abortions performed without the documentation required by federal regulations (See 42 CFR 441.206 and 441.256). As such, claims for payment submitted without the required documentation or with incomplete or inaccurate documentation will be denied. The Division does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

911.1 Abortion

Effective, November 13, 1997, as part of the Department of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 1998, Public Law Number 105-78 (1997), Congress passed a revision of the Hyde Amendment pertaining to Federal funding of abortions under the Medicaid program. Enacted as 509 of the Department of Labor Appropriations Act, 1994, 107 Stat. 1082. Section 510 directs that "none of the funds appropriated under this Act shall be expended for any abortion except when it is made known to the Federal entity or official to which funds are appropriated under this Act that such procedure is necessary to save the life of the mother of that the pregnancy is the result of an act of rape or incest.

A "Certificate of Necessity for Abortion" form, DMA-311, certifying the above situation must be properly executed and attached to the claim at the time of submission to the Division. This form may be filled out and signed by the physician before or after the abortion is performed. See Appendix I for a copy of this form.

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To ensure that abortions are not being billed through the use of other procedure codes, the Division requires **the following procedures to require an abortion certification along with** submission of the History& Physical, Operative Report, and the Pathology Report with all claims that have the following procedures;

- Other cesarean section of unspecified type
- Other genitourinary installations
- Dilation and curettage for termination of pregnancy
- Aspiration curettage of uterus for termination of pregnancy
- Hysterectomy to terminate pregnancy
- Intra-amniotic injection for abortion

911.2 Sterilizations

NOTE: Medicaid funds are unavailable for sterilization, hysterectomies, or abortions performed without the documentation required by federal regulations (See 42 CFR 441.206 and 441.256). As such, claims for payment submitted without the required documentation or with incomplete or inaccurate documentation will be denied. The Division does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

The Division is prohibited from making payment for sterilizations performed on any person who: is under twenty-one (21) years of age at the time he/she signs the consent; or is not mentally competent; or is institutionalized in a correctional facility, mental hospital, or other rehabilitation facility. See Appendix J for a copy of the required consent form.

For sterilization procedures performed on and after March 8, 1979, the mandatory waiting period between signed consent and sterilization is thirty **(30)** days.

The signed consent form expires one hundred and eighty (180) days from the date of the member's signature.

In the case of premature delivery or emergency abdominal surgery performed within thirty (30) days of signed consent, the physician must certify that the sterilization was performed less than thirty (30) days but not less than seventy-two (72) hours after informed consent was obtained. Although these exceptions are provided, the conditions of the waiver will be subject to review.

In the case of premature delivery or emergency abdominal surgery, the sterilization consent form must have been signed by the member thirty 30 Days prior to the originally planned date of sterilization. A sterilization consent form, DMA- 69, must be properly filled out and signed for all sterilization procedures and attached to the claim at the time of submission to the Division. The member must sign the consent form at least thirty (30) days, but not more than one hundred and eighty (180) days, prior to the sterilization. The physician must sign the consent form after the sterilization has been performed.

For information on ordering forms, please refer to the Hospital Billing Section published by Georgia Healthcare Partnership.

The following is a list of procedures associated with sterilization. All claims with these procedures will be reviewed prior to payment to ensure proper coding and to ensure that the sterilization consent form is attached to those claims requiring a form.

NOTE:
Two (2) of the procedures always require a sterilization consent form. The remaining codes require the consent form if the procedure was done for sterilization purposes.

Sterilizations that always requires the Sterilization Consent Form.

- Male sterilization procedure, not otherwise specified
- Other bilateral destruction or occlusion of fallopian tubes

If done for sterilization purposes, requires Sterilization Consent Form.

- Vasectomy and ligation of vas deferens
- Vasectomy
- Bilateral Salpingo-oophorectomy
- Removal of both ovaries and tubes at same operative episode
- Removal of remaining ovary and tube
- Operations on fallopian tubes
- Salpingostomy

- Bilateral endoscopic destruction or occlusion of fallopian tubes
- Bilateral endoscopic ligation and crushing of fallopian tubes
- Bilateral endoscopic ligation and division of fallopian tubes
- Other bilateral endoscopic destruction or occlusion of fallopian tubes
- Other bilateral destruction or occlusion of fallopian tubes
- Other bilateral ligation and crushing of fallopian tubes
- Other bilateral ligation and division of fallopian tubes
- Total unilateral salpingectomy
- Total bilateral salpingectomy
- Removal of both fallopian tubes at same operative episode
- Removal of remaining fallopian tube
- Other salpingectomy
- Bilateral partial salpingectomy, not otherwise specified
- Other partial salpingectomy

911.3 **<u>Hysterectomy</u>**

NOTE: Medicaid funds are unavailable for sterilization, hysterectomies, or abortions performed without the documentation required by federal regulations (See 42 CFR 441.206 and 441.256). As such, claims for payment submitted without the required documentation or with incomplete or inaccurate documentation will be denied. The Division does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

Hysterectomy procedures are reimbursable only when the following requirements are met:

A) The hysterectomy was performed for medical necessity and <u>not</u> for the purpose of family planning, sterilization, hygiene or mental incompetence.

B) The member was informed prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if

the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);

C) The member and the attending physician sign the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information," form DMA-276, either before or after the surgery is performed. The individual is not required to sign in the cases of prior sterility or emergency hysterectomy; and the properly executed "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" form is attached to the claim submitted to the Division. See Appendix H for a copy of this form.

D) The following is a list of procedures associated with hysterectomies. All claims with these procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the hysterectomy acknowledgement form is attached. All hysterectomy procedures listed require a hysterectomy acknowledgement form.

E) Hysterectomies that require the Hysterectomy Acknowledgement form:

- Subtotal abdominal hysterectomy
- Total abdominal hysterectomy
- Vaginal hysterectomy
- Radical abdominal hysterectomy
- Radical vaginal hysterectomy
- Pelvic evisceration
- Other unspecified hysterectomy

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

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

separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

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

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

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

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

The following resources are available for more information:

- Access the department's DCH-I newsletter and FAQs at http://dch.georgia.gov/publications

- Search to see if a provider is enrolled at

  https://www.mmis.georgia.gov/portal/default.aspx

  Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and Provider's last name.

- Access a provider listing at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Notices/tabId/53/Default.aspx

  Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

PART II CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001. Reimbursement Methodology

Distinct methods of reimbursement have been established for inpatient services provided by Georgia hospitals, for outpatient services provided by Georgia hospitals, and for all services provided by non-Georgia hospitals.

1001.1 Inpatient Services

Inpatient services provided by in-state hospitals enrolled in Georgia Medicaid are reimbursed through the Inpatient Prospective Payment System (IPPS). Under the IPPS, claims are categorized into a diagnosis-related group (DRG) for payment purposes by the Tricare grouper software within the Georgia Medicaid Management Information System (GAMMIS). Each DRG has a payment weight assigned to it, calculated from the average cost to treat patients with conditions that fall into that DRG.

- To calculate payment for a claim with a date of admission prior July 1, 2015, under the IPPS, the following formula is used:

  = (DRG Weight x Hospital-Specific Base Rate) + Capital Add-On Payment + GME Add- on Payment

- To calculate payment for a claim with a date of admission on or after July 1, 2015, under the IPPS, the following formula is used:

  = DRG Weight x Hospital-Specific Base Rate

Occasionally, a hospital may have an inpatient claim that falls outside of the expected range of cost for the DRG. These cases are referred to as outlier claims. In the event that the cost of a claim meets or exceeds the outlier threshold for a DRG, the hospital may receive an outlier payment in addition to the DRG payment.

- To calculate the outlier payment for claims with a date of admissions prior to January 1, 2019, the following formula is used:

  = {[(Allowable Charges x Hospital-Specific Operating Cost to Charge Ratio) – (Hospital-Specific Base Rate x DRG Weight)] x Outlier Payment Percentage}

- To calculate payment for the outlier payment for claims with a date of admission on or after January 1, 2019, the following formula is used:

  ={[(Allowable Charges x Hospital-Specific Cost to Charge Ratio) – DRG Outlier Threshold] x Outlier Payment Percentage

Additional information on the grouper version, DRG weights, and outlier thresholds may be found on the DCH website at: https://dch.georgia.gov/diagnosis-related-groups. Additional instructions on the submission of outlier cases are found in Appendix L.

1001.2 Inpatient Reimbursement for New Hospitals

For the purposes of inpatient hospital reimbursement, a new hospital is defined as a hospital:

A) Established by the initial issuance of a Certificate of Need, Medicare certification, and state license, and

B) For which historical base year paid claims data did not exist.

New hospitals will be reimbursed under the same inpatient payment formulas as stated in Section 1001.1. New hospitals enrolling in Georgia Medicaid on or after January 1, 2019 will be reimbursed utilizing the statewide base rate and the Georgia statewide average of the cost-to-charge ratios.

A hospital formed as a result of a merger, acquisition, other change of ownership, business combination, etc. is not a new hospital. Each hospital of this type will maintain the DRG system reimbursement components it would otherwise be assigned. When rates are adjusted after the transaction, the appropriate base period information will be used in determining the hospital's rebased reimbursement components.

1001.3 Outpatient Services

A) Outpatient services by Georgia hospitals are reimbursed on an interim payment basis and are subject to cash settlement as described in Section 1003. The Department captures outpatient charges used in the settlement calculation on the Hospital Statistical and Reimbursement (HS&R) report. The HS&R report shows the detailed allocation of charges according to UB revenue codes billed by the hospital. Effective with settlements completed on or after 7/1/2003, no other allocation or methodology will be used to determine allowable and reimbursable outpatient costs other than the HS&R report.

B) The determination of allowable and reimbursable costs is made retrospectively and is based on a cost report submitted by the hospital in accordance with Section 1002 and data included in the Non-allowable Cost Questionnaire. Only costs incurred in providing patient care are eligible for reimbursement. In determining reimbursable cost, the lower of costs or charges (LCC) methodology will be applied to all providers to ensure that reimbursable costs will not include costs that exceed total charges. This determination/methodology will be calculated at the time of outpatient settlements using as-filed or audited cost reports.

The Division will reimburse for cost-based outpatient services at 90 percent of allowable operating costs plus 90 percent of allowable capital costs. The final determination of reimbursable costs will be made at the time outpatient settlements are made using audited cost reports.

For those hospitals that are currently reimbursed at 90% of the cost of services provided, the reimbursement rate will be reduced to 85.6% of costs. For those hospitals that will be subject to the reimbursement rate of 85.6% of costs, the percentage of charges that will be used for interim payments will be proportionally to reflect the reduction from 90% of cost to 85.6% of cost. The Department will also use trend adjustments to reflect ongoing changes in hospital charges compared to costs.

Critical access eligible hospitals (CAH), which meet departmental requirements, will be reimbursed at 100% of reimbursable costs at the time initial and final outpatient settlements are made using the as-filed and audited cost reports. State owned or operated hospitals will be reimbursed at 100% of reimbursable costs at the time final outpatient settlements are made using audited cost reports. Reimbursable costs, however, cannot exceed customary charges (LCC) for any provider. (See 1001.3 (B))

Historically minority-owned hospitals will be reimbursed at 100% of reimbursable costs at the time final outpatient settlements are made using audited cost reports. Reimbursable costs, however, cannot exceed customary charges (LCC) for any provider. (See 1001.3 (B))

Payments to hospitals that are designated as a Critical Access Hospital, a historically minority owned hospital or as a state owned hospital will continue to be reimbursed at 100% of costs. Interim payments made on and after July 1, 2004 will be made at a percentage of covered charges estimated to equal 100% of costs. The LCC methodology will be applied to all providers when determining the outpatient settlements. (See 1001.3(B))

C) The amount of interim payment is calculated as a particular percentage of covered charges submitted to the Division. This percentage of charges is specific to each hospital and is based on the actual experience of the hospital during the last period for which the Division has performed a cost report review. The percentage of charges represents an estimate of a payment rate that approximates the amount of subsequently determined allowable cost. An interim reimbursement rate cannot exceed eighty five point six percent of covered charges. Interim payments are subject to a cash settlement determination as described in Section 1003, and cannot exceed the Medicaid maximum allowable payment. The Medicaid maximum allowable payment is the hospital-specific DRG base rate including the capital and graduate medical education add-ons. The Medicaid maximum allowable payment is the hospital-specific DRG base rate including the capital and GME add-on multiplied by eighty five point six percent.

D) All clinical diagnostic laboratory services performed for outpatients and non- patients are reimbursed at lab fees for outpatient hospitals (excluding critical access hospitals and state-owned hospitals) and will be paid based on the established fee schedule. Note: Reimbursement of the clinical laboratory CPT codes is based on Medicaid's pricing methodology for Outpatient Lab services which reimburses the lesser of the following: The Medicaid Allow Amount {Medicaid Rate + Hospital Add-On Rate (Medicaid Rate x .1188) x Number of Units} **OR** The Medicare Allowed Amount (Medicare Rate x Number of Units).

E) All injectable drugs are reimbursed in accordance with the HCPCS Level II dose and descriptions. Effective September 1, 2009, the Department of Community Health amended the maximum allowable reimbursement for approved drugs to the lessor of; The provider's usual and customary charge,

Average Sales Price (ASP) plus 6% as defined January 1st of each year or the ASP + 6% upon the drug's initial availability in the marketplace whichever is later; or Wholesale Acquisition Cost (WAC) for injectable drugs that do not have ASP pricing until such time that ASP plus 6% pricing becomes available. Drugs on the PADL that are priced without an ASP rate are denoted by an inverted triangle [▼].

Only the administration fee is reimbursable for vaccines and immunizations supplied through the Vaccine for Children's (VFC) Program or the Federal Government. These products are supplied at no charge to providers. The vaccine administration fee for adults over 19 years of age is covered when the drug is provided by the Federal Government free of charge to the provider.

1. Any provider enrolled in the outpatient drug program that purchases drugs pursuant to the 340B pricing schedule, (Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act) must bill the claim the maximum amount or the lesser of the cost of all drugs

2. Out-of-state entities who are enrolled with Georgia Medicaid must contact the Department at 340B@dch.ga.gov and provide notification of intent to carve-in or carve-out Georgia Medicaid claims.

3. Contract pharmacy billing arrangements that are utilized to provide 340B drugs to Medicaid patients are not permitted unless prior arrangements are made with the Department of Community Health.

F) The maximum allowable payment for any outpatient hospital claim is the total of the DRG base rate plus the hospital specific add-on amount. When the outpatient cost-based settlements are made, claims for outpatient services which were paid at the maximum allowable payment will be excluded from the settlement calculations.

G) The Division reimburses enrolled hospitals that offer (either directly or through contract) birthing and parenting classes to Medicaid eligible pregnant women. Services may be billed once per year per member.

Reimbursement is the lower of billed charges or $70. When the outpatient cost-based settlements are made, claims for outpatient services for birthing and parenting classes will be excluded from the settlement calculations.

H) A $3 member co-payment is required on all non-emergency outpatient hospital visits. Pregnant women, members under twenty-one (21) years of age, nursing facility members, community care participants, hospice care participants and persons who have both Medicare and Medicaid coverage are not subject to the co-payment. When the outpatient cost-based settlements are made for hospital services, the co-payment plus Medicaid payment will be compared to the allowable cost to determine the amount of final settlement.

I) Co-payments will apply to the groups of members outlined below who were previously exempt from participation in co-payments.

1) Acute renal dialysis members

2) Medicare/Medicaid dually eligible members.

3) Members in waivered services programs.

These groups are required to co-pay beginning with dates of service January 1, 1995, and after, for those services designated as co-pay services.

Maintenance dialysis services for end-stage renal disease are not designated as co-payment services and no co-payment is required for these services.

J) The professional services of certified registered nurse anesthetists (CRNAs), pediatric nurse practitioners, obstetrical nurse practitioners, family nurse practitioners, and physician's assistant anesthesiologist's assistant (PAAAs) will not be reimbursed through the Medicaid cost report. CRNAs, specified nurse practitioners and PAAAs must enroll in the Medicaid program to receive payment for their services directly.

K) Governmental facilities and Critical Access eligible hospitals which meet departmental requirements will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that based on their governmental status, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities.

The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State governmental facilities, non-State governmental facilities and non-governmental facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:
All amounts paid for services provided to Medicaid patients including interim Medicaid claim payments and estimated Medicaid cost report settlement amounts, based on data from cost report worksheet E-3 Part III, and Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

Comparisons of amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. If an individual facility cannot be paid a portion of its full rate adjustment payment due to a facility-specific charge limit, this rate adjustment amount can be allocated to other facilities that are eligible to receive additional rate adjustment payments without exceeding facility-specific charge limits. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims. UPL payments will be made on an interim basis. These payments will be subject to a retrospective settlement at a future date, when HS&R report data can be prepared based on complete, paid claims data and when audited cost reports are available. This is necessary as a result of the care management organizations participating in the Georgia Families program. The interim payments will reflect reductions in UPL payments to hospitals.

L) The Medicaid maximum allowable payment is the hospital-specific DRG base rate including capital and graduate medical education add-ons multiplied by 85.6% (eighty-five point six percent)

1001.4 Services Provided By Non-Georgia Hospitals

A) **Inpatient Services for Enrolled Non-Georgia Hospitals**

Participating (Enrolled) Non-Georgia Hospital will be reimbursed under the same inpatient payment formulas as stated in Section 1001.1.

Prior to July 1, 2015, enrolled non-Georgia hospitals will receive a hospital specific base rate, capital add-on, cost-to-charge ratio, and a semi-private room rate that is equal to the statewide average rate for the appropriate peer group in which the hospital is classified.

Effective for dates of admission on or after July 1, 2015, but prior to January 1, 2019, enrolled non-Georgia hospitals will receive the statewide average rate for the appropriate peer group without any adjustments for indirect medical education or Medicaid utilization. In addition, there will be no capital add-on payment as capital is incorporated into the base rate.

Effective for dates of admission on or after January 1, 2019, enrolled non-Georgia hospitals will be reimbursed utilizing the statewide base rate and the Georgia statewide average of the cost-to-charge ratios.

B) Outpatient services provided by enrolled non-Georgia hospitals are reimbursed at a rate of 65% of covered charges not to exceed the Georgia Medicaid maximum allowable payment. The Medicaid maximum allowable payment is the hospital-specific DRG base rate including the capital and graduate medical education add-ons multiplied by eighty five point six percent.

For out-of-state enrolled hospitals, payments will be made at the statewide average percentage of charges that will be paid to Georgia hospitals being reimbursed at 85.6% of costs. The payment rate for out-of-state enrolled hospitals will not exceed 65% of covered charge

C) Nonparticipating (non-enrolled) Non-Georgia Hospitals

Effective with dates of admission or service of July 1, 1989, and after, inpatient services provided by non-Georgia hospitals not enrolled in the Georgia Medicaid program are reimbursed according to rates established by the Medicaid program in the state in which the hospital is located for those procedures covered by that state. If the state in which the hospital is located reimburses DRG rates or per diem rates exceeding $999.99, reimbursement by Georgia Medicaid will be at a rate not to exceed 65% of covered charges. For procedures or services not covered by the state Medicaid program in the state in which the hospital is located, reimbursement will be at a rate of 65% of covered charges if the procedures or services are covered by Georgia Medicaid. Georgia Medicaid will reimburse the lesser of the above payment methodologies.

For certain specialized procedures for which services may not be available at the reimbursement rate as stated above, the Division may approve a percentage of charges rate in excess of 65%.

D) Outpatient services provided by non-Georgia hospitals not enrolled in the Georgia Medicaid program will be reimbursed at a rate of 45% of covered charges.

1001.5 Medicare Crossover Claims

The maximum allowable payment to enrolled Georgia and non-Georgia hospitals for Medicare inpatient and outpatient deductible and coinsurance (crossover claims) will be the applicable per case rate under the DRG payment system. The maximum allowable payment to non-Georgia hospitals not enrolled in the Georgia Medicaid program for Medicare inpatient and outpatient crossover claims will be the weighted average inpatient per case rate of enrolled non-Georgia hospitals.

Effective with dates of admission on and after October 9, 1997, the Division will limit payment on outpatient Medicare crossover claims as follows:

A) Multiply the allowable deductible and coinsurance amount by the hospital- specific percent of charges rate in effect on the date of payment;

B) Compare the product from (a) to the applicable per case rate under the DRG payment system; and

C) Reimburse the lower of the two amounts in (b). The Division will reimburse for Medicare coinsurance and deductible obligations as follows:

Inpatient hospital services

A) The Medicaid maximum allowable payment is the hospital specific DRG base rate including capital and graduate medical education add-ons multiplied by 85.6% (eighty-five point six percent)

B) The Medicare coinsurance and deductible amounts for a claim are compared to the Medicaid allowable payment minus the Medicare payment.

C) The actual Medicaid payment will be the lower of the amounts in item (b), less applicable third party liabilities and patient co-payments.

D) The Medicaid maximum allowable payment is the hospital-specific DRG base rate including capital and graduate medical education add-ons multiplied by eighty five point six percent.

E) The Medicare coinsurance and deductible amounts are multiplied by the hospital-specific percent of charges rate for outpatient services.

F) The actual Medicaid payment will be the lower of the amounts in items (a) and (b), less applicable third party liabilities and patient co-payments.

These changes would apply to services provided to all patients dually eligible for the Medicaid and Medicare programs, including Qualified Medicare Beneficiaries.

1001.6 Third-Party Claims

Hospital providers must attempt to pursue third party resources prior to filing a Medicaid claim. If a third party does not pay at or in excess of the applicable Medicaid reimbursement level, a hospital may submit a Medicaid claim and will be paid the applicable reimbursement less any reimbursement received from third party resources. If a third party pays at or in excess of the amount that Medicaid would pay, the hospital should not submit a claim to the Division for payment (see Part I Section 303, Third Party Payments). If a claim is submitted, it will be excluded from paid claims data used to establish per case rates and calculate outpatient settlements. For newborns; once the newborn is showing as an eligible Medicaid member, the provider should submit two separate claims, one for the mother and one for the newborn. The payment from the primary insurance must be reflected on both the mother and baby claim. In the event that the primary insurance pays for a partial stay, such as the first 30 days of a continuous hospital stay, the DOS on the claim submitted to Medicaid must be inclusive of the entire hospital stay in which the member is Medicaid eligible, and any prior payment from the primary insurance must be present on the claim. The Coordination of Benefit (COB) payment should be prorated between the mother and newborn claims. The prorated amount is entered in field 54 on the UB-04 form (i.e., the Prior Payments field). A copy of the EOB must be submitted with each claim. The EOB must show the prorated COB Paid Amount and prorated Patient Liability.

1001.7 Reserved

1001.8 Hospital Provider Rate (Fee) Add-On

In order to recognize the Medicaid Hospital Provider Agreement Act of 2010, as amended by the Hospital Medicaid Financing Program Act of 2013:

(1) Effective for inpatient payments with admissions on or after July 1, 2010 through June 30, 2025 the inpatient DRG payment (inclusive of the capital and GME add-ons) will be multiplied by 11.88% to receive an additional add-on payment. This payment will be the Hospital Rate (Fee) Add-on;

(2) Effective for outpatient interim payments made on or after July 1, 2010 through June 30, 2025, the outpatient interim payment will be multiplied by 11.88% to receive an additional add-on payment. This payment will be the Hospital Rate (Fee) Add-on;

(3) Effective for outlier payments with admission dates on or after July 1, 2010 through June 30, 2025, the outlier supplemental payments will be multiplied by 11.88% to receive an additional add-on payment. This payment will be the Hospital Rate (Fee) Add-on; and

(4) The allowable percentage used to determine reimbursable cost in the outpatient settlement calculation for services on or after July 1, 2010 through June 30, 2025 will be 95.77 percent (calculated as follows: 0.856 x 1.1188) to reflect the increase in payments due to the addition of the hospital provider fee add-on payment.

Critical Access State Owned/State Operated, and Out of State enrolled providers are exempt from the rate adjustment increase.

1002 Cost Reporting Requirements

1002.1 Each participating (enrolled) hospital must submit a cost report using the appropriate Form HCFA-2552. The Division requires hospitals to list inpatient and outpatient costs and charges separately on Worksheet E-3 Part III or other revised forms as appropriate.

1002.2 A hospital with a cost reporting period ending on or after June 27, 1995, must furnish its cost report within five months after its fiscal year end. If the report has not been received after this five-month period and a request for extension has not been granted, a written warning will be issued. This warning will indicate if, after an additional month (total six months), the cost report has not been received, a one hundred percent reduction will be imposed on all payments made during the period that the cost report is late.

These payments will be withheld until an acceptable Medicaid cost report is received. After the cost report is received and is determined to be acceptable, the withheld funds will be released. If the cost report is not received after a total of seven months from a hospital's fiscal year end, the hospital's agreement of participation will be subject to suspension or termination.

When a hospital undergoes a change of ownership or voluntarily or involuntarily terminates from the Medicare/Medicaid program, the hospital must notify the Division and file a terminating cost report within five (5) months of the date of termination. If a cost report is not received within this period, all Medicaid payments will be withheld until an acceptable cost report is received and accepted by the Division. The Department may sanction a hospital for failure to submit the required cost report as outlined in Section 1002.

1002.3 The Division has entered into a "common audit" agreement with Myers and Stauffer, LC. The hospital's Medicaid cost report should be sent to the following address**:**

John D. Kraft, CPA, CHFP
MYERS AND STAUFFER LLC
10200 Grand Central Avenue, Suite 200
Owings Mills, MD 21117
PH 410. 581. 4643 (Direct)
PH 800. 505. 1698 (Main)
FX 410. 356. 0188
www.mslc.com

In addition to the cost report, the following listing of items must also be submitted along with the cost report in electronic format if possible.

1. ECR files of submitted cost report
2. Working Trial Balance
3. Expense mapping for Worksheet A
4. Revenue mapping for Worksheet C
5. Supporting work papers for A-6 reclassifications
6. Supporting work papers for A-8 adjustments
7. CMS Form 339
8. Medicaid charge mapping Worksheets for D-4 and D Part V
9. Audited Financial Statements (if available)

1002.4 As part of the cost report review process, a hospital must make available to authorized representatives of the Division all medical and fiscal records, including Medicare cost reports and work papers prepared by Medicare fiscal intermediary auditors.

1003 Cash Settlements

1003.1 As described in Subsection 1001.3 (c), a determination will be made which may show that a hospital's interim payments were less than or more than a retrospectively determined settlement amount.

1003.2 Where the determination of reimbursable cost shows that additional payments due to the hospital, the Division will provide payments upon receipt, review and acceptance of an audited Medicaid cost report from the intermediary. Tentative settlement will not be made based on an as filed Medicaid cost report or an audited report which has not been reviewed and accepted by the Division. Tentative settlements will **only** be made for approved Critical Access Hospitals, based on an as-filed Medicaid cost report or an audited report that has been reviewed and accepted by the Division.

1003.3 Where the determination of reimbursable cost shows that an overpayment has been made to a hospital, the hospital must refund the overpayment as outlined in Section 304. A hospital also must refund the Division the amount by which total Medicaid payments are in excess of total charges for Medicaid patients, as described in Section 1011.

1003.4 For those hospitals that do not have a Medicare intermediary, the Department will have the option of using the as-filed cost report as submitted by the provider to compute the outpatient settlement or use the submitted as-filed report audited by the Department's assigned agent.

1003.5 If an authoritative unit within the department of Community Health (i.e. Office of the Inspector General, Division of Medical Assistance, etc) makes a determination which impacts a hospital outpatient settlement, the hospital settlement will be amended accordingly. Amendments to the charges and payments that appear in the original hospital outpatient settlement are made based upon the authoritative unit's final determination. Concessions based upon settlement agreements are not considered when making these recalculations.

1004. Room Rate Reimbursement

1004.1 For those hospitals subject to Subsections 1001.1 and 1001.2, the Division does not reimburse for a private room under any circumstance. The difference in the cost of private and semi-private rooms should be identified and, if appropriate, excluded in the determination of allowable cost for services provided to Medicaid patients.

1004.2 For those hospitals subject to Subsections 1001.4, the Division does not reimburse for a private room under any circumstance. This provision will, if applicable, be taken into consideration for determining the appropriate payment for services provided to Medicaid patients.

1004.3 Semi-private room rate increases will be collected periodically by the Division through a survey process. The timeframe for collecting the data and incorporating new semi-Private room rate changes into the claims processing system will be specified in the survey instrument. The Division reserves the right to deny any increase that is determined to be inappropriate.

1005. Hospital-Based Rural Health Clinics

Reimbursement for Hospital Based Rural Health Clinics will be determined in accordance with the Policies and Procedures for Rural Health Clinic Services manual. Please reference this manual for additional information about this program.

1006. Reserved

1007. Inpatient Co-payments

A co-payment of $12.50 will be imposed on hospital inpatient services. Refer to Appendix M for the current co-payment policy and requirements.

1008. Graduate Medical Education (GME) Supplemental Payment Pool

Effective July 1, 2015, hospitals which have GME costs in the base period cost report, receive a GME payment as a GME Supplemental Payment. GME is paid in at least four quarterly equal payments or more frequently if funds are available.

a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's GME. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.
b) Use the hospital's reimbursable GME costs from the cost report.
c) Determine the Medicaid allocation of GME costs from the cost report by multiplying the Medicaid allocation ratio (Item 1 (a)) by total GME costs from the cost report (Item 1 (b)).
d) Determine the GME CCR by dividing the Medicaid allocation of GME costs (Item 1 (c)) by the total allowed Medicaid charges for the cost report period.
e) Calculate the base year GME costs by multiplying the GME CCR by the base year allowed charges, adjusted for inflation.
f) Divide the total Medicaid allocation of GME (Item 1(e) by the number of payments.

Effective January 1, 2019, hospitals with accredited GME programs receive a Graduate Medical Education Supplemental Payment. GME supplemental payments are made in quarterly installments. The annual amount of each GME supplemental payment is determined as follows:

a) Determine the number of FTE residents.
b) Determine the Medicaid Allocation Ratio (MAR). For facilities with DSH surveys, the Medicaid Allocation Ratio is Total Medicaid Hospital Revenue divided by Net Hospital Revenue. For facilities without DSH surveys, the Medicaid Allocation Ratio is Total Medicaid Inpatient Cost (Medicare Cost Report Worksheet E-3, Part VII, Title XIX, Line 1.00, Column 1.00) divided by Total Inpatient and Outpatient Cost (Medicare Cost Report Worksheet B, Part I, Line 118, Column 24).
c) Determine the hospital's base GME funding as follows: $49,000 x (FTE resident count determined in step (a)) x (MAR determined in step (b))
d) Hospitals with FTE residents in the residency programs listed below will receive additional funding above the base funding allocation

1. Family Medicine: $33,000/FTE Resident
2. OB/GYN: $33,000/FTE Resident
3. General Pediatrics: $28,500/FTE Resident
4. Pediatric Specialty Programs: $13,500/FTE Resident
5. General Surgery: $10,000/FTE Resident

1009. Disproportionate Share Hospitals (DSH) Payment

A. Eligibility

Effective for DSH payment adjustments made on or after December 1, 2007, hospitals that are eligible to receive DSH payment adjustments under federal DSH criteria per Social Security Act Section 1923(d) will be eligible to receive an allocation of available DSH funds.

Federal Criteria:

1. The hospital has a Medicaid inpatient utilization rate of at least 1%; AND

2. The hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid recipients. This requirement does not apply to a hospital of which the inpatients are predominately individuals under 18 years of age or to hospitals which did not offer non-emergency obstetric services to the general population as of December 22, 1987. In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. For rural hospitals subject to a federal requirement to provide obstetric services, as an alternative to determining whether deliveries are provided at the hospital, the Department will consider the following factors:

   a. The hospital must have two or more physicians with staff privileges that are:
      i. Enrolled in the Medicaid program.

ii. Credentialed to provide OB services at the hospital in family practice, general practice, or obstetrics; and
iii. Located within 25 miles of the hospital or in an office in the hospital network or must attest to attendance at the hospital on some routine basis; and

b. The hospital must be able to provide at least one obstetric service that is currently covered by Medicaid and appropriate to be provided in a hospital-based setting.

For federal DSH criteria, a hospital will be considered a rural hospital if a hospital's county is not in a Metropolitan Statistical Area, as defined by the United States Office of Management and Budget, OR is a county having a population of less than 35,000 according to the United States decennial census; provided, however, that for counties which contain a military base or installation, the military personnel and their dependents living in such county shall be excluded from the total population of that county.

B. Allocation Methodology

Effective for DSH payment adjustments made on or after December 1, 2007, the following methodology will be used for determining payment amounts:

1. For each federal fiscal year, the amount of funds available for DSH payments will be determined based on the state's federal allotment and required state matching contribution.

2. Hospitals that meet federal DSH eligibility criteria will be eligible to receive an allocation of available DSH allotment funds.

3. The maximum amount of DSH payments (i.e., DSH Limit) for each hospital will be the hospital's loss incurred for services provided to Medicaid and uninsured patients based on federal definitions. Medicaid costs will be determined by applying per diem costs to Medicaid inpatient days and ratios of cost to charges to Medicaid inpatient and outpatient charges grouped by cost center. The patient day and charge amounts will be determined by Medicaid HS&R reports of paid claims, while per diem costs and ratios of cost to charges will be determined by available 2552 cost reports. Medicaid payments will include interim claim payments, outpatient settlement estimates and non-DSH rate adjustments.

   Uninsured costs will be determined by applying Medicaid inpatient and outpatient cost to charge ratios, from available 2552 cost reports, to charges for uninsured reported on DSH data surveys. The DSH data surveys will also be used to determine amounts received for services provided to uninsured patients. DSH data surveys are conducted annually and subject to desk reviews and onsite reviews of supporting documentation, as warranted.

4. The amount of funds available for DSH payments will be allocated among eligible hospitals.

Total available DSH funds will be divided into two pools:

a. Pool 1 – For FY 2008 DSH payments, Pool 1 will be equivalent to $53,735,261 and used in the calculation of DSH allocations for small, rural hospitals. For DSH payments after

FY 2008, Pool 1 would change relative to changes in the state's federal DSH allotment as compared to the FY 2008 state DSH allotment;

b. Pool 2 – For FY 2008 DSH payments, Pool 2 will be equivalent to $347,439,065 and used in the calculation of the DSH allocations for all other, eligible hospitals. For DSH payments after FY 2008, Pool 2 would change relative to changes in the state's federal DSH allotment as compared to the FY 2008 state DSH allotment.

5. Each hospital's DSH limit is subject to the following DSH limit adjustments for allocation purposes:

a. For hospitals receiving Upper Payment Limit (UPL) rate adjustments, the allocation basis will be increased by the amount of any intergovernmental transfer or certified public expenditure provided on behalf of the hospital.

b. For hospitals receiving rate adjustment payments related to medical education, neonatal services or services provided under contract with the Georgia Department of Human Resources, the allocation basis will be increased by the amount of such rate adjustments.

6. The department will utilize the following steps to determine the amount each hospital is eligible to receive in DSH payments.

a. Step 1: Determine the adjusted DSH limit (as determined in section (III) (B) (5)) as a percentage of total cost for each hospital.
b. Step 2: For each hospital, multiply the hospital-specific percentage determined in Step 1 by the hospital's adjusted DSH limit. For private hospitals, the outcome of this calculation will be multiplied by the rate of federal matching funds for Medicaid benefit payments.
c. Step 3: For each hospital, divide the hospital-specific amount identified in Step 2 by the aggregate "step 2" amount derived from all hospitals in the applicable pool, as defined in section (III)(B) (4), which will result in a hospital-specific allocation factor.
d. Step 4: Apply the hospital's allocation factor calculated in Step 3 to the total amount of DSH funds available in the applicable pool, as defined in section (III)(B)(4). This will result in the hospital's DSH payment. Should the DSH payment amount calculated for a hospital exceed the hospital's DSH limit, as determined in section (III)(B)(3), the excess amount will be redistributed to the remaining hospitals in the applicable allocation pool.

7. To mitigate significant increases and decreases in hospital specific DSH payments as compared to state fiscal year 2007, the following adjustments will be applied for the allocation of DSH funds:

a) Maximum DSH allocations for all hospitals are set at 75% of their specific adjusted DSH limits; however, for facilities ineligible for DSH payment adjustments prior to December 1, 2007 but newly eligible under the criteria specified in section A above or facilities who do not receive a DSH payment prior to December 1, 2007, their

maximum DSH allocation factor, as calculated in Section (III) (B) (6), step 2, is limited to 10% of the calculated amount.

b) Final DSH payment amounts for small, rural hospitals reflects blending of 75% of state fiscal year 2007 net DSH payments and 25% of the allocation calculation based on the methodology specified in section (III)(B)(6);
c) Final DSH payment amounts for all other hospitals reflects blending of 50% of state fiscal year 2007 net DSH payments and 50% of the allocation calculation based on the methodology specified in section (III)(B)(6).

8. For private hospitals that meet the eligibility requirements of Section (III) (A) and meet Social Security Act Section 1923(b) criteria, allocations payments will be made at 100 % of calculated allocation amounts as determined by steps 1 through 7 of Section (III) (B). For private hospitals that meet the eligibility requirements of Section (III) (A) but do not meet Social Security Act Section 1923(b) criteria, allocation payments will be made at 100% of calculated allocation amounts as determined by steps 1 through 7 of Section (III) (B).

9. The state share of DSH payment amounts for state governmental and non-state governmental hospitals will come from intergovernmental transfers made on behalf of or by the hospital.

For allocation of 2008 DSH funds, provider eligibility and DSH limit calculations will be based on information available from hospital fiscal years ending in 2005; for hospitals not in operation during 2005, data for 2006 may be used. For allocation of DSH funds after 2008, eligibility and DSH limit calculations will be based on the most recent year for which comparable data would be available.

1010. Adjustments to Rate (Georgia Hospitals Only)

1010.1

The Division will issue survey forms for completion by hospitals to document any changes for any additional building and fixed equipment costs associated with a Certificate of Need approved capital improvement since the hospital's base year. Surveys received after the due date will not be used to increase a hospital's capital add-on amount.

1010.2

Effective with per case rates calculated for dates of admission on and after July 1, 1993, costs related to the professional services of certified registered nurse anesthetists (CRNAs), pediatric nurse practitioners, obstetrical nurse practitioners and family nurse practitioners will be excluded from base year costs prior to calculating the rates. Effective July 1, 1993, CRNAs and specified nurse practitioners must enroll in the Medicaid program to receive payment for their services directly.

1010.3

The Division reviews a hospital's cost report to verify various rate components. The reimbursement methodology assumes that services in the base period will continue; therefore, audited cost reports are reviewed to determine that all services and facilities included in the base period will continue in the

reimbursement year. Additionally, all surveyed items are subject to verification. As appropriate, the Division's findings on such items may cause a hospital's rate of payment to be adjusted.

1010.4

Subject to the availability of funds, hospitals designated by the Georgia Department of Human Resources as Regional Perinatal Centers will be eligible for rate payment adjustments. These hospitals provide intensive care to high-risk neonatal patients and incur significant unreimbursed costs associated with the provision of such services. The payment adjustments will be reasonably related to cost, volume or proportion of services provided to Medicaid patients. These rate payment adjustments will be made on a monthly or quarterly basis in lump-sum amounts.

1010.5

Subject to the availability of funds, hospitals will be eligible for rate payment adjustments for providing the following program services for the Georgia Department of Human Resources: AIDS Clinic, Poison Control Center, Genetics/Sickle Cell Screening and Maternal and Infant Health Services. Hospitals can incur significant unreimbursed costs associated with the provision of such services. The payment adjustment will be reasonably related to cost, volume or proportion of services provided to Medicaid patients. These rate payment adjustments will be made on a monthly or quarterly basis in lump-sum amounts.

1010.6

Subject to the availability of funds, hospitals participating in the residency grant programs administered by the Georgia Board for Physician Workforce will be eligible for rate payment adjustments. These hospitals operate post-graduate training programs for physicians preparing to enter family practice and other medical specialties and incur significant graduate medical education costs associated with the operation of such training programs. The payment adjustment will be reasonably related to cost, volume or proportion of services provided to Medicaid patients. These rate payment adjustments will be made on a monthly or quarterly basis in lump-sum amounts.

1010.7

Subject to the availability of funds, any State owned or operated teaching hospital will be eligible for an inpatient rate payment adjustment. Such a hospital can incur significant unreimbursed medical education and other operating costs. The payment adjustment will be the difference between the hospital's Medicaid per case reimbursement rate, exclusive of any DSH payment adjustments, and the hospital's calculated per case rate using Medicare principles of reimbursement. The adjustment results in reimbursement of reasonable cost of inpatient hospital services provided to Medicaid patients and will be made on a monthly, quarterly or annual basis in lump-sum amounts.

1010.8

For payments on or after January 1, 2001, State government-owned or operated facilities, non-State government owned or operated facilities and Critical Access eligible hospitals which meet departmental requirements will be eligible for rate payment adjustments, subject to the availability of funds. A facility's status as government owned or operated will be based on its ability to make direct or indirect intergovernmental transfer payments to the State. The rate payment adjustments will be subject to federal upper payment limits and will be based on amounts that would be paid for services under Medicare payment principles. These rate payment adjustments will be made on a monthly, quarterly or annual basis in a manner that will not duplicate compensation provided from payments for individual patient claims.

1010.9

Upper Payment Limit Rate Adjustments

For payments made for services provided on or after July 1, 2005, the following types of hospitals will be eligible for rate payment adjustments:

- State government-owned or operated facilities;
- Non-State government owned or operated facilities;
- Federally defined Critical Access hospitals;
- Hospitals designated by the Georgia Department of Human Resources as Regional Perinatal Centers;
- Hospitals providing the following program services for the Georgia Department of Human Resources: AIDS Clinic, Poison Control Center, Genetics/Sickle Cell Screening and Maternal and Infant Health Services; and
- Hospitals participating in selected residency grant programs administered by the Georgia Board for Physician Workforce.

The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that need sufficient funds for their commitments to meet the healthcare needs of all members of their communities and to ensure that these facilities receive financial support for their participation in programs vital to the state's healthcare infrastructure.

The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State government-owned or operated facilities, non-State government owned or operated facilities and all other facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:

- Amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

Comparisons of amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. If an individual facility cannot be paid a portion of its full rate adjustment payment due to a payment due to a facility-specific charge limit, this rate adjustment amount can be allocated to other facilities that are eligible to receive additional rate adjustment payments without exceeding facility-specific charge limits. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

UPL payments will be made on an interim basis. These payments will be subject to a retrospective settlement at a future date, when HS&R report data can be prepared based on complete, paid claims data and when audited cost reports are available. This is necessary as a result of the care management organizations participating in the Georgia Families program. The interim payments will reflect reductions in UPL payments to hospitals.

A sample of how a rate adjustment payment is calculated is presented as follows:

line	Facility Name	Comments	XYZ Hospital
1	base period report period beginning date		9/1/xxxx
2	base period report period ending date		8/31/xxxx+1
3	HS&R processing date for Medicaid data		9/6/xxxx+2
4	adjustment factor (if period not equal to 1 year)		1.00000
	Medicaid inpatient claims paid at amount > 0:		
6	covered charges	From HS&R report	3,949,268
7	payments	From HS&R report	1,828,506
8	annual covered charges	From HS&R report	3,949,268
9	annual payments	From HS&R report	1,828,506

10	Cost of Medicaid services	worksheets C, Part 1 and D-1, Part II	1,661,931
11	Covered charges for Medicaid services	worksheets C, Part 1 and D-1, Part II	3,725,000
12	inpatient CCR	Line 10 / line 11	0.446156
13	annual cost of services	Line 4 x line 6 x line 12	1,761,990
	adjustment factors		
14	claim completion	For interim calculation only	1.029799
15	inflation	For interim calculation only	1.073852
16	volume allowance	For interim calculation only	1.212883
17	combined adjustment factors	Line 14 x line 15 x line 16	1.341269
18	adjusted annual charges	Line 4 x line 6 x line 17	5,297,031
19	adjusted cost of services	Line 13 x line 17	2,363,303
20	adjusted Medicaid payments	Line 4 x line 9 x line 17	2,452,518
21	supplemental inpatient rate adjustments		0
22	total Medicaid payments	Line 20 + line 21	2,452,518
23	DRG differential		1.176249
24	adjusted Medicare-based annual payments	Line 20 x line 23	2,884,772
25	UPL estimate	Line 24 – line 22	432,254

1011. Settlement

For inpatient payments occurring during each calendar year, a comparison of a hospital's total Medicaid payments and its total charges will be made after completion of the calendar year. A refund will be due from the hospital for any amount by which total Medicaid payments are in excess of a hospital's total charges for Medicaid patients. For enrolled non-Georgia hospitals, the comparison will be made beginning with payments and charges for admissions occurring during calendar year 1990 and after. Total Medicaid payments included in the comparison shall not include payment adjustments made to disproportionate share hospitals, but will include inpatient co-payment amounts that the hospitals should collect from members. There will be no other cash settlements except as noted in Sections 1001.3, and 1006.

Effective December 1, 1999, this provision will not affect critical access eligible hospitals which meet departmental requirements.

1012. Amended Cost Reports

An amended audited cost report will not be recognized by the Department for the purpose of adjusting reimbursable costs (outpatient) unless it is received within three (3) years after completion of the initial audit of the cost report. (For definition purposes, this date is established as the date of initial notification of audit completion to the provider.) The Division's paid claims data (Hospital Statistical and Reimbursement Report) used with the audited cost report will be used with the amended audited cost report to calculate the revised outpatient settlement.

Amended audited cost reports will not be used to adjust DRG rates and components.

1013. Transfer Cases

If a patient is transferred from one hospital for admission to a second hospital for medically appropriate cause and the claims for both hospitals fall into the same DRG, both hospitals will be eligible for payment. If the claims would otherwise be paid under the DRG rate methodology, each hospital's payment will be the lesser of the DRG rate or a rate calculated by the CCR methodology. If a patient is transferred from one hospital for admission to a second hospital for medically appropriate cause and the claims for both hospitals fall into different DRGs, each hospital's payment will be the amount that a non-transfer claim would be paid. All transfers are subject to either precertification or retrospective review.

For transfers back to the originating hospital, the originating facility receiving the back-transfer for lower level of care is eligible to receive reimbursement for both confinements. To ensure accurate claim processing, the originating facility must request an adjustment to the precertification date span and adjust any previously paid claim for the initial hospitalization; and combine and resubmit as a single claim for both date spans. The dates of service spent in the alternate facility are reflected as leave of absence days.

CHAPTER 1100
UTILIZATION CONTROL

1101. General

The Utilization Review Program of the Georgia Division of Medical Assistance is designed to promote both quality and utilization control. The requirements of the program apply to all hospitals that have executed a Statement of Participation, thereby contracting to participate in the Georgia Medicaid Program (Title XIX of the Social Security Act). The requirements further apply to all hospital services provided to individuals who are Georgia Medicaid members.

1101.1 Program Objectives

1101.1A To ensure that Medicaid members receive care in the setting determined by current professional standards to be the most appropriate and cost effective for the treatment of the individual's medical condition;

1101.1B To ensure that Medicaid members receive those services determined to be medically necessary and by current professional standards to appropriately treat the individual's medical condition;

1101.1C To ensure that Medicaid members receive necessary services that meet currently accepted professional quality standards of medical practices;

1101.1D To ensure that Medicaid members are not subject to over utilization or underutilization of medical services;

1101.1E To ensure that providers participating in the Georgia Medicaid program provide appropriate, cost effective quality services; and

1101.1F To ensure that hospitals participating in the Georgia Medicaid program monitor patient care by establishing and administering effective Utilization Review Plans.

1101.2 Activities and Services Encompassed by the Program

The Utilization Review Program of the Georgia Division of Medical Assistance meets the requirements of Part 456 - Utilization Controls of the Code of Federal Regulations as revised October 1, 1986, which are based on Subpart C Utilization Control Hospitals of the Social Security Act 1903(g)(1)(a). 1903(g) (1) (b), 1902(a) (30), 1903(g) (1) (c) and 1903(i) (4).

The program includes, but is not limited to:

- Certification of need for acute care;
- Plan of treatment;
- Review of need for continued stay;
- Discharge planning and coordination;
- Oversight of hospital utilization review committee monitoring activities;
- Data gathering;
- post payment review and assessment; including length of stay and ancillary service review; and
- Referral for educational services.

1101.3 Review Functions for Authorized Hospitals

Hospitals must meet the federal and state requirements for control of utilization of inpatient services including:

- Certification and recertification of the need for acute care;
- Treatment pursuant to a plan of care; and
- Operation of utilization review plans.

1101.3 A) The admitting physician must certify that inpatient services are medically necessary. The certification must be made at the time of admission, or in the case of pending eligibility, before Medicaid payment is authorized. This requirement can be met by a comprehensive note in the medical record at the time of admission.

The attending physician, or authorized representative, must recertify that inpatient services continue to be medically necessary and appropriate to the acute care setting. This requirement can be met by a comprehensive progress note in the medical record at least every two days.

B) Before admission to a hospital for elective admissions, within twenty-four for emergency admissions or, for pending Medicaid-eligible' s, a written plan for each member must be completed prior to authorization for payment. The must include:

A) Diagnoses, symptoms/complaints indicating the need for admission;

B) A description of the functional level of the individual.

C) Medication or treatment orders.

D) Diet and activity level.

E) Plans for hospital course; and

F) Plans for discharge. This plan of care should be a multi-discipline plan of care but at a minimum must include the attending physician and the nursing staff.

1101.3C A current, signed Utilization Review Plan must be submitted every two years. This plan must be approved by the hospital's current governing body (including the UR Committee Chairman and the Hospital Administrator) and must contain the requirements set forth in the Code of Federal Regulations 456, Subpart C, and Utilization Control: Hospitals and Subpart H, Hospital Review Plans.

1101.3D The hospital must follow the protocols set forth in the plan submitted to and approved by the Division of Medical Assistance when performing a review of Medicaid (Title XIX) members.

1101.3E Determinations regarding medical necessity for treatment rendered in an acute care setting are to be made by the Utilization Committees and DMA'S contracted peer review agent. The Division reserves the right to retrospectively review the appropriateness of all committee determinations.

1101.4 Submission of the Utilization Review Plan

Rev. 07/11

The Utilization Review Plan and the name, title and telephone extension of the individual who is to serve as the contact for the hospital should be submitted to:

Rev. 01/12

- Attaching your electronic (scanned) UM Plan utilizing the Case Number provided via www.mmis.georgia.gov ; PA/Provider Workspace

1101.5 Program Functions

The Utilization Review Program has four principal functions: admission and continued stay review, data gathering, retrospective assessment and discharge coordination.

1101.5A Admission and Continued Stay Review

Rev. 12/14

Based on professionally generated criteria, the admissions to and services provided in an acute care setting will be reviewed by the Division or authorized contract staff as well as the UR Committee of the Medicaid participating hospital. The maximum number of days that will be approved between the continued stay reviews must be included in the Utilization Review Plan. All participating hospital reviews must conform with substantial compliance to procedures outlined in the hospital's utilization review plan. At a minimum, an entry must be made in the utilization review notes on the review date, indicate the name and title of the reviewer and be signed by the reviewer on the review

date. This entry must also indicate if he inpatient review criteria was Met or Not Met for medical necessity of the hospital stay. Failure to document the review criteria (Met/ Not Met) in the utilization review notes may result in the denial for reimbursement of your claim. The UR notes will be reviewed for adherence to the UR Plan.

In the event that electronic entries are made in the utilization review notes, the entry must indicate a unique identifier with the name and title of the reviewer on file as well as the date the entry was made (on the review date) or utilizes an affidavit approved by Medicaid if special conditions are involved.

1101.5B Data Gathering

Information related to hospital practices, professional performance and patient outcomes will be collected through the billing process and utilization review reporting mechanism and integrated through the Division's computerized profile system.

1101.5C Retrospective Assessment

Focused studies will be performed on defined problem areas. These areas will be identified through the on-going analyses of reports generated through the utilization review reporting system.

1101.5D Discharge Coordination

Through coordination with the Division, the hospital will work to identify alternative services and to maintain continuity of care when transferring members from an acute care setting to a nursing care facility or home care setting.

1101.6 Notice of Adverse Decisions (Termination of Benefits -TOB)

Rev. 07/11

Each hospital is required to notify the Division of all adverse decisions made by its Utilization Review Committee regarding a member's need for admission or continued stay. Members must receive WRITTEN notification of these decisions within two working days after the date of the adverse decision. The termination letter used by the hospital to inform the members of adverse decisions should contain the information in the draft shown at the end of this chapter. Copies of all adverse determinations are to be sent to:

Alliant Health Solutions
Medical Review
P.O. Box 105330
Atlanta, GA 30348
Fax # 678-527-3066

1101.7 Admissions Requiring Review

Federal regulations require that all Medicaid admissions be screened through the Utilization Review program. The Division permits focused review, provided the approach for this review is defined in the Utilization Review plan and the "focused out" categories are periodically monitored to assure continued compliance with utilization and quality standards.

A) Review of Pending Eligibility

Utilization review is required when it is known that a patient's Medicaid eligibility is pending. The hospital will be deemed to have knowledge of pending eligibility if the patient can be included in an eligibility group identified in Chapter 100 of this manual.

B) Retrospective Reviews

Retrospective reviews by the hospital are only allowed on those members who are admitted and discharged prior to the routine admission review (such as weekends, holidays). All medical claims are subject to retrospective review by the Division.

1102. Utilization Review Coverage Issues

A) Compliance with Policies

The hospital Utilization Review Committee is not authorized to approve admissions, services, or continued stays, which are not in compliance with policies contained in the Hospital Manual.

B) Continued Stay

Continued stay in an acute care hospital is covered only when the acute care setting is appropriate to the specific medical needs of the member with the exception of the grace period and administrative days.

C) Grace Period

The grace period is the length of time a member remains in the hospital after the issuance of a denial letter. Each hospital will be reimbursed for a grace period of one day for medically necessary inpatient admissions.

D) Administrative Days

Administrative days are those days a member remains in the acute care setting awaiting placement in a nursing facility due to the unavailability of a bed. Administrative days may occur in one of two situations:

- Following the physician's written order for discharge on the chart;
- When a denial letter is given prior to the physician's written order for discharge.

The allowed reimbursable number of administrative days is three days or 72 hours for either of the above-defined situations. Additional Days a member remains in the Acute Care setting awaiting placement in a Nursing Facility are not Reimbursable.

Leaves of Absence:

Leaves of absence are non-covered services in the Georgia Medicaid program. Our claims processing system will accommodate leaves of absence if these services are shown on the UB-04 with the non-covered revenue code listed below:

180 General classification

Rev. 11/10

Providers are not to go through the actual administrative process of discharging a member when he begins a leave of absence nor are they to complete new admission forms when he returns. The number of leave days and appropriate services should be recorded on the provider's Medicaid Log and shown on the UB-04 as non-covered services using the non-covered revenue code cited above. The date of service field on the UB-04 is to include the period from the date of admission through the date of discharge. The leave of absence days and services, if any, must be itemized in the body of the claim form with a non-covered revenue code and the date of each day of the leave of absence.

E) Present on Admission (POA) Indicators, Hospital Acquired Conditions (HAC) and Never Events

The **POA** indicator identifies conditions present at the time the order for an inpatient admission occurs, including conditions that develop during an outpatient encounter such as an emergency department visit, observation, or outpatient surgery. A POA indicator is assigned to each principal and secondary diagnosis code according to the ICD-10-CM Official Guidelines for Coding and Reporting. There are five (5) different POA Indicators: Y, N, U, W, and 1.

HAC's diagnoses determined by Medicare to be reasonably preventable. The conditions targeted by the Centers for Medicare and Medicaid Services (CMS) are high in cost, high in volume, or both. Medicare selected specific reasonably

preventable conditions that have the potential to increase reimbursement under MS-DRGs.

Effective November 1, 2010, and in accordance with Section 5001(c) of Deficit Reduction Act of 2005, the Department will no longer provide reimbursement to hospitals for POA/HAC events, identified as non-payable by Medicare on FFS Medicaid and crossover claims. Effective October 1, 2015, CMS released under ICD-10 implementation an additional 30,000 new diagnosis codes as HACs. Participating hospitals are required to begin submitting their UB-04 claims with the proper POA indicator on **all** diagnosis. Inpatient claims that are submitted for payment that do not contain the proper reporting of the POA indicator will be denied. The HAC diagnoses will be disallowed, and the claim will be reassigned to a lower DRG for reimbursement.

Effective with the implementation of 5010, Inpatient Prospective Payment System (IPPS) hospitals shall no longer report the POA indicator of "1". ICD-10-CM diagnosis codes that are exempt from the POA reporting requirement shall be left blank instead of populating a "1".

A list of the 28 Never Events is available in Appendix T. DCH's mechanism to review Never Events will be a retrospective review process.

Effective July 1, 2012, the Centers for Medicare and Medicaid Services (CMS) directs states to implement its final rule outlined in 42 CFR 447.26 regarding PROVIDER PREVENTABLE CONDITIONS (PPCs) and HOSPITAL ACQUIRED CONDITIONS (HACs). These two components listed in the final CMS rule applies to ALL hospital settings and other non-inpatient health care settings. GA Medicaid will not reimburse inpatient facilities (if applicable) nor any enrolled Medicaid providers with any HACs and/or PPCs identified through the claims adjudication and/or medical records review process in accordance to the CMS' directive.

Participating hospitals are required to begin submitting their UB-04 claims with the proper POA indicator on all diagnosis. Inpatient claims that are submitted for payment that do not contain the proper reporting of the POA indicator will be denied. Claims submitted with HAC diagnoses and without supporting medical records attachments—the HAC diagnoses will be disallowed, and the claim may be reassigned to a lower DRG for reimbursement.

The Present on Admission (POA) Indicator requirement and Hospital-Acquired Conditions (HAC) payment provision only apply to Inpatient Prospective Payment

Systems (IPPS) Hospitals. At this time, the following hospitals are EXEMPT from the POA Indicator and HAC per CMS:

1. Critical Access Hospitals (CAHs)
2. Long-term Care Hospitals (LTCHs
3. Maryland Waiver Hospitals
4. Cancer Hospitals
5. Children's Inpatient Facilities
6. Rural Health Clinics
7. Federally Qualified Health Centers
8. Religious Non-Medical Health Care Institutions
9. Inpatient Psychiatric Hospitals
10. Inpatient Rehabilitation Facilities
11. Veterans Administration/Depart of Defense Hospitals

1. **General Reporting Requirements for POA**

- POA indicator reporting is mandatory for all claims involving inpatient admissions to general acute care hospitals or other facilities.
- POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered POA.
- A POA Indicator (listed below) must be assigned to each principal and secondary diagnosis.
- Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.
- If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, then the POA Indicator would not be reported.

Rev. 11/10

2. **POA Indicators and Definitions and Claim Dispositions**

Code	Reason for Code	Claim Disposition
Y	Diagnosis was present at time of inpatient admission.	Process & Pay
N	Diagnosis was not present at time of inpatient admission.	(Pend for clinical review) Pay at lower DRG
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission.	(Pend for clinical review) Pay at lower DRG
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	(Pend for clinical review) Pay at lower DRG

1 Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the version 4010A1. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list. Effective with the implementation of 5010, Inpatient Prospective Payment System (IPPS) hospitals shall no longer report the POA indicator of 1.ICD-10-CM diagnosis codes that are exempt from reporting POA shall be left blank instead of populating a 1.	Deny **DO NOT USE**

NOTE: For UB-04 claims submitted with multiple HACs and multiple POAs, the HAC diagnosis codes will be excluded and paid at the lower DRG.

3. **Hospital Acquired Condition Codes:**

Hospital-Acquired Conditions	
Selected HAC	**CC/MCC (ICD-10-CM Codes)**
Foreign Object Retained After Surgery	998.4 (CC) ICD-10 – T81.500A to T81.599A 998.7 (CC) ICD-10 – T81.60XA to T81.69XA
Air Embolism	999.1 (MCC) ICD-10 – T80.0XXA
Blood Incompatibility	999.60 (CC) ICD-10 – T80.30XA 999.61 T80.319A 999.62 T80.310A 999.63 T80.311A 999.69 T80.39XA
Pressure Ulcer Stages III & IV	707.23 (MCC) ICD-10 - L89.003 to L89.93 707.24 (MCC) L89.004 to L89.94
Falls and Trauma: - Fracture - Dislocation - Intracranial Injury - Crushing Injury - Burn - Electric Shock	Codes within these ranges on the CC/MCC list: ICD-10: 800-829 S02.0XXA to T07 830-839 S03.0XXA to S91.109A 850-854 S06.0X0A to S01.90XA 925-929 S07.0XXA to S77.20XA 940-949 T26.50XA to T32.99 991-994 T33.011A to T70.9XXA
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC) ICD-10 – T83.51XA Also excludes the following from acting as a CC/MCC:

Hospital-Acquired Conditions	
Selected HAC	**CC/MCC (ICD-10-CM Codes)**

	112.2 (CC) ICD-10: B37.41 to B37.49 590.10 (CC) N10 590.11 (MCC) N10 590.2 (MCC) N15.1 590.3 (CC) N28.84 to N28.86 590.80 (CC) N11.9 to N13.6 590.81 (CC) N16 595.0 (CC) N30.00 and N30.01 597.0 (CC) N34.0 599.0 (CC) N39.0
Vascular Catheter-Associated Infection	999.31 (CC) ICD-10:T80.218A to T80.219A 999.32(CC) T80.211A 999.33(CC) T80.212A
Manifestations of Poor Glycemic Control:	250.10-250.13 (MCC) E10.10 to E13.10 250.20-250.23 (MCC) E10.65 to E13.01 251.0 (CC) E15 249.10-249.11 (MCC) E08.10 to E13.10 249.20-249.21 (MCC) E08.00 to E13.01
Surgical Site Infection, Mediastinitis, following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) ICD-10: J98.5
Surgical Site Infection Following Certain Orthopedic Procedures Spine Neck Shoulder Elbow	996.67 (CC) ICD-10:T84.60XA to T84.7XXA 998.59 (CC) K68.11 and T81.4XXA See CMS.Gov for HAC's listing of procedures
Surgical Site Infection Following: Bariatric Surgery Laparoscopic Gastric Bypass Gastroenterostomy Laparoscopic Gastric Restrictive Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)	*Principal Diagnosis* – 278.01- E66.01 998.59 (CC) K68.11 and T81.4XXA See CMS.Gov for HAC's listing of procedures 996.61 (CC) T82.6XXA,T82.7XXA 998.59 (CC) K68.11,T82.4XXA See CMS.Gov for HAC's listing of procedures
Deep Vein Thrombosis and Pulmonary Embolism: Following Certain Orthopedic Surgeries	ICD-10: 415.11 (MCC) T80.0XXA to T82.818A I26.90, I26.99 415.19 (MCC) I26.09, I26.99 453.40-453.42 (MCC) I82.401 to I82.4Z9 See CMS.Gov for HAC's listing of procedures
Selected HAC	**CC/MCC (ICD-10-CM Codes)**

Iatrogenic Pneumothorax with Venous Catheterization	512.1 (CC) ICD-10 - J95.811 See CMS.Gov for HAC's listing of procedures

Reference: CMS Hospital Acquired Conditions (HAC) - FY2015

1103. Administrative Review Process for Medicaid Members

A Medicaid member or authorized representative may request that the Division review the procedures, decision making and hospital appeals procedures of the discharging hospital. The Division's review will be limited to assuring that the facility acted in compliance with all procedural requirements. A written request for review must be received at the following address within thirty (30) days of the date of the denial letter.

Division of Medicaid
Director of Medical Policy and Provider Reviews Unit
37th Floor
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

1104. Lock-In Members

The Division may restrict the number of providers from whom a member may receive services. This restriction is known as a "lock-in."

The "lock-in" program is limited to those members who have demonstrated a pattern of utilization abuse and who have failed to correct this pattern after notification and counseling.

If a member is found to have utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the division, the member will be locked-in to a single physician and pharmacy provider for an initial period not to exceed twelve (12) months. At the conclusion of the lock-in period, member usage will be reevaluated to determine whether or not restriction should continue. The member will be given notice of a hearing prior to the lock-in. The Division will select the single physician or pharmacy to provide services to the locked-in member. The provider chosen will be geographically situated to give reasonable access to the member.

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

The selected physician and pharmacy will be contacted by the Division and that physician and pharmacy may decline participation if so desired. Claims submitted for a lock-in member by providers other than those selected will be denied.

Hospitals should be alert to possible abuse of the emergency room and emergency room services by the member whose use of the Medicaid program has been restricted. When such a member seeks services from a hospital that appear questionable and obviously non-emergent in nature, the hospital should contact the physician indicated on the bottom of the Medicaid card. This physician is to be considered the members attending physician, and should be consulted prior to rendering services of a non-emergency nature. This may prevent the hospital from incurring costs for non-reimbursable expenditures.

Further, hospitals are asked to identify and report emergency room abuse by Medicaid members who are not currently monitored by the "lock-in" program.

DRAFT TERMINATION LETTER FOR
GEORGIA DIVISION OF MEDICAL ASSISTANCE

(DATE)

Dear _____:

The Georgia Medicaid program provides payment for necessary hospital, physician and other health-care services. Like most insurance programs, the Medicaid program will not provide payment when services are not services covered under the Medicaid program or are determined to be medically unnecessary.

The Utilization Review Committee of this hospital, acting for the Georgia Division of Medical Assistance, has reviewed your medical record and has discussed your need for hospital care with your physician. Based on information that has been presented regarding your current medical needs, the Committee has determined that hospital care is no longer medically indicated to treat your present condition.

The Committee, in reaching this decision, does not imply that you may not continue to require medical services, nor should this be considered in any way a criticism of the care ordered by your physician. This decision is meant only to inform you that any further services that you wish to be covered by the Medicaid program should be provided in a non-acute hospital setting. Services provided to you as an acute hospital patient will not be paid for by the Medicaid program after Date .

Your physician has been notified of the Committee's decision and will discuss with you plans for your continued treatment. The hospital will also be happy to assist you in making any necessary arrangements.

As a Medicaid member, you may request a review of the Committee's decision. You may ask your doctor to request a review while you are in the hospital or you may, within 30 days of your discharge from the hospital, request a review from:

Georgia Division of Medicaid
Medical Policy Unit, 37th Floor
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

The review by the Division of Medical Assistance Plans will be limited to assuring that the Committee followed proper procedures in reaching a medical conclusion regarding the level of care required for your condition.

(UR Coordinator) at (Phone Ext.), a member of the Utilization Review Committee's review staff, may be contacted if you have any further questions or concerns.

Sincerely,

Hospital Administrator
Or/Committee Chairman

cc: Attending Physician
Division of Medical Assistance

This is to acknowledge that this notice of non-coverage has been received.

Signed: _____

Date: _____

CHAPTER **1200**

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CHAPTER 1300
PATIENT SAFETY PROGRAM

1301. General

The Division of Medical Assistance is committed to improving safety and reducing medical errors for patients within the hospital. Effective October 1, 2001, each hospital must implement a patient safety program that meets the following requirements:

1302. Program Requirements

Hospital shall implement a patient safety program that will meet the following minimum criteria:

1302.2 Peer review protected infrastructure to promote reporting and sharing of information on patient safety and medical errors;

1302.3 Uniform reporting standards and definitions for adverse patient events;

1302.4 Safety alerts for quick communication of strategies to prevent errors identified as the most frequently occurring types of sentinel events and other patient safety risk factors;

1302.5 Dissemination of evidence-based best practices for reducing medical errors, improving patient safety and enhancing quality of care;

1302.6 Provider education to promote adoption of patient safety practices into their clinical practice guidelines and standards;

1302.7 Participating agreements, which require the implementation of internal programs for corrective actions and continuous improvement. The participating hospital shall:

A) Develop and implement an ongoing, proactive program for defining, identifying and managing risks to patient safety and medical errors throughout the organization with defined executive responsibility for the program;

B) Measure the effectiveness of process and system improvements;

C) Establish data reporting systems for the collection of data on defined processes that affect patient safety; and

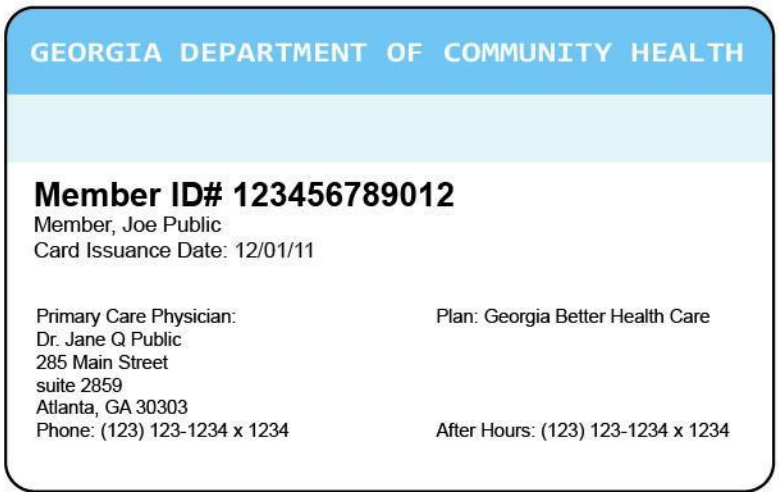
D) Implement pertinent best practice for reducing medical errors and enhancing positive care outcomes.

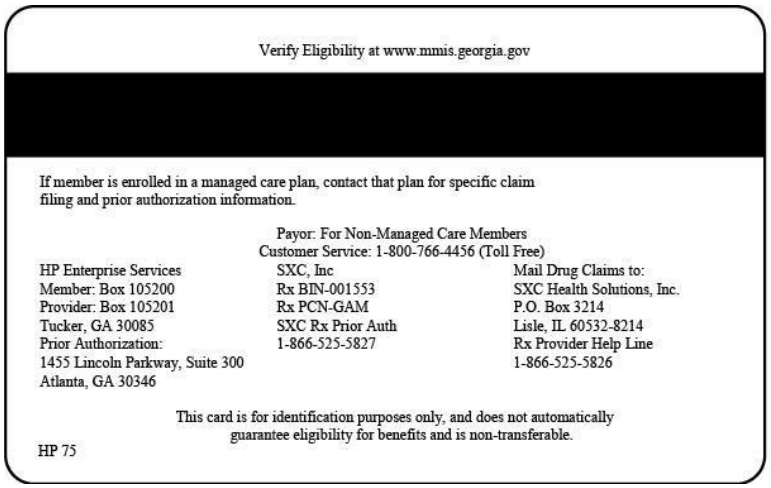
1303. Program Compliance

Hospital providers shall demonstrate compliance with Section 1302. In the event the hospital does not demonstrate compliance, the Division may require the hospital to submit a plan of action. If the plan of action is approved, the Division will permit the hospital to become compliant with policy within a prescribed time period.

APPENDIX A
MEDICAL ASSISTANCE ELIGIBILITY CERTIFICATION

MEDICAID & PEACHCARE FOR KIDS MEMBER IDENTIFICATION CARD SAMPLE





APPENDIX B

STATEMENT OF PARTICIPATION

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

Written request for copies should be forwarded to:

Gainwell Technology
Provider Enrollment Unit
P. O. Box 105200
Tucker, GA 30085-5201

OR

Phone your request to:

800-766-4456

APPENDIX C

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APPENDIX D

OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER PROCEDURES REQUIRING PRIOR APPROVAL

Please refer to the Part II Policies and Procedures for Physician Services Appendix E, O and L (Radiology Codes) for a list of procedure codes that must be pre-certified and/or prior approved before services are rendered in the Outpatient Hospital or Ambulatory Surgical Center setting.

Note that Prior Approval for some procedures, including but not limited to Tonsillectomies and/or Adenoidectomies, Hysterectomies, and Cataract procedures, can be completed by telephone, written submission, or web portal submission. Other procedures are limited to submission in writing or via web portal. For further information, contact the Georgia Health Partnership at (404) 298-1228 (Metro Atlanta) or (800) 766-4456 (Toll free).

APPENDIX E
STATE LABORATORY SERVICES

Services available through the State Laboratories are not reimbursable through the Hospital program. The following policies and procedures on Public Health Laboratory services must be followed:

Newborn Screens

The following follow up tests are allowed on infants less than **three (3) months** of age when the initial screenings are positive. These claims must be billed with diagnosis code ICD 9 CM 796.6 (ICD 10 CM P09). However, the neonatal metabolic screens are required by the State on all infants between 24 hours after birth or by the seventh day of life. The initial screening specimen shall continue to be sent on filter paper (DHR Form 3491) to the Public Health Laboratory, Central Facility in **Atlanta** only.

Procedure Codes

82016	82017	82127	82131	82261	
82776	83020	83498	83788	83789	
84030	84436	84437	84442	84443	84150

Specimens for the above battery of tests may be on a full blood sample (not filter paper) and must be performed by any CLIA certified participating laboratory.

Hemoglobin Testing

The **Division will not make payment** for the following test for sickle cell detection, confirmation or follow-up for infants and family members of infants suspected of sickle cell anemia or trait. Diagnosis codes include ICD 9 CM 282.6 – 282.69 (ICD 10 CM D57.1 through D57.812).

83020 include SS, SC, SE, S Beta Thalassemia, SO, and SD.

All blood specimens with a sickle cell indicator must be forwarded in an appropriate sickle cell outfit to the Albany or Waycross laboratories.

The Division will provide reimbursement for hemoglobin tests for possible diagnosis other than sickle cell.

Gonorrhea and Syphilis Testing

The Department will not provide reimbursement for diagnosis codes ICD 9 CM 098 - 099.9 (ICD 10 CM A54.00 – A64) with the following procedure codes:

Procedure codes

86592 86593 87070 87081 87205

For diagnosis codes ICD 9 CM 090-097.9 (ICD 10 CM A50.09 – A53.9), the **Division will not** reimburse for:

86592 86593

All blood/serum specimens for gonorrhea and syphilis must be routed in outfits provided by the State laboratory. Specimens for VDRL's and RPR's may be routed to any of the three State laboratories. Specimens for VDRL's and FTA's must be routed to the laboratory in Atlanta only.

Under no conditions will the Division reimburse for gonorrhea or syphilis testing.

Patients requiring dark field exams must be referred to their local Health Department.

Tuberculosis Testing

The following procedures are for tuberculosis (diagnosis codes ICD 9 CM 010.00 - 018.96 (ICD 10 CM A15.7 – A19.9) testing:

87116 87118

All sputum with a tuberculosis indicator must be forwarded in the sputum outfit provided by the State to the State laboratory in **Atlanta** only. **Under no condition will the Division reimburse for tuberculosis testing.**

Salmonella and Shigella Testing

Diagnoses included are ICD 9 CM 003.0 to 004.9 (ICD 10 CM A02.0 – A03.9).

The procedures are: 87045, 87081, and 87084.

Stool culture (87045) is often used for the detection of salmonella and/or shigella. Therefore, all stool cultures with a salmonella or shigella indicator must be forwarded in a stool culture outfit (provided by the State) to the State laboratory in Atlanta. Under no condition will the **Division reimburse** for salmonella or shigella testing.

Rev 10/14

HIV/AIDS Test Procedures:

All blood specimen and test requests are no longer restricted to the state laboratory.

The State Laboratory Locations and Telephone Numbers are listed below:

1. Decatur Central Public Health Laboratory
   Georgia Department of Public Health
   Laboratory Services & Supply
   1749 Clairmont Road
   Decatur, Georgia 30033-4050
   Phone # (404) 327-7920
   Fax # (404) 327-7922

2. Waycross Public Health Laboratory
   Georgia Department of Public Health
   Laboratory Services & Supply
   1751 Gus Karle Parkway
   Waycross, Georgia 31503
   Phone # (912) 388-7050
   Fax # (912) 338-70611.

Specimen outfits for testing to be done in the Regional Laboratories are available from the preceding addresses; however, the outfits for the tests in the Atlanta Central Laboratory must be obtained from:

Laboratory Services and Supply
1749 Clairmont Road
Decatur, Georgia 30033-4050
Phone # (404) 327-7920

Fax # (404) 327-7922

APPENDIX F

Non-Emergency Transportation

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

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

What if I have problems with a NET broker?

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

Region	Broker / Phone number	Counties served
North	Southeastern Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	Southeastern 404-209-4000	Fulton, DeKalb and Gwinnett
Central	LogistiCare Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	LogistiCare Toll free 1-888-224-7988	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro,

		Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	LogistiCare Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

APPENDIX G
NEWBORN CERTIFICATION
SUMMARY OF NEWBORN ELIGIBILITY

The Department implemented a new process to expedite the enrollment of Medicaid eligible newborns. This process enables authorized providers to immediately obtain a Medicaid identification number for a newborn infant, born to a mother eligible for Georgia Medicaid benefits.

Any Physician, Nurse Midwife, Nurse Practitioner, Health Check Provider, Pharmacy, Hospital, Health Department, Durable Medical Equipment Provider, or Birthing Center enrolled as a Georgia Medicaid Provider can obtain a Medicaid identification number for these newborn infants. Enrolled providers can access Gainwell Technology on-line to obtain a Medicaid identification number. Additionally, the manual process, requiring completion of the Newborn Medicaid Certification form, DMA-550, remains in place for enrolled providers who are unable to execute the on-line process. Procedures for both the on-line and manual processes for obtaining a Medicaid identification number for a newborn are specified in this section.

Manual Procedures for Obtaining Newborn Identification

The manual process requires completion of the form **DMA-550, Newborn Medicaid Certification**. Upon completion of the form and obtaining the parent's/relative's signature, adhere to the following:

1. Contact Gainwell Technology at 1-800-766-4456 to obtain a Medicaid identification number. Enter that number on the form.

2. The blue or Certifying Provider copy is retained in the certifying provider's records.

3. Give the parent the pink (Client) and yellow (Pharmacy) copies of the form. These are temporary Medicaid certificates. They serve as proof of Medicaid eligibility and they should be presented to the infant's medical care and pharmacy providers.

4. In order to confirm issuance of the number and Medicaid eligibility, mail the white copy of the form to:

   Gainwell Technology
   P.O. Box 105200
   Tucker, Georgia 30085-5200

NOTE:
The month after the number is issued; the infant will receive the plastic Medicaid member identification card.

On-line Procedures for Obtaining Newborn Identification Numbers

The on-line process eliminates completion of the form DMA-550, Newborn Medicaid Certification. Required information is entered directly into the Georgia Health Partnership. After accessing and entering the data, adhere to the following:

1. If all data are entered correctly, the system will issue a Medicaid identification number and allow production of a temporary Medicaid Certificate. Print out two copies of the certificate.

2. Give the parent one copy of the temporary certificate. It serves as proof of Medicaid eligibility and it should be presented to the newborn's providers.

3. Retain the other copy of the certificate in the record (certifying providers).

NOTE:
The month following issuance of the temporary Medicaid certificate, the infant will receive the plastic Medicaid member identification card.

CAUTION: Providers are encouraged to exercise care when executing the on-line process. Errors on a Presumptive Eligibility record will cause denials or delays in the payment of claims.

After the system accepts the information and issues a member identification number, errors on a record, such as an incorrect date of birth, the wrong gender, or an improper spelling of a name cannot be corrected through the system. This must be corrected by contacting the PROVIDER UNIT AT 1-800-766-4456. When contacting the Provider Unit, describe the erroneous information and state the correct information on the Presumptive Eligibility Pregnancy Medicaid Corrections Report.
COMPLETION OF THE NEWBORN MEDICAID CERTIFICATION

This section includes instructions for completing the Newborn Medicaid Certification (DMA-550). This form should only be used for infants who have not yet received their Georgia Medicaid member ID card. After this form has been completed, contact the Newborn Enrollment unit at 1-800-766-4456 to receive the infant's member ID number. This number should be entered in the upper right-hand corner of the DMA-550.

Sample of DMA-550: Newborn Medicaid Certification form next page:

DMA-550 REV (07/10)

NEWBORN MEDICAID CERTIFICATION
(TEMPORARY)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Division of Public Health

Please mail completed form to

GHP
P.O. Box 105209
Tucker, GA. 30085-5209

NEWBORN MEDICAID ID NUMBER
Certifying provider must contact GHP to obtain a newborn I.D.

NEWBORN'S NAME *First* *MI* *Last* *Suffix*

DATE OF BIRTH **SEX** Male ☐ Female ☐

Mother's Medicaid ID No. *Mother's Social Security No.* YES ☐ NO ☐ *Is the mother a U.S. Citizen?*

MOTHERS NAME *First Name* *MI* *Last*

MAILING ADDRESS *Number and street* *City*

State *Zip* *County* *Telephone Number*

Date of Request *Parent/Relative Signature*

COMPLETED BY *Please Print*

TITLE *Please Print*

PROVIDER NAME *Please Print*

TELEPHONE

PROVIDER SIGNATURE

By signing, I certify to the best of my knowledge that the information above is verified and accurate

DATE COMPLETED

PROVIDER NO.

Please contact GHP to verify the mother's Medicaid eligibility for the month of the newborn's birth, and to obtain the newborn's Medicaid I.D. number.

DMA-550 REV. (07/10)

Item 1: **Newborn Medicaid I.D. No.**
Certifying provider must contact the Newborn Enrollment unit to obtain the newborn I.D. number.

Item 2: **From (DOB)**
Enter the newborn's date of birth in MM/DD/YY format.

Item 2a: **Thru**
The Newborn Enrollment unit will provide this date.

Item 3: **Newborn's Name**
Enter the complete name. The first name should be entered first, followed by the middle initial, last name and suffix.

Item 4a: **Date of Birth**
Enter the newborn's date of birth in MM/DD/YY format.

Item 4b: **Sex**
Check the appropriate box for the sex of the newborn.

Item 5a: **Mother's Name**
Enter the mother's complete name. The first name should be first, followed by the middle initial and last name.

Item 5b: **Mother's Medicaid I.D. No.**
Enter the mother's Medicaid identification number exactly as it appears on the mother's Medicaid member identification card.

Item 5c: **Mother's Social Security Number**
if available, enter the mother's Social Security number.

Item 5d: **U.S. Citizen**
Check the appropriate box indicating the citizenship status of the mother.

Item 6: **Mailing Address**
Enter the mailing address of the newborn. Also enter the name of the county of residence and telephone number of the mother including the area code.

Item 7: **Date of Request**
Enter today's date.

Item 8: **Parent/Relative Signature**
The parent or guardian must sign the certification. An unsigned certification will not be accepted for processing.

Item 9: **Completed by (Please Print)**
Enter the name of the person completing this certification.

Item 10: **Title**
Enter the title of the person who is completing the certification.

Item 11: **Provider Name**
Enter the provider's name.

Item 12: **Telephone No.**
Enter the provider's telephone number including the area code.

Item 13: **Provider Signature**
The provider must sign or signature-stamp each certification. Unsigned certifications will not be accepted for processing.

Item 14: **Date Completed**
Enter the date the provider signed the certification.

Item 15: **Provider Number**
Enter the provider's Medicaid number.

APPENDIX H

HYSTERECTOMY INFORMATION

The Division will make reimbursement only for those hysterectomy procedures, which meet the criteria established in Subsection 911.3 of this Manual.

A copy of the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" (DMA-276) is shown on Page I-2 of this Appendix. This form must be signed, either before or after the hysterectomy, as follows and must be attached to the claim form submitted to the Division for payment:

- **Section I - Member's Statement**

  The member or her representative must sign and date this form in the spaces provided unless the member was sterile prior to the hysterectomy or the hysterectomy was an emergency.

- **Section II - Physician's Statement**

  The physician must sign and date this form on all hysterectomies performed. If the member was sterile prior to the hysterectomy, the physician must indicate this condition beside #1 and state the reason for prior sterility. If the hysterectomy was an emergency, the physician must indicate this condition beside #2 and attach the discharge summary and operative record.

NOTE: Medicaid funds are unavailable for sterilization, hysterectomies, or abortions performed without the documentation required by federal regulations (See 42 CFR 441.206 and 441.256). As such, claims for payment submitted without the required documentation or with incomplete or inaccurate documentation will be denied. The Division does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

GEORGIA DIVISION OF MEDICAL ASSISTANCE

Medicaid Program

This is a Federally mandated form that must accompany all claims for hysterectomy.

MEMBER INFORMATION

MEMBER NAME: LAST | FIRST | INITIAL | SUFFIX

MEMBER MEDICAID CASE NO.

PATIENT'S ACKNOWLEDGEMENT OF PRIOR RECEIPT OF HYSTERECTOMY INFORMATION

Section I — Member's Statement

I have been told and I understand that this hysterectomy (operation to remove my womb/uterus) will cause/has caused me to be permanently sterile (unable to bear children).

Signature of Medicaid Member _____ Date _____

OR

Signature of Member's Representative _____ Date _____

STATEMENT OF MEDICAL NECESSITY

Section II — Physician's Statement

The above mentioned hysterectomy will be/has been performed for medical necessity, not for sterilization, hygiene purposes or mental retardation.

Check one of the below **if applicable** — (Member's signature not required if number 1 or 2 is applicable.)

1 Member was sterile prior to hysterectomy. The member was sterile because _____

2 Emergency Hysterectomy: (Attach a copy of the discharge summary and operative record to validate the emergency hysterectomy.)

Physician's Name (Please print) _____

Physician's Signature _____ Date _____

DMA-276 (3/03) 746-276 (ATT 05)

APPENDIX I

CERTIFICATE FOR NECESSITY FOR ABORTION (DMA-311)

The Certification of Necessity for Abortion form is required when filing a claim for an abortion procedure and may be submitted online or as a hard copy.

CERTIFICATE OF NECESSITY FOR ABORTION (DMA-311)

This is a federal mandated form that must be completed and attached to all invoices containing claim lines submitted for reimbursement for abortion procedures and abortion-related procedures.

The Department will reimburse *only* for abortions which meet the criteria established in Part II, Chapter 900 of the *Policies and Procedures for Physician Services* Manual.

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

CERTIFICATION OF NECESSITY FOR ABORTION

THE INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL UNDER FEDERAL LAW AND REGULATIONS AND CANNOT BE DISCLOSED WITHOUT THE INFORMED CONSENT OF THE MEMBER.

MEMBER INFORMATION

NAME: _____

MEDICAID #: _____

ADDRESS: _____

STATEMENT OF MEDICAL NECESSITY

This is to certify that I am a duly licensed physician and that in my professional judgment, an abortion is medically necessary for the reason indicated below:

☐ This patient suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place this woman in danger of death unless an abortion is performed.

☐ Fetal Demise

☐ The pregnancy is the result of rape.

☐ The pregnancy is the result of incest.

NOTE: Please attach all supporting medical documentation.

_____, MD
(Print Name)

_____, MD
(Signature of Physician)

DMA-311 (Rev. 07/15)

APPENDIX J
STERILIZATIONS

The Division will make reimbursement only for those sterilization procedures, which meet the criteria established in Section 911.2 of this manual. A copy of the "Informed Consent for Voluntary Sterilization" (Form DMA-69) is attached as Pages K-3 and K-4 of this Appendix. The member and the attending physician must properly complete this form on both sides.

Some important points in obtaining and submitting a properly executed Form DMA-69 are listed below.

A. Under the physician's statement:

1. The applicable paragraph, (a) or (b) must be designated. (a) States "At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed".

(a) States "At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed".

(b)States "This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on the consent form because of the following circumstances."

If (b) is designated, the applicable box must be checked and the information requested must be filled in.

If the box indicating "Premature delivery" is checked, the individual's date of expected delivery must be given on the line provided.

If the box indicating "Emergency abdominal surgery" is checked, the circumstances of the emergency surgery must be described on the line provided.

2. The physician **must** sign and date the consent form after the surgery is performed.

3. The physician **must** sign and date the consent form. Signature stamps are not acceptable.

A. All lines on the consent form must be completed, with the exception of the interpreter's statement. The interpreter's statement does not need to be completed unless a language other than English was used to explain the sterilization procedure to the member.

B. The method used by the Division to calculate the 30-day wait is: Begin count with the first day **after** the day the member signs the consent form and count forward 30 days. The sterilization may be performed as early as the 30th day.

C. The only consent form acceptable to the Division is: "Informed Consent for Voluntary Sterilization" (DMA-69). No other form can be used.

D. The sterilization informed consent form may not be used for hysterectomy procedures. Medically necessary hysterectomy procedures require the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" form (DMA-276).

E. Using a generic description and not a specific physician's name is acceptable on line seven (7) of the sterilization consent form when it is not known in advance which specific physician will perform the procedure. The member must be informed that the procedure will be performed by the physician on-call or on duty at the time. The name of the provider (hospital, physicians group, surgical center, or whomever) should also be entered on line seven (7) of the sterilization consent form.

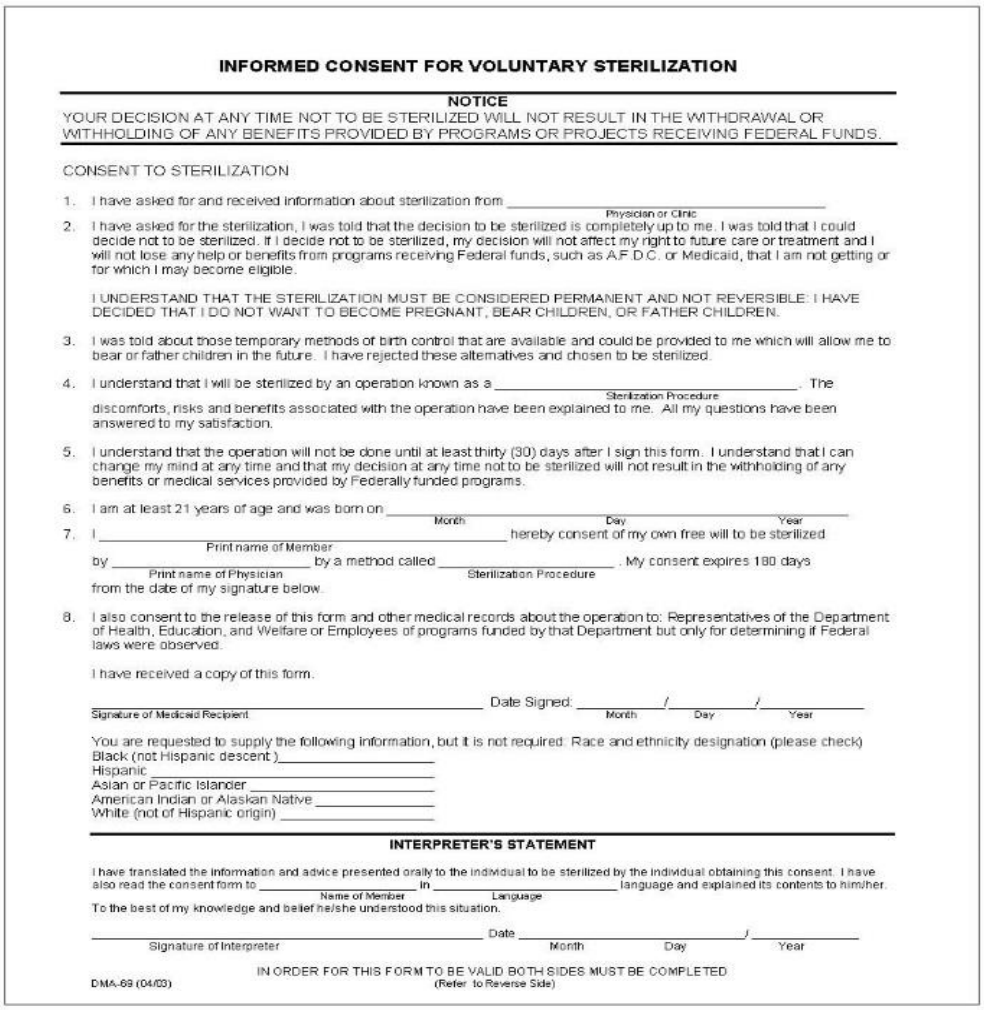
A copy of the properly executed "Informed Consent for Voluntary Sterilization" form must be attached to the all claims for services rendered in conjunction with the sterilization when submitted to the Division for payment.

NOTE: Medicaid funds are unavailable for sterilization, hysterectomies, or abortions performed without the documentation required by federal regulations (See 42 CFR 441.206 and 441.256). As such, claims for payment submitted without the required documentation or with incomplete or inaccurate documentation will be denied. The Division does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

CONSENT FOR VOLUNTARY STERILIZATION (DMA-69)

This federally mandated form may be submitted online or as a hard copy. When submitting the hard copy, you must complete both sides and submit it with all claims for sterilization. Review Part II, Chapter 900

of the Policies and Procedures for Hospital Services manual for details on completion of the form. Review blanks and dates on the form to verify age requirements, time lapse, and signature fields (use black ink).



INFORMED CONSENT FOR VOLUNTARY STERILIZATION

NOTICE

YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

1. I have asked for and received information about sterilization from _____ (Physician or Clinic)
2. I have asked for the sterilization. I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment and I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid, that I am not getting or for which I may become eligible.

   I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN, OR FATHER CHILDREN.
3. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father children in the future. I have rejected these alternatives and chosen to be sterilized.
4. I understand that I will be sterilized by an operation known as a _____ (Sterilization Procedure). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.
5. I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.
6. I am at least 21 years of age and was born on _____ (Month) _____ (Day) _____ (Year)
7. I _____ (Print name of Member) hereby consent of my own free will to be sterilized by _____ (Print name of Physician) by a method called _____ (Sterilization Procedure). My consent expires 180 days from the date of my signature below.
8. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare or Employees of programs funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (Signature of Medicaid Recipient) Date Signed: _____ (Month) / _____ (Day) / _____ (Year)

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check)
Black (not Hispanic descent) _____
Hispanic _____
Asian or Pacific Islander _____
American Indian or Alaskan Native _____
White (not of Hispanic origin) _____

INTERPRETER'S STATEMENT

I have translated the information and advice presented orally to the individual to be sterilized by the individual obtaining this consent. I have also read the consent form to _____ (Name of Member) in _____ (Language) language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this situation.

_____ (Signature of Interpreter) Date _____ (Month) / _____ (Day) / _____ (Year)

DMA-69 (04/03)

IN ORDER FOR THIS FORM TO BE VALID BOTH SIDES MUST BE COMPLETED
(Refer to Reverse Side)

DMA-69: Front page

FOR FISCAL AGENT USE ONLY

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed this consent form, I explained to him/her the nature of the
Name Of Member

sterilization operation, _____, the fact that it is intended to be a final and
Sterilization Procedure

irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____
Signature Of Person Obtaining Consent

_____
Date

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on
Name of Member

_____, I explained to him/her the nature of the sterilization operation
Date Of Operation

_____, the fact that it is intended to be a final and irreversible procedure and
Sterilization Procedure

the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

SELECT THE APPROPRIATE PARAGRAPH: NUMBER (1) OR NUMBER (2)
(Cross out the paragraph which is not used.)

Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used.

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Individual's date of expected delivery _____

☐ Emergency abdominal surgery (describe circumstances): _____

_____

_____

Physician's Signature _____ Date _____

DMA-69 (04/03)

DMA-69: Back page

COMPLETION OF THE INFORMED CONSENT FOR VOLUNTARY STERILIZATION (DMA-69)

The DMA will reimburse providers only for the sterilization procedures, which meet the criteria, established in Part II, Chapter 900 of the Policies and Procedures for Hospital Services manual. The recipient and the attending physician must properly complete this form on both sides.

Consent to Sterilization

Item 1 **Physician or Clinic**
Enter the name of the physician performing the sterilization process.

Item 2 **Sterilization Procedure**
Enter the medical name of the sterilization procedure.

Item 3 **Birth date**
Enter month, day, and year of the member's birth.

Item 4 **Name of Member**
Print the name of the member

Item 5 **Name of Physician**
Print the name of the physician performing the sterilization procedure.

Item 6 **Sterilization Procedure**
Enter the medical name of the sterilization procedure.

Item 7 **Signature of Medicaid Member**
The Medicaid member must sign the consent form. This field cannot be changed or clarified.

Item 8 **Date Signed**
Enter the date that the Medicaid member signed the consent form. This field cannot be changed or clarified and must match date witness signed and dated.

Item 9 **Race and Ethnicity Designation**
the member is requested to supply the race and ethnicity designation, but it is not required. Please check if you elect to do so.

INTERPRETER'S STATEMENT

If the member is not knowledgeable of the English language or is unable to read the Consent to Sterilization, an interpreter must be present to translate the information orally. In addition, the interpreter must complete this portion of the Informed Consent for Voluntary Sterilization form.

Item 10 **Name of Member**
Enter the name of the member signing this form.

Item 11 **Language**
Enter the name of the language used in interpreting the Consent to Sterilization form.

Item 12 **Signature of Interpreter**
The interpreter must sign this statement.

Item 13 **Date**
Enter the date the interpreter signs the statement.

STATEMENT OF PERSON OBTAINING CONSENT

Item 14 **Name of Member**
Enter the name of the member who signed the Consent to Sterilization Form.

Item 15 **Sterilization Procedure**
Enter the medical name of the sterilization procedure.

Item 16 **Signature of Person Obtaining Consent**
the person who counseled the member and explained to her/him the nature of the sterilization operation must legibly sign this line. This field cannot be changed or clarified.

Item 17 **Date**
Enter the date that the signature of person obtaining consent was written. This field cannot be changed or clarified.

Item 18 **Facility**
Enter the name of the facility or provider obtaining the consent.

Item 19 **Address**
Enter the complete address of the facility or provider obtaining the consent.

PHYSICIAN'S STATEMENT

Item 20 **Name of Member**
Enter the name of the member who signed the Consent to Sterilization form.

Item 21 **Date of Operation**
Enter the date that the operation was performed.

Item 22 **Sterilization Procedure**
Enter the medical name of the sterilization procedure.

Item 23 **Select Appropriate Paragraph**
Cross out the paragraph which is not used.

Item 23 **Physician' s Signature**
Physician must sign the form and enter the date the form is signed. Signature stamps are not acceptable. This form must be signed and dated after the sterilization is performed to be accepted as a valid consent for reimbursement for sterilization procedures.

APPENDIX K

REIMBURSEMENT OF CLINICAL DIAGNOSTIC OUTPATIENT LABORATORY SERVICES

As described in Section 1001.3, effective on and after October 1, 1984, clinical diagnostic laboratory services performed in hospital-based outpatient facilities will be reimbursed at the littlest of 60% of the prevailing charge or the submitted charges. As stated in Section 902, the coding system required for reimbursement of these charges is the Current Procedural Terminology (CPT). These codes must be used in conjunction with the appropriate laboratory revenue code. Additionally, the Principle Diagnosis Description and Principle Diagnosis Codes (ICD-10 CM) must be identified on the submitted claim.

A. The following laboratory services are non-covered by the Division.

1. CPT procedures deleted from previous and current editions of the Current Procedural Terminology book and those shown as "Unlisted Procedures" which end in "99."

2. Collection fees except for the services identified in Appendix E.

3. Services provided free of charge to Medicaid members by State or public laboratories. (Refer to Appendix E).

B. Exclusions:

The following laboratory test codes are excluded from the schedule of maximum allowable payments and will be reimbursed in accordance with the policy outlined in Section 1001.3.

- **85060-85197, Codes dealing with bone marrow smears and biopsies**
- **88104-88140-Certain cytopathology services**
- **86920-Transfusion Medicine**

- *Reimbursement of the clinical laboratory CPT codes is based on the Medicaid's pricing methodology for outpatient lab services which pays the **lesser** of the following:*

*The **Medicaid Allow Amount** {Medicaid Rate + Hospital Add-On Rate (Medicaid Rate x .1188) x Number of Units} OR The Medicare Allowed Amount (Medicare Rate x Number of Units).*

APPENDIX L

REIMBURSEMENT FOR OUTLIER CASES

Cost Outlier

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The prospective reimbursement system for inpatient hospital services is described in Chapter 1000 of this manual. In addition to the specific per case rate amount, an enrolled Georgia or non-Georgia hospital which has an unusually costly admission (or admissions) during the reimbursement year may obtain additional reimbursement for that admission under circumstances described below. This additional reimbursement, determined on a case- by-case basis, may be granted if the cost of the admission in question exceeds the established threshold.

To obtain additional reimbursement for an unusually expensive admission (cost outlier), the claim must first qualify as an outlier with edit code 4399 which is documented on the Remittance Advice (RA). Effective 10/1/16, Gainwell Technologies will no longer accept any paper Outlier Requests. The Outlier request is to be submitted electronically to Alliant/GMCF by the GAMMIS web portal under *Provider Workspace/Medical Review Portal*, under "Outlier Reviews".

The hospital must submit the required information which will be displayed at the time of the electronic request. The itemized bill is required for ALL Outlier requests. Requests submitted without the required documentation will not be accepted. If the request and all required documentation is not received within (90) days from the paid (RA) in which the Division reimburses the case rate, outlier payment will be denied.

Once an outlier request has been submitted to Alliant/GMCF for review, the providers CAN NOT void the claim via the web. Providers who repeatedly request adjustments or voids generating the need for a positive adjustment may be subject to adverse action by the Division.

1. Itemized Charges for Admission

a. The itemized bill **must** be submitted in the following formats indicated below. A sample template is available under the *Outlier Review tab.*

- XML
- Excel
  - Excel Worksheet should be named "Sheet1"

o The column headers should be as follows:
  - ACCOUNT_NUMBER, DATE_OF_SERVICE, REVENUE_CODE, ITEM_NUMBER, DESCRIPTION, QUANTITY, AMT_BILLED

o Files should only contain data elements only (no formatting, ie. no blank rows, no page numbers, headers, footers)

o Failure to submit the Excel file in the required format will **result** in a denial

Example below:

ACCOUNT_ NUMBER	DATE_OF_ SERVICE	REVENUE _CODE	ITEM_NUMBER	DESCRIPTION	QUANTITY	AMT_BILLED
123456789	4/5/2016	164	16000000	ISOLATION MED SURG	1	$2,100.00
123456789	4/6/2016	164	16000000	ISOLATION MED SURG	1	$2,100.00
123456789	4/5/2016	113	15000000	HCHB R&B PRIVATE	1	$938.00
123456789	4/6/2016	113	15000000	HCHB R&B PRIVATE	1	$938.00
123456789	4/5/2016	250	24000000	OMEPRAZOLE 40 MG CAP, DELAYED RELEASE	1	$25.75
123456789	4/6/2016	250	24000000	OMEPRAZOLE 40 MG CAP, DELAYED RELEASE	1	$25.75
123456789	4/6/2016	270	20000000	BIOPSY SET, LIVER	1	$1,950.00
123456789	4/5/2016	301	30000000	COMPREHENSIVE METABOLIC PANEL	1	$251.00
123456789	4/6/2016	301	30000000	COMPREHENSIVE METABOLIC PANEL	1	$251.00
123456789	4/6/2016	360	36000000	BIOPSY LIVER NEEDLE PERC	1	$1,600.00

b. The itemization must be listed by revenue code.

c. The revenue codes included on the itemized bill must match the revenue codes on the claim and UB-04.

d. The itemized bill revenue totals must match the billed revenue totals on the claim and UB-04. The totals billed must match.
   - Example: revenue 301 billed amount on the claim and UB04 of $3,265.00 but the billed amount on the itemized bill of $3,465.00. The billed amount on the itemized bill is greater than the billed amount on the claim and UB04.

e. Each item must contain the description, quantity (units) billed, and the charge for that item. Itemizations that reflect rolled up charges into one-line item will be denied.

f. There cannot be any zero charge items on the itemized bill. The billed amount on the itemized charges and UB claim form must be in agreement.

g. Negative charges should not be submitted/included on the itemized bill.

h. Claim revenue codes should not be listed individually. All charges for the revenue code should be billed as one line.
   - Example: revenue 250, 250, 250, 250, 250, instead revenue code 250 should only be billed once.

i. Hospital Acquired Conditions/Never Events must be highlighted or marked through from the itemized claim unless on exception list. (See Section *1102. E of Part II Policies and Procedures*

j. for Hospital Services Manual for these exceptions).

k. The electronic files are labeled for review and only the documents listed are submitted.

l. The request is submitted within the 90-day deadline of the paid RA.

2. The UR notes must be signed and dated on the review date with *Severity of Illness/Intensity of Service (SI/IS) criteria* indicated or indicate the guideline stage and progression to next day. UR notes must indicate the severity of illness/intensity of service (SI/IS) that was met for medical necessity of the hospital stay and must be written concurrently on the review date. Failure to document the SI/IS criteria (met/not met) in the utilization review notes may result in the denial of your DRG outlier request. The UR notes must adhere to the frequency indicated in the UR Plan.

3. When the Outlier request is submitted, the system will identify which documents are needed for the review. The itemized bill is required for all requests. **Additional information may be requested**. Only the requested documentation should be submitted. If the entire medical record is submitted, the request will be denied.

All charges to be considered for additional reimbursement must be in a paid status in the claims processing system prior to submission of the outlier request. Claims for which a third party pays at or in excess of the DRG payment are not to be billed to the Division; therefore, cost outlier reimbursement for such claims is not available. Any services listed on the itemized charges and not billed to the Division must be identified by the hospital. The billed amount on the itemized charges and UB claim form must be in agreement.

For a claim to meet the criteria for consideration of additional reimbursement, the submitted utilization review notes must demonstrate compliance with the hospital's Utilization Review Plan on file and approved by the Division. Hospital utilization review programs must include review of the medical necessity for admission, the appropriateness of services and the medical necessity for continued stay. If this frequency is not followed, this may result in a denial.

In some cases additional information is required to complete the review process. When additional information not identified above is requested, it must be received within (**30**) days of the date of the paid RA request. If not received by the due date, the request for outlier payment will be denied.

Hospitals billing for services provided through contractual shared agreements are responsible for submitting a combined itemized bill of both hospitals itemized charges and both set of documents for review if required

Second and Administrative requests are to be requested the same way listed above with **30** days of the review determination denial letter or within **30** days of the paid RA date

It is the responsibility of the provider to assure that each and every outlier claim and all information necessary to complete the review is received by the Division or its agent.

Your Outlier request's status may be viewed on the GAMMIS web portal under the *Provider Workspace/Medical Review Portal*, under "Outlier Reviews". Questions regarding your Outlier may be sent to GMCF via *Provider Workspace/Medical Review Portal* under "Contact Us". Please refer to the "Provider Education and Training" link for instructions.

Calculation of reimbursement for claims that meet outlier criteria is discussed in Chapter 1000 for Reimbursement.

Day Outlier
For dates of admission on or after October 9, 1997, there is no longer an outlier policy for day outliers.

REQUIRED OUTLIER DOCUMENTS CHECKLIST

When the Outlier request is submitted, the system will identify which documents are required for the review. All requests must have an itemized bill submitted. Only the requested documents should be submitted for the review. If the entire record is submitted the Outlier request will not be reviewed and the provider must resubmit the Outlier record with only the required documents.

All Outlier Requests:

- Itemized bill
  - File format should be one of the following:
    - XML
    - Excel
      - Excel Worksheet should be named "Sheet1"
  - The column headers should be as follows:
    - ACCOUNT_NUMBER, DATE_OF_SERVICE, REVENUE_CODE, ITEM_NUMBER, DESCRIPTION, QUANTITY, AMT_BILLED
  - Files should only contain data elements (no formatting)
- Billed amount on the itemized charges and UB claim form must be in agreement
- The revenue codes included on the itemized bill must match the revenue codes on the claim and UB-04.
- The itemized bill revenue totals must match the billed revenue totals on the claim and UB-04. The totals billed must match.
- Negative and zero charges should not be submitted/included on the itemized bill.
- Claim revenue codes should not be listed individually. All charges for the revenue code should be billed as one line. Example: revenue 250, 250, 250, 250, 250, instead revenue code 250 should only be billed once.

Additional Documents that may be required:

- Cover Letter
  - Indicates initial, second or administrative request
  - Includes the members name, member number and dates of service. (If this information does not match the RA, an explanation needs to be provided.)
  - Contact person name, e-mail address and phone number.

- Claim - UB form
    - The billed amounts
- Utilization Review (UR) Notes
    - Signed and dated on the review date
    - Severity of Illness/Intensity of Service (SI/IS) criteria indicated (met/not met) guideline stage and progression to the next day
- Physician Discharge Summary
- Physician Progress Notes
- Operative (OP/OR) Procedure Notes (if applicable)

Gainwell Technology
Special Handing Documents
P.O. Box 105208 Suite 750
Atlanta, Georgia 30085-5208

REQUIRED OUTLIER DOCUMENTS CHECKLIST

The following items must be submitted as outlined below for Outlier review. Only required chart documents should be submitted for review. If the entire chart is submitted the record will not be reviewed and the provider must resubmit the Outlier record with only the required documents.

- ☐ _____ **Cover Letter includes:**
    - Member name and number
    - Contact Person, number and e-mail address.
    - Member name, member number and dates of service.
      (If this information does not match the RA, an explanation needs to be provided.)
    - ICN
    - Initial request, second request or administrative request.
- _____ **Claim – UB form -** Claims a third party pays at or in excess of the DRG payment are not to be billed to the Division.
- ☐ _____ **Itemized Bill - Excel Format containing the following:**
    - Column headers should be as follows: ACCOUNT_NUMBER, DATE_OF_SERVICE, REVENUE_CODE, ITEM_NUMBER, DESCRIPTION, QUANTITY, AMT_BILLED
    - Excel Worksheet tab should be named "Sheet1"
    - Files should only contain data elements only (no formatting, ie. no blank rows, no page numbers, headers, footers, etc.)
- ☐ _____ **Total charges and DOS match on itemized bill, RA and UB-04 unless a HAC/ Never Event is present. HAC/Never Events should be highlighted or crossed out.**
- ☐ _____ **Billed charges on the itemized bill and revenue codes match the UB-04.**
- ☐ _____ **Charges documented in the itemized bill but not billed on the UB-04 are identified and marked through on the itemized bill**
- ☐ _____ **Utilization Review (UR) Notes includes:**
    - Inpatient review criteria (Met/Not Met) indicated for each review date or indicate the guideline stage and progression to the next day
    - Indicate the name and title of the reviewer
    - Signed by the reviewer on the review date. Retro entries are not acceptable.

- Adhere to the frequency indicated in the UR plan

☐ _____ **Physician Progress Notes**
☐ _____ **Physician Discharge Summary**
☐ _____ **Operative (OP/OR) Procedure Notes (if applicable)**
☐ _____ **Request submitted within 90-day deadline of paid RA**

Completed by:_____Date of completion: _____

APPENDIX M

COPAYMENTS FOR CERTAIN SERVICES

Outpatient Copayment:

A $3 member copayment is required on all non-emergency outpatient hospital visits. Pregnant women, members under twenty-one (21) years of age, nursing facility members, hospice care members and woman diagnosed with breast or cervical cancer who is receiving Medicaid under the Breast and Cervical Cancer (BCC) program or Presumptive Eligibility Aid Categories 245 and 800 only are not subject to the copayment. The copayment does not apply to the following services: Emergency Services, Family Planning Services, Waiver Services and Dialysis Services. When the outpatient cost-based settlements are made for hospital services, the copayment plus Medicaid payment will be compared to the allowable cost to determine the amount of final settlement.

Inpatient Copayment:

A copayment of $12.50 will be imposed on hospital inpatient services.

Members affected by the co-payment are limited to adult members of Supplemental Social Security Income (SSI) benefits, certain other adult disabled and aged members and parents of children receiving Aid to Families with Dependent Children (AFDC) benefits. Children under age twenty-one (21), pregnant women, nursing facility residents, or hospice care members and members receiving family planning services are not required to pay this co-payment. Emergency services received by Medicaid members do not require a co-payment. Services cannot be denied based on the inability to pay these co-payments.

Women diagnosed with breast or cervical cancer and receiving Medicaid under the Women's Health Medicaid Program (aid category 245 and 800 only) are exempt from co-pay.

Inpatient services must have the Type of Admission, Form Locator 19, and Source of Admission, Form Locator 20, completed on the UB-04 claim form. Type of Admission one (1) Emergency and two (2) Urgent are exempt from inpatient co-payment.

Source of Admission codes 4, 5, and 6 are exempt from inpatient co-payment.

- 4 = Transfer from a Hospital
- 5 = Transfer from a Skilled Nursing Home
- 6 = Transfer from another Health Facility

The provider should check the member's eligibility via web or telephone each month in order to identify those individuals who may be responsible for the co-payment.

Gainwell Technology will automatically deduct the copayment amount from the provider's payment for claims processed. Do not deduct the copayment from your submitted charges. The application of the copayment will be identified on the remittance advice. An explanation of benefit (EOB) code will indicate payment has been reduced due to the application of copayment.

COMPLETION OF THE MEDICAID PRECERTIFICATION FORM

The DMA guidelines, set forth in Part II, Chapter 800 of the Policies and Procedure for Hospital Services manual discuss precertification program requirements and procedures. Request for Medicaid precertification should be initiated at least one (1) week prior to the planned admission or procedure. Precertification may be requested by contacting GMCF by any one of the following two methods: (1) telephone: Telephone: 1-800-766-4456 (Provider Call Center) or (2) web portal.

APPENDIX N
MEDICAID PRECERTIFICATION FORM

This form is used to submit requests to the Georgia Medical Care Foundation (GMCF) for precertification.

ALLIANT | GMCF
MAKING HEALTH CARE BETTER

Prior Authorization Department
P.O. Box 105329
Atlanta, GA 30348
www.mmis.georgia.gov

Phone 800-766-4456
FAX 678-527-3003
FAX 877-393-8226

All requests regardless of setting may be submitted via the web portal at above web site address

Request for Authorization

Date of Request _____ *Member Name _____

*Member ID _____ *DOB _____ ____M ____F

*MD Provider ID _____ *MD Name _____

*Facility Reference ID REF _____ *Facility Name _____

Request Information

*Contact Name _____ *Contact Phone _____ Ext ____

*Contact Fax _____ Contact Email

*Place of Service ____ Inpatient Hospital ____Outpatient Facility/Hospital ____Office

*Admission Type _____ Emergency _____Urgent _____ Elective

Admission Date _____ Discharge Date _____

*Release of Information Code Plan Sponsor

Diagnosis (1 required)

ICD-9	Description	ICD-9 Date	Primary?

Procedures

Procedure Code	From Date	To Date	Units	Modifier

*** Patient Transfer Information**

*If patient is being transferred to your facility, provide reason: _____

*If patient being transferred from your facility, provide reason: _____

***Clinical Data to Support Request**

_____

_____

_____

_____

_____

***Treatment Plan**

_____

_____

_____

_____

_____

Is member retro-eligible? ____No ____Yes

If yes, indicate effective date of retro-eligibility _____

ALLIANT GMCF

Prior Authorization Department
P.O. Box 105329
Atlanta, GA 30348
www.mmis.georgia.gov
Out of state request may be submitted via Web Portal

Phone 800-766-4456
FAX 678-527-3003
FAX 877-393-8226

Authorization Request for Out of State Services

Required fields

* Date of Request _____
* Member Name _____ * Member ID# _____
* Requesting Georgia Provider Name _____

* GA Provider ID # _____ *Provider Specialty _____

RENDERING PHYSICIAN INFORMATION

*Out of State Physician Name _____ *Specialty _____

* Street Address _____

*City _____ * State _____ Zip Code _____

* Phone _____ * Fax _____

RENDERING FACILITY INFORMATION

* Out of State Facility Name _____ *Specialty _____

* Street Address _____

* City _____ *State _____ *Zip Code _____

*Phone Number _____ ext _____ *Fax Number _____

GEORGIA (GA) PROVIDER REQUEST INFORMATION

* GA Contact Name _____ * Contact Phone _____

* Contact Fax _____ Contact email _____

*** OUT of STATE SERVICES**

_____ Inpatient _____ Outpatient Hospital/Facility _____ Office _____ Lab

*** OUT of STATE ADMISSION/VISIT TYPE**

_____ Emergency _____ Urgent _____ Elective

* Admit/Visit Date _____ Discharge Date _____

*** Diagnosis (1 Required)**

ICD -9	ICD-9 Date	Primary	Admission Diagnosis

*** Procedure / Visit Code**

Procedure Code	From Date	To Date	Units

*****SEND THE FOLLOWING INFORMATION WITH REQUEST*****

Letter of Medical Necessity should be submitted by Georgia Specialist and Include:

* 1) Current Clinical Summary with diagnostic testing, imaging and surgical findings
* 2) Out of state treatment plan recommended and anticipated length of stay
* 3) Statement that requested services are:

_____ Not available in Georgia at higher level facilities/ teaching institutions
_____ Not investigational or experimental
_____ Covered services for Georgia Medicaid Members

APPENDIX O

BILLING INSTRUCTIONS

Claims must be filed on the required form (Electronically) with appropriate information in specific blocks for payment. Claims (must be submitted electronically) for hospital services are:

- 01 UB-04 (National Uniform Billing Form)

- Claim(s) must be submitted within six (6) months from the month of service. Claim(s) with third party resource(s) must be submitted within twelve (12) months from the month of service.

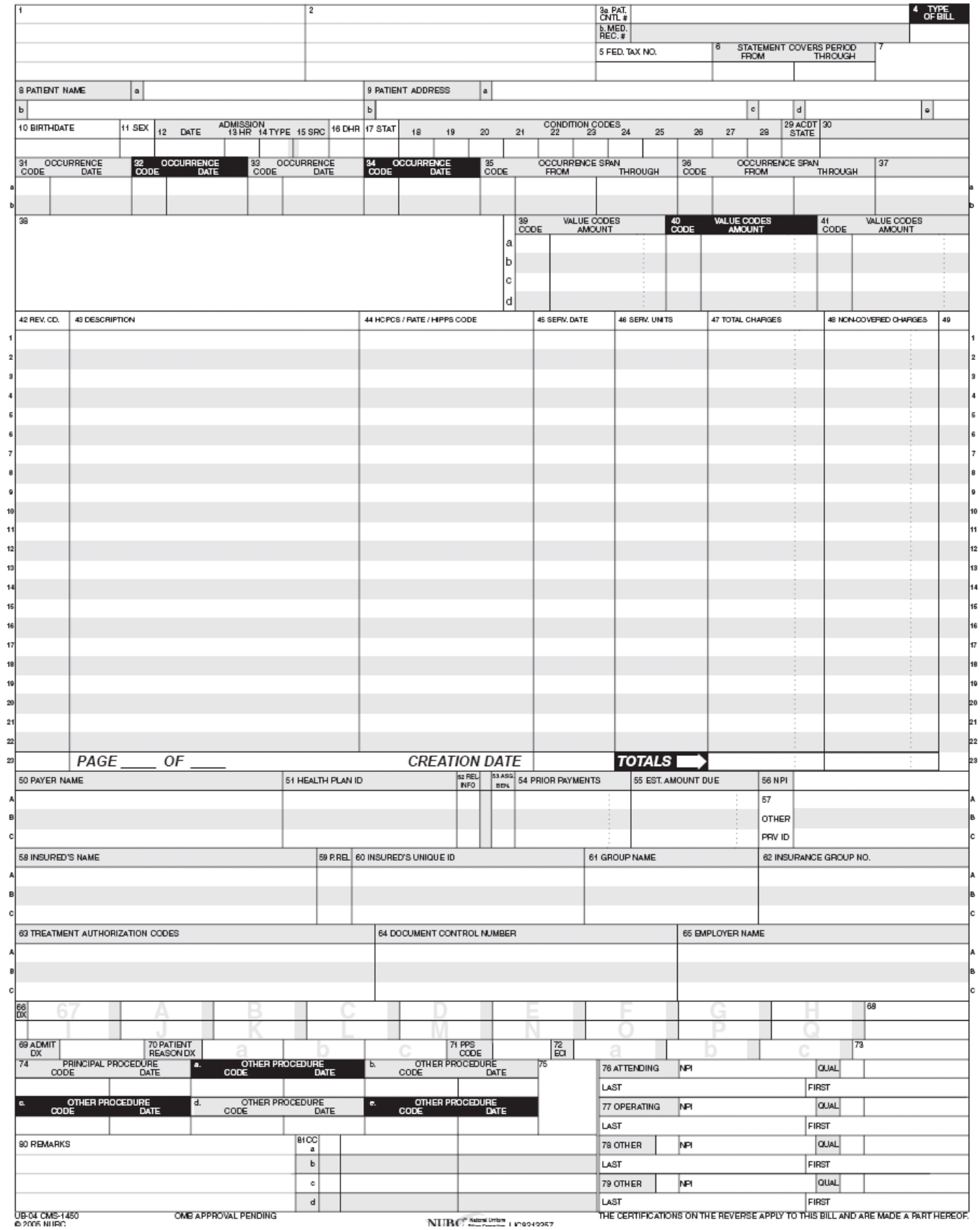
- Effective 07/01/2010 a special crossover claim for is no longer required. Claims must be submitted using the UB-04 format. The claim must have an Explanation of Medicare Benefits (EOMB) from Medicare for Medicaid payment if filing hardcopy. Claims must be submitted within twelve (12) months from the month of service.

- The Billing Manual has been added to Part I of the Policies and Procedures for the Medicaid/Peach Care for Kids Manual. Please refer to this Billing Manual for general billing instructions and/or questions.

- All providers filing claims must type the required information in the appropriate fields. No handwritten claims will be accepted for processing. Hospital providers must follow the established billing and timely filing protocols, in accordance with Appendix O and Part 1 of Policies and Procedures Medicaid and Peach Care for Kids.

- Effective December 15, 2016 and as part of the GA Medicaid Paperless Initiative which [1]went into effect May 1, 2015. GAINWELL TECHNOLOGY and A Solutions/GMCF (Alliant/GMCF) will no longer be accepting Paper requests of any type or Outlier paper request. All supporting documentation must be electronically via the GAMMIS Web Portal (www.mmis.georgia.gov) click the Medical Review Portal link located under the Provider information tab. Outlier requests must be electronically requested and all supporting documentation must be electronically attached directly to the user's request through 24/7 access via the Medical Review Portal. Please refer to the DCH Hospital Policy Manual, Appendix L regarding this change.

UB-04 CLAIM FORM



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

NOTE:

Form Locators (FL) not required by Georgia Medicaid are not included in these instructions. Form Locators (FL) appearing in bold are used by Georgia Medicaid for claims adjudication and must be present on the claim if applicable.

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

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

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

FL 3b **Medical/Health Record Number**

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

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

FL 4 **Type of Bill**
Enter a code indicating the specific type of bill (e.g., inpatient, outpatient). This three-digit code requires one (1) digit each, in the following sequence:

Type of Facility
Always use '1' (Hospital).

Bill Classification
Must be '1' (Inpatient, including Medicare Part A), '3' (Outpatient), or '4' (Diagnostic Referral patient).

Frequency
The only acceptable inpatient frequencies are '1', '2', '3', or '4'. The only acceptable outpatient frequency is 1. Refer to the definitions for Frequency.

FL 5 **Federal Tax Number**

Enter provider's federal tax identification number.

FL 6 **Statement Covers Period (From-Through)**
Enter the beginning and ending service date(s) of the period included on this bill. When combining prior outpatient services to an inpatient claim the "statement covers from "date will be the date of inpatient admission. The outpatient charges should be reported on the inpatient claim with the appropriate revenue code.

FL 8 **Patient's Name**

Enter the patient's last name, first name, and, if any, middle initial... If the name on the Medicaid care is incorrect, the member or the member's representative should contact the local DFCS to have it corrected immediately.

FL 9 **Patient's Address**

Enter the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and Zip code.

FL 10 **Patient Birth date**

Record date of birth (MMDDCCYY) exactly as it appears on the Medicaid card. An unknown birth date is not acceptable. If the date on the Medicaid card is incorrect, the member or the member's representative should contact the DFCS to have it corrected immediately.

.**FL 11** **Patient Sex**

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

FL 12 **Admission Date**

For inpatient services, the date of admission is considered to be the date the patient began receiving care, including the observation period. Preadmission testing must be included on the inpatient claim.

FL 13 **Admission Hour**

Enter the hour (00-23) during which the patient was admitted for inpatient or outpatient care. An unknown hour is not acceptable.

FL 14 **Type of Admission/Visit**

Enter the appropriate code to indicate the priority of this admission.

1. Emergency-the patient requires immediate medical intervention as a result of severe, life-threatening, or potential disabling conditions. Generally, the patient is admitted through the emergency room. This type of admission is exempt from inpatient co-payment.

2. Urgent-the patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation. This type of admission is exempt from inpatient co-payment.

3. Elective-the patient's condition permits adequate time to schedule the availability of a stable accommodation.

4. Newborn-use of this code necessitates the use of Special Source of Admission Codes-see FL 20. (When an infant is transferred from the delivery hospital to a

second hospital, the type 4 admission code must not be entered on the claim form submitted by the second hospital.)

FL 15 **Source of Admission**

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

Code Structure (for Emergency, Elective, or Other Type of Admission):

1. Physician Referral
2. Clinic Referral
3. Managed Care Plan Referral
4. Transfer from a Hospital (different facility)
5. Transfer from a Skilled Nursing Home
6. Transfer from another Health Facility
7. Emergency Room
8. Court/Law Enforcement
9. Information Not Available

NOTE:
Source of Admission codes 4, 5, and 6 are exempt from inpatient co-payment.

Rev. 04/15

Code Structure (for Newborn):

1. Normal Delivery (discontinued 9/30/2007)
2. Premature Delivery (discontinued 9/30/2007)
3. Sick Baby (discontinued 9/30/2007)
4. Extramural Birth (discontinued 9/30/2007)
5. Born Inside This Hospital
6. Born Outside of This Hospital

FL 16 **Discharge Hour**

Enter the hour (00-23) that the patient was discharged from inpatient care. An unknown hour is not acceptable.

FL 17 **Patient Status**

Enter a code indicating patient status as of the "Statement covers thru date".
Use the applicable code from the list below:

01 Discharged to home or self-care (routine discharge)

02 Discharged/transferred to another short-term general hospital

03 Discharged/transferred to Skilled Nursing Facility (SNF)

04 Discharged/transferred to an Intermediate Care Facility (ICF)

05 Discharged/transferred to another type of institute

06 Discharged/transferred to home under care of organized home health service organization

07 Left against medical advice

20 Expired

21 Discharged/ transferred to Court/ Law Enforcement

30 Still patient

41 Expired in a medical facility

61 Discharged/transferred within Institution

66 Discharged/Transfer to a Critical Access Hospital

70 – Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this code list

83 Discharged/Transferred to Skilled Nursing

** **Note**Status codes 50, 51, 62, 63, 64 and 65 are billable for straight Medicaid claims, in accordance with Medicare.**

FL 18 Thru 28 **Condition Codes**

Enter the appropriate codes(s) used to describe conditions or events relating to this bill that may affect payer processing.

When billing for Partial Hospitalization condition code 41 must be entered.

FL 31 Thru 34 A & B **Occurrence Codes and Dates**

Enter the codes and associated dates defining a significant event relating to this bill that may affect processing. Format for all dates is MM/DD/YY. Use only those occurrence codes listed in Appendix O.

NOTE:

Occurrence codes and dates are required for Type of Bill "131", when billing Physical Therapy (PT), Speech Therapy (ST), Occupational Therapy (OT), and Psychiatric Services (PY). When billing for PT, OT, and ST, on the same claim form, the occurrence code and date should be specific for PT services. For combined OT and ST claims, the occurrence code and date should relate to ST services. If only one type of therapy is billed, the information should be recorded in the same manner as for a PT claim.

The First occurrence code should always be the onset 11, followed by the date that the accident or illness first occurred.

FL 34 **Occurrence Span Code and Dates**

Inpatient, provider enters codes and associated beginning and ending dates defining a specific event relating to this billing period.

FL 39 Thru 41 A, B, C & D **Value Codes**

Enter the appropriate value codes and the units or dollar amounts necessary for the processing of the claim.

Rev. 10/07

Value code:
NOTE:

80-Covered Days-the number of covered days for inpatient admission.
81-Non-Covered Days-the number of non-covered days for inpatient admission.

FL 42 **Revenue Code**

Enter the appropriate Revenue Code. Refer to the Uniform Billing Manual for a listing of revenue codes. FL 44 lists the revenue codes billable to GA Medicaid. "Outpatient only" revenue codes cannot be billed on inpatient claims and Inpatient only codes cannot be billed on Outpatient claims. For emergency and outpatient services, when a span of dates is entered in FL 6 (from thru date of service), a revenue code may be entered more than one time on the claim if the actual dates of service entered in FL 45 and/or the HCPCS codes entered in FL 44 are different.

NOTE:

When billing partial hospitalization, enter revenue code 912 and the number of visits in the units of service field. This is an all-inclusive day rate. Therapy services included in the PHP should not be billed under other therapy revenue codes.

When billing for newborn hearing screening test(s), enter revenue code 479. Also, indicate the CPT code such as 92587, in FL 44.

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

Partial Eligibility/ Revenue Code 180

When a member has lost eligibility during the middle of a hospital stay, this is considered as partial eligibility and the Revenue Code 180 must be entered along with the number of units for the days that the member was not eligible as well as the associated charges incurred during the ineligible period. ***For example***: A patient is admitted to the hospital from 04/18/09 to 07/17/09, and the member loses eligibility for 05/01/2009 through 05/31/2009; Enter Revenue Code 180 in Field Locator 42, Enter the first date of the ineligible period 05/01/2009 in Field Locator 45, Enter the number of days the member is not eligible in Field Locator 46. The associated charges incurred during the ineligible period are entered in Field Locator 47.

FL 43 **Revenue Description**

Enter narrative description of the related revenue categories included on this bill. Abbreviations may be used. The description and abbreviations should correspond with the revenue codes as defined in the 1992 Georgia Uniform Billing Manual. Accommodations must be entered first on the bill.

Rev.10/11

Rev.06/11

Rev. 10/11

FL 44 **CPT/HCPCS/Rates**

Enter the accommodation rate for inpatient bills and the HCFA Common Procedure Coding System (HCPCS) applicable to ancillary services.

Outpatient surgical, obstetrical, diagnostic laboratory, injectable drugs, and radiology procedures require HCPCS/CPT-4 coding regardless of the revenue code billed. Injectable drugs require NDC (National Drug Code) coding for each injectable drug billed under revenue code 636. The CPT-4 codes must be entered in the field, adjacent to the appropriate revenue code.

The revenue codes most frequently utilized to identify those services are 260,261, 300-302, 304-307, 310-312, 314, 320-324, 333, 340-342, 351-359, 360-369, 401-403, 413, 420, 424, 430, 439, 440, 444,480-481,450, 510-519, 610-612, 636, 730, 731, 732, 760, 761, 762 790, 901 and 943. Claims submitted without CPT-4 codes adjacent to these codes will reject or deny. The appropriate revenue code must also be entered in FL 42. Do not use CPT-4 codes on inpatient claims.\

When billing **IV Infusion/solutions for hydration therapy, use the appropriate primary revenue code** with the charge for that procedure code on each line. The CPT codes used for the revenue code are to be reported below as 96360-96379. The primary procedure code must be either billed and paid in history prior to billing the add-on infusion code on the claim or can be billed along with the add on code on the same claim with the revenue code. Bill the appropriate CPT/HCPCS infusion code on each detail line. Do not combine the IV infusion codes on one detail line. The primary CPT/HCPCS code must be billed with the appropriate add on codes as listed follows according to the:

2011 Current Procedural Terminology (Standard Edition):

Add-on code	IV Infusion Primary Codes
96361	96360, 96365, 96374, 96409, 96413
96366	96365
96367	96365, 96374, 96409, 96413
96368	96365, 96413, 96415, 96416
96370	96369
96371	96369
96375	96365, 96374, 96409, 96413
96376	96365, 96374, 96409, 96413
96411	96409, 96413
96415	96413
96417	96413
96423	96422

NOTE:

When billing for multiple surgeries, each procedure should be listed adjacent to the appropriate surgical revenue code with the charge for that procedure on each line. Do not combine surgical charges on one line. All 360 revenue code charges must have a valid CPT/HCPCS code and a valid dollar amount entered on the claim.

When billing emergency room visit list revenue code 450 and the appropriate CPT/HCPCS code. If a surgical procedure is performed in an emergency room setting, the appropriate surgery code (CPT codes 10021-69990) must be reported in FL 44 HCPCS/Rates, with Revenue Code 450.

When billing injectable drugs the 11 digit NDC (National Drug Code) must be billed along with revenue code 636. When billing using an electronic format (EDI, Web) the appropriate CPT/HCPCS code must be entered along with the NDC code. The 11 digit NDC (National Drug Code) must be billed in Field Locator 43. Enter the 2 digit qualifier "N4" as a prefix to the 11 digit NDC number. Example: N4455513028310. The associated CPT/HCPCS code must be entered into Field Locator 44.

FL 45 **Service Date**

Enter the actual date the service was provided if a span of dates is billed, the actual date the service was provided must be entered adjacent to the appropriate revenue code(s). For emergency and outpatient services, if a span of dates is entered in FL 6 (from thru date of service), the actual date of service must be entered in FL 45 adjacent to the appropriate revenue code(s).

FL 46 **Units of Service**

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

NOTE:

When billing for observation revenue code 762, units must be entered to indicate number of hours. For example: if member is in the observation room for ten (10) hours, the units are ten (10). Revenue code 762 is covered for both inpatient and outpatient claims. When combining prior observation/outpatient services to an inpatient claim the "statement covers from" date will be the date of inpatient admission. The outpatient charges should be reported on the inpatient claim with the appropriate revenue code.

FL 47 **Total Charges (by Revenue Category)**

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

FL 48 **Non-covered Charges**

The total non-covered charges pertaining to the related revenue code in FL 42 are entered here.

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

FL 50 **Payer Identification**
A, B, C Enter payer name and carrier code of any liable third party payer other than Medicare. A reasonable effort must be made to collect all benefits from other third party coverage. Federal regulation requires that Medicaid be the payer of last resort. (See Chapter 300 of the Policies and Procedures Manual applicable to all Medicaid providers.)

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

FL 51 **Health Plan ID**
A, B, C Enter the number assigned to the provider by the payer indicated.

FL 52 **Release of Information Certification Indicator**
A, B, C

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

FL 56 **National Provider ID (NPI)**

FL 57 **Other Provider ID (primary, secondary, and/or tertiary)**
Report other provider identifiers as assigned by a health plan (as indicated in FL50 lines 1-3) prior to May 23, 2007

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

FL 59 **Patient's Relationship to Insured**
A, B, C If the provider is claiming payment under any of the circumstances described under FL's 58 A, B, or C, code must be entered indicating the relationship of the patient to the identified insured, if this information is readily available.

FL 60 **Insured's Unique ID (Certificate/ Social Security Number/ HI Claim / ID Number (HICN).**
A, B, C Enter on the same lettered ling (A,B, or C) that corresponds to the line on which the payer information is shown in FLs50-54, the provider enters the patient's number as it appears on the patient's ID card.

FL 61 **Insured Group Name**

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

FL 62 **Insurance Group Numbers**

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

FL 63 **Treatment Authorization Code (Precertification)**

A, B, C A number or other indicator that designates that the treatment covered by this bill has been authorized by the DMA. Enter the 12-digit authorization number as required for inpatient hospital admissions and selected outpatient procedures, if applicable.

FL 64 **Document Control Number (DCN)**

A, B, C Enter the control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.

FL 65 **Employer Name**

A, B, C Enter employer name that might or does provide health care coverage for the individual in FL58

FL 66 **Diagnosis and Procedure code Qualifier (ICD Version Indicator)**

This qualifier denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD-10 codes Revision.

FL 67 **Principle Diagnosis Code**

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

FL 67A- **Other Diagnosis Codes**

67Q Enter ICD-10 codes for up to eight additional conditions if they co-exist at the time of admission or developed subsequently, and which had an effect upon the treatment or length of stay. It may not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis. Note: Medicaid will ignore data submitted in 67I-67Q.

FL 69 **Admitting Diagnosis**

The admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL 70A- **Patient's Reason for Visit**

70C Patient's Reason for visit is required for all un-schedules outpatient visits for outpatient bills.

FL 74 **Principal Procedure Code and Date**

Inpatient claims when a procedure was performed. Not required on outpatient claims.

FL 74A **Other Procedure Codes and Dates**

-74E Inpatient claims when additional procedures must be reported.

FL76 **Attending Provider name and Identifiers (including NPI)**

Required when claim/encounter contains any services other than nonscheduled transportation services. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in the claim/encounter.

0B-State License Number
1G-Provider UPIN Number
G2-Provider Commercial Number

FL 77 **Operating Provider Name and Identifier (including NPI)**

Required when a surgical procedure code is listed on the claim. The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).

- **0B-State License Number**
- **1G-Provider UPIN Number**
- **E1-Employer's Identification Number**
- **SY-Social Security Number**

FL 78 &79 **Other Provider Name and Identifiers (including NPI)**

The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim.

DN-Referring Provider: The provider who sends the patient to another provider for services. Required on an outpatient claim when the referring provider is different that the attending physician.

ZZ-Other Operating Physician: An individual performing a secondary surgical procedure or assisting the Operating Physician.

82-Rendering Provider: The health care professional who delivers or completes a particular medical service or non-surgical procedure.

Second Identifier Qualifiers:

- 0B-State License Number
- 1G-Provider UPIN Number
- EI-Employer's Identification Number
- SY-Social Security Number

Helpful Hints

- Interim billing valid type of bills: 112,113 and 114. When billing Medicare interim claims, do not bill Medicaid until the final bill has been submitted and paid by Medicare. Medicaid does not accept interim Medicare Crossover claims.

- **TOB 141** – Revenue code allowed:

  300-329, 341-350, 380-409, 460-469, 471, 482, 730, 731, 740, 749, 001

- Value code units for therapies should reflect total number of visits at this facility from onset of condition.

- If code is not an emergency code and provider feels it is an emergency, bill and attach documentation to claim.

- $3.00 co-pay per visit for outpatient services.

Guidelines for submitting Medicare Crossover claims UB-04

ALL CLAIMS ARE SUBMITTED ELECTRONICALLY.

DEFINITIONS FOR FREQUENCY (FL 4)

Admit Through Discharge Claim (1)

This code is to be used for a bill that is expected to be the only bill to be received for a course of treatment or impatient confinement. This will include bills representing a total confinement or course of treatment, and bill which represent an entire benefit period of primary third party payer.

Interim First Claim (2)

This code is to be used for the first of a series of bills to the same third party payer for the same confinement or course of treatment.

Billing for Interim Claims Effective for Dates of Admission 07/01/1998 or Greater

Admit through discharge claims are the preferred method of submission.

First Interim Claims – Bill Type 112

First Interim claims can only be submitted if the covered days span at least 61 days. All first interim claims submitted with an interim Bill Type and less than a 61-day span will deny. The first interim claim should be submitted with a 112 Bill Type, indicating Interim-First Claim and a Patient Status of 30 (still a patient). The DRG is assigned to this claim. The DRG allowable will be paid. This amount may NOT be the final DRG payment. Subsequent claims, interim/final, may affect payment.

Rev. 11/10

Continuing Interim Claims – Bill Type 113

All continuing interim claims received after the initial interim claim will be treated as "replacement claims".

When the replacement claim is processed, the Remittance Advice (R/A) will reflect a complete recoupment of the previous claim submitted with a 112 Bill Type. Each time a replacement claim is processed, the previous payment is recouped on the same R/A. The new payment amount will include any change in DRG.

Continuing interim claims may only be submitted if there are at least 60 days from the To Date of Service on the previous claim and the To Date of Service on the current claim.

Hospital must submit a discharge claim for each stay so that information on each stay will be complete. To encourage timely billing and prevent open-ended sets of claims (series with no discharge), some claims may be recouped. If a subsequent claim is not received within 180 days of the pay date on the R/A of the previous claim, the previous claim will be recouped. The claims processing cycle auditing interim claims run every 30 days; therefore, some claims outside of the 180-day guideline may not be recouped on the exact 180th day. Recoupments will not occur until a minimum of 180 days has elapsed. Medicaid will pay for stays that have been recouped in cases where the discharge claim was not submitted within 180 days. In order to receive payment, the provider should resubmit a claim for the entire stay using Bill Type 111 or combination of Bill Type 112 and Bill Type 113. Medicaid's objective is to obtain a discharge claim for every stay.

Rev. 11/10 The only valid Bill Type for replacement claim is 113.

Rev. 11/10 Discharge Claims – Bill Type 114

Rev. 11/10 The final claim, or discharge claim, must be submitted with a 114 Bill Type and a Patient Status of discharged, expired or transferred (01-08 or 20).

The discharge claims MUST be received no more than 180 days from the previous interim claim. If a discharge claim is not received within 180 days of the pay date on the R/A of the previous claim, all previous payments will be recouped. The claims processing cycle auditing discharge claims runs every 30 days; therefore, some claims outside of the 180 day guideline may not be recouped on the exact 180th day.

Reminders:

- All interim claims must have an Admit Date equal to the From Date of Service.
- First interim claims can only be billed with a Patient Status of 30 (still a patient).
- All discharge claims must be billed with a Bill Type 114 and Discharge Status of 01-08 or 20.
- The only valid Bill Type for first interim claim is 112. The only valid Bill Type for other interim claims is 113.
- Information submitted on replacement claims must reflect all accumulated charges.
- All third party and patient liability amounts must be accumulated amounts for the entire stay.
- Every claim must reflect the appropriate diagnoses and procedures for the entire stay.
- Interim claims must be submitted at least every 180 days and no more than every 60 days.

This claim will pay at the DRG allowable.

Claim 1					
Type of Bill	112	Patient Status	30	Admit Date	070198
FDOS	070198	TDOS	110598		

This claim replaces the previous claim. Payment for Claim 1 is recouped and paid for Claim 2, if appropriate. There are at least 60 days from the TDOS for Claim 1 and the TDOS for Claim 2.

Claim 2					
Type of Bill	113	Patient Status	30	Admit Date	070198
FDOS	070198	TDOS	020199		

This claim will pay at the DRG maximum allowable. Payment for Claim 2 is fully recouped and the claim is replaced and repaid by Claim 3. For claims 2 and 3 in this example, all accumulated charges, third party and patient liabilities, and appropriate diagnoses and procedures entered reflect the entire length of stay.

Claim 3					
Type of Bill	114	Patient Status	01	Admit Date	070198
FDOS	070198	TDOS	040699		

CONDITION CODES (FL 18-28)

Insurance Codes

Insurance Codes		Description
01	Military Services Related	Medical condition incurred during military service.
02	Condition is Employment Related	Patient alleges that medical condition is due to Environment/events resulting from employment.
03	Patient Covered Not Reflected Here	Indicates that patient/patient beyond that reflected on this Bill.
04	Information Only Bill	Bill is submitted for information purposes only.
05	Lien Has Been Filed	Provider has filed legal claim for recovery of funds Potentially due a patient as a result of legal action initiated by or on behalf of patient.
06	ESRD Patient in First Year of Entitlement Covered by Group Health	Indicates Medicaid may be a secondary insurer if the patient is also covered by employer group health insurance during his first year of end stage renal disease entitlement.
41	Partial Hospitalization	Indicates that the claim is for partial hospitalization services.
G0	Distinct Medical Visits	Multiple medical visits occurred on the same day, but the visits were distinct, and constituted independent visits.

Rev.01/01/2014

OCCURRENCE CODES (FL 31-34)

Accident Related Codes		Description
01	Accident/Medical Coverage	Code and corresponding date indicate an accident-related injury for which there is medical payment coverage.
02	Accident/No Fault Insurance	Indicates the date of an accident where state has applicable no fault liability law (i.e., legal basis for settlement without admission or proof or guilt).
03	Accident/Tort Liability	Indicates the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault Liability.
04	Accident/Employment Related	Indicates the date of an accident allegedly relating to the Patient's employment.
05	Accident/No Medical or Liability Coverage	Code and corresponding date indicate that an accident or injury for which there is no medical payment or third-party liability coverage.
06	Crime Victim	Code and corresponding date indicate that the patient's medical condition resulted from an alleged criminal action.

Service Related Codes		Description
11	Onset	Indicates the date of onset of the symptoms or illness. (Must be entered on the UB-04 field immediately preceding the field in which the occurrence code identifying a specific service is entered.
35	Date Treatment Started for PT	Indicates the date that treatment was started by the billing provider.
42	Date of Discharge	Only to be used when "Through' date in Form Locator 22 (Statement Covers Period) is not the actual discharge date and the frequency code in Form Locator 4 is that of a final bill.
44	Date Treatment Started for OT	Indicates the date that treatment was started by the billing provider.
45	Date Treatment Started for ST	Indicates the date that treatment was started by the billing provider.
74	Non-covered	Non-covered Level of Care (LOC)/Leave of Absence (LOA) indicate the date the LOC or LOA started.

Rev. 01/01/08
Rev. 01/01/11

CODING STRUCTURE
FOR
ADMISSION/DISCHARGE HOUR (FL 13 & FL 16)

Code	Time AM	Code	Time PM
00	12:00-12:59 (midnight)	12	12:00-12:59 (noon)
01	01:00-01:59	13	01:00-01:59
02	02:00-02:59	14	02:00-02:59
03	03:00-03:59	15	03:00-03:59
04	04:00-04:59	16	04:00-04:59
05	05:00-05:59	17	05:00-05:59
06	06:00-06:59	18	06:00-06:59
07	07:00-07:59	19	07:00-07:59
08	08:00-08:59	20	08:00-08:59
09	09:00-09:59	21	09:00-09:59
10	10:00-10:59	22	10:00-10:59
11	11:00-11:59	23	11:00-11:59

APPENDIX P

Gainwell Technology

Provider Inquiry Number (Call Center):

- **1-800-766-4456 or (Metro Atlanta) 404-298-1228**

Member Inquiry Number: (Call Center):

- **1-866-211-0950**

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

Confirmation of Medicaid eligibility mail the white copy of the form to:
Gainwell Technology
Attn: Provider Unit
P.O. Box 105200
Tucker, Georgia 30085-5200

Requests for prior approval or questions regarding out-of-state services must be directed to:

- **1-800-766-4456 or (Metro Atlanta) 404-298-1228**

Appendix Q

INDIGENT CARE TRUST FUND (ICTF) PROGRAM

I. Introduction

A. General Information

The Indigent Care Trust Fund (ICTF) program provides funds to certain hospitals to cover all or a portion of the costs of medical services to the medically indigent that, for example, may be uninsured or have accrued medical bills that Medicaid does not cover. The Department of Community Health (Department) is authorized by statute to establish rules that support the purposes for which contributions, deposits and transfers to the ICTF may be made. Chapter 111-3-6 of the Rules of the Department sets forth those rules, which include a provision for the issuance of this Manual.

In this Manual, the Department provides the conditions for participation, policies, procedures, instructions, forms, dispute-resolution procedures, sanction provisions for non-compliance, and other items for use by each eligible hospital in operating programs consistent with the Rules for the ICTF program. In addition to this, the Department's Policies and Procedures for Hospital Services, the Policies and Procedures outlined in Part I for all Medicaid providers shall also apply to each participating hospital.

Funds appropriated or transferred to the Department for the ICTF program only may be used for the following purposes:

(1) To expand Medicaid eligibility and services;

(2) For programs to support rural and other health care providers, primarily hospitals, who serve the medically indigent;

(3) For primary health care programs for medically indigent citizens and children of the state of Georgia; or

(4) Any combination of the above-stated purposes.

Such funds shall be used to match federal funds or any other funds from a public source or charitable organization that are made available for these purposes.

B. ICTF Program Objectives

The objectives of the ICTF program are designed by the Department to guide each participating hospital in the appropriate utilization of funds in accordance with the purposes outlined by the General Assembly. Although this list is not intended to be exhaustive, these program objectives will assist the hospital in formulating and implementing its program for which ICTF payments may be allocated:

(1) To ensure that quality medical services are made available and accessible to patients eligible for Medicaid, Medicare or determined to be medically indigent according to criteria established by the Department.

(2) To support the provision of medical services to medically indigent persons so that they may receive care without charge or at a reduced rate.

(3) To ensure that medically indigent patients receive care in the setting determined by current professional standards to be the most appropriate and cost effective for the treatment of the individual's medical condition.

(4) To ensure that medically indigent patients are not denied medical care or subjected to the under-utilization of medical services.

(5) To reduce significant local health care problems within the hospital's medical service area.

(6) To establish and identify an appropriate and regular source of primary care for medically indigent patients.

(7) To provide services in which evidence of community support and linkage to local health planning is shown.

C. ICTF-Eligible Hospitals

Each hospital that is designated as a Disproportionate Share Hospital (DSH) is eligible to participate in the ICTF program. The hospital must be licensed in Georgia and meet at least one of the criteria established by the Department for designation as a hospital which serves a disproportionate number of low-income patients with special needs.

II. Requirements for Participation in the ICTF Program

Each hospital shall meet the conditions specified by the Department in this Manual in order to begin and continue participation in the ICTF program. Requirements for participation in the ICTF program are divided into the following categories:

- Contractual Obligations
- Conditions for Receipt of ICTF Payment Adjustments
- Free and Reduced-Charge Care
- Public Notification about the ICTF Program
- Financial Reporting
- Hospital's Resolution Process
- Compliance

A. Contractual Obligations

1. **Letter of Agreement**.

Each participating hospital shall execute a Letter of Agreement (or similar form) provided by the Department, which incorporates the provisions of the Rules, the Manual, and the

applicable policies and procedures of the Department. The Letter of Agreement permits the Department to assess liquidated damages against the hospital as follows:

1. In an amount established by the Department for each calendar day in which the hospital fails to comply with the Department's Rules, Policies and Procedures of the Department or this Manual.

   (A.)In an amount not greater than the disproportionate share payment for the year in which the hospital knowingly and willfully makes or causes to be made any false statement or misrepresentation of material fact with respect to:

   a. The use of funds from the Trust Funds by the hospital; or

   b. The response of the hospital to any request for information from the Department related to the Trust Funds, including without limitation the submission of any report required under the Department's Rules, Policies and Procedures or this Manual.

   The assessment of liquidated damages against the hospital shall be in addition to every other remedy available to the Department at law, in equity, by statute or under contract. In its discretion, the Department may also require the hospital to submit a corrective plan of action, if applicable, that demonstrates the hospital's compliance with its contractual obligations.

2. **Intergovernmental Deposits and Transfers**

ICTF payments to hospitals are dependent, in part, on the availability of funds received from intergovernmental deposits and transfers. Under Georgia law, hospital authorities and other governmental or public entities are authorized to make such deposits and transfers to the ICTF. Each year, the Department provides instructions to participating hospitals and affiliated hospital authorities regarding the amount of funds needed and the manner by which funds can be deposited or transferred.

(A.) Conditions for Deposits and Transfers to the ICTF

All moneys that are deposited or transferred to the Trust Fund are irrevocable, and no limitation on the use of the moneys is permitted except as set forth by the Department or the Rules. Hospital authorities, counties, municipalities, or other state or local public or governmental entities may deposit or transfer moneys to the Trust Fund. To facilitate the deposit or transfer, each entity must execute a Letter of Intent to deposit or transfer funds as outlined in Section II.A.5.

3. **Refunds or Returns of Deposits and Transfers to the ICTF**

A. **Inappropriate Deposits and Transfers**. Deposits and transfers to the ICTF that are not properly designated or that do not satisfy the Rules and the contracts, agreements or other instruments with the Department shall be returned to the depositor or transferor with interest earned after payments are collected from the appropriate hospital, except that penalties so transferred to the Trust Fund shall not be refunded.

B. **Hospital Closing.** If a participating hospital closes during the fiscal year in which funds are received, deposits and transfers shall be returned with interest earned pro rata to such hospital, unless the hospital has received a DSH payment for that fiscal year.

C. **Failed or Void Appropriations**. Deposits and transfers to the ICTF and interest earned thereon will be refunded to the entity depositing or transferring if such moneys:

(i) Have not been appropriated by the end of the fiscal year; or

(ii) Have been appropriated but have been determined to be:

(a) A void appropriation in violation of O.C.G.A. 31-8-156;

(b) ineligible for anticipated matching federal funds;

(c) Not contractually obligated at the end of the fiscal year for which they were appropriated;

(d) Subject to return based on any Rule of the Department; or

(e) Void because the Department violated the terms of a contract, agreement or other instrument facilitating transfers to the ICTF. The Department will ensure that any appropriate refunds are made no less than thirty (30) days from the end of the fiscal year or other time determined by the Department as applicable.

B. Conditions for Receipt of ICTF Payment Adjustments

As a condition for receipt of ICTF payments, each participating hospital must:

H. continue participation in the Medicaid program;

- comply with the Department's Rules and the Department's Policies and Procedures, including specifically Part II of the Hospital Services manual including the Appendix Q;
- comply with the Department's requests for reports and verification thereof on the use of the funds from the ICTF;
- use the funds from the ICTF to provide health care services to Medicaid recipients and medically indigent citizens of the state; and
- meet the following additional conditions, if the hospital is a Disproportionate Share Hospital:

1. Continue participation in the Medicare program.

2. Make available medical services to Medicaid and Medicare recipients without discrimination.

3. Provide obstetrical care services if such services are presently provided.

4. Comply with the patient transfer requirements provided in the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986, as amended.

5. Ensure that patients are not transferred or denied services based solely or in significant part on economic reasons.

6. Make arrangements with sufficient numbers of physicians for each service to assure that Medicaid patients have full access to the facility's services without being required to pay physicians for Medicaid covered services.

7. Make arrangements with physicians to ensure Medicaid and medically indigent patients are not required to have a physician with staff privileges as a condition of admission or treatment when such admission or treatment is determined to be medically necessary and within the scope of service capability of the hospital.

8. Document which physicians with staff privileges accept and will treat Medicaid patients in their offices, and assist Medicaid patients with referrals to such physicians. The hospital shall encourage full provider participation in the Medicaid program.

9. Ensure that preadmission deposits are not required on demand as a condition of treatment of Medicaid eligible persons or medically indigent persons.

10. For treatment of medically indigent patients, ensure that inability to pay does not act to deny or substantially delay receipt of medically necessary services. The hospital shall provide assistance to medically indigent patients by operating a program under which patients may receive care without charge or at a reduced charge, as more specifically set forth in this Manual under Section II.D, **Free and Reduced - Charge Care**.

11. Effectively advise the public of the hospital's participation in the program, the availability of services provided, the terms of eligibility for free and reduced charge services, the application process for free and reduced charge services, and the person or office to whom complaints or questions about the hospital's participation in or operation of the program may be directed. Upon request by the Department, the hospital shall provide evidence of its compliance with the public notification requirements of this section. Refer to the subsection in this manual entitled **Public Notification about the ICTF Program**.

12. Submit to the Department a report on the use of ICTF payment adjustments each calendar year. Such reports shall:

    (a) Be in a format established by the Department;

    (b) Be available to the public for examination; and

    (c) Include a report of the number of medically indigent persons served without charge in both inpatient and primary care settings and the dollars expended for such services. Hospitals shall report dollars expended using a cost-to-charges ratio of 65 percent. Over a twelve-month period, each hospital will be expected to report a medical indigence services expenditure of an amount equal to no less than 100 percent of the hospital's total ICTF payment adjustments minus the amount transferred or deposited to the Trust Fund by or on behalf of the hospital.

The following example describes the amount as the medical indigence services requirement to be calculated as follows:

($100 - $40) x 100% = $60

$100 = Total DSH payment adjustment

$40 = Amount transferred or deposited to the Trust Fund by or on behalf of the hospital

$60 = Amount to be reported to the Department as indigence services expenditures

Failure to provide such reports in the format prescribed and within the time periods established by the Department, or to demonstrate timely accessibility to ICTF supported services may result in a withholding or recoupment of ICTF payment adjustments.

13. Complete and fulfill the requirements as more specifically set forth in this Manual under Section II.A, **Contractual Obligations**.

14. For the development and provision of new institutional health services or health care facilities, comply with the rules and requirements of the Certificate of Need program under the Division of Health Planning of the Department, as set forth more specifically in O.C.G.A. Sections 31-6-40 *et seq*., and the annual reporting requirements under O.C.G.A. Section 31-6-70.

D. Free and Reduced-Charge Care

Each disproportionate share hospital must ensure that, for treatment of medically indigent patients, the inability to pay does not act to deny or substantially delay receipt of medically necessary services. The hospital shall provide assistance to medically indigent patients by operating a program under which such patients may receive care without charge or at a reduced charge, except that no hospital shall be required to provide services without charge or at a reduced charge once the hospital's expenditures meet the medical indigence services requirement described on page R-7 subsection II.B (e) 12(c) in this Manual

The Department may approve a plan for the operation of a disproportionate share hospital's program under Rule 111-3-6-.03(4)(e)10 which contains one or more variances from the manual for the purpose of allowing a disproportionate share hospital to coordinate its program with an existing program of care for the medically indigent sponsored by a local government, provided that the program is operated in a manner consistent with these Rules and further provided that no patients are rendered ineligible for serviced without charge or at a reduced charge who would have been eligible if the variance had not been granted. The hospital can mail their request to:

Director of Medical Policy Unit
Division of Medicaid, 37th Floor
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

1. **Eligibility Criteria**

The hospital shall apply standard eligibility criteria for each person requesting free and reduced charge care that enables the hospital to:

(a) Provide services for no charge to persons with incomes below 125 percent of the federal poverty level; and

(b) Provide services for no charge or adopt a sliding fee scale (reduced-charge services) for persons with incomes between 125 and, at a minimum, 200 percent of the federal poverty level.

(c) General instructions for hospital include:

(1) Income:

a. Income is the family unit's gross income. Use either the average monthly income for the previous three months or for the previous year, whichever is more favorable to the applicant. (This is consistent with Hill-Burton uncompensated care regulations.)

b. For self-employed individuals, the amount of income to be counted is gross income minus work expenses directly related to producing the goods or services and without which the goods or services could not be produced.

c. For money received that may be considered as a non-recurring lump sum (insurance settlements, accumulated back RSDI payments, etc.), consider the gross amount received as income in the month received.

d. Temporary Assistance Needy Families (TANF) or Social Security Insurance (SSI) income received by any family member should be excluded.

e. Do not count income from any person who is not financially responsible for the patient. For example, do not count income from one sibling as available to another sibling for purposes of paying medical bills. Likewise, do not count income from any child (minor or adult) in considering eligibility under the ICTF for the child's parent.

(2) Verification of income:

a. You may require reasonable methods of income verification such as pay stubs, award letters, employer statements, income tax returns, etc.

b. The applicant's statement of zero income maybe accepted.

(3) Sliding fee scale:

a. Outline and publish the sliding scale you intend to apply.

(4) Family unit:

a. The family unit consists of individuals living alone; and spouses, parents and their children under age 21 living in the same household.

   A family unit may include minor children living with a legal guardian. The child, legal guardian, and the legal guardian's family unit living in the same household may comprise a family unit.

2. **Program Requirements**

The hospital shall comply with each provision below to implement and maintain its program for free and reduced charge services:

(a) Designate a point of contact within the facility to receive applications and determine eligibility for free and reduced-charge services. Consider the out-stationed eligibility worker assigned to the facility so that individuals also may receive help to apply for Medicaid if appropriate. You must also establish adequate procedures to safeguard confidentiality of patient information.

(b) Provide application forms or an application request sheet in the admissions area, business office, emergency room, and outpatient department so that individuals receiving services at times when the designated office is closed may apply or indicate their intention to apply for assistance.

(c) Apply the eligibility criteria included in this manual.

(d) Accept applications at any time, including after initiation of a collection effort.

(e) For patients applying for Medicaid or other assistance and those attempting to obtain any necessary verification of income, make a determination that they are conditionally eligible for assistance under the ICTF. Adjust the Log of Patient Accounts to reflect the final determination when it is made.

(f) Make determinations of eligibility within 5 working days from the date of application information is complete.

(g) Issue written notices to applicants informing them of the results of the determinations. If an applicant is determined ineligible, include the reasons and the information you relied upon to make the determination.

(h) Include in the notice information on how to be reconsidered if the patient disagrees with the initial decision. Appoint someone different from the person who makes initial determinations of eligibility to reconsider applications.

(i) Issue a written final determination of eligibility. Include the Department's toll-free number 1-877-261-3117 or local 404-463-5827 to call if the applicant still disagrees with the determination you have made.

(j) Maintain and make available for inspection by the Department and members of the public a Log of Patient Accounts, with patient identifying information deleted that is specific to the free and reduced-charge services available at the hospital under the

Trust Fund program. Refer to Page R-32 for the form entitled "Log of Patient Accounts".

(k) Maintain written records and documentation of each application and all notices to applicants for free and reduced-charge services for a minimum period of five (5) years. All such documentation shall be made available to the Department upon request.

3. **Program Limitations**

If the hospital plans to place any limitations on services available under the free and reduced-charge services program, it must obtain written prior approval from the Department for its policy. Upon approval from the Department, the hospital must include information on any such limitations on its signs and on written notices for patients and the public. Limitations that are prohibited and will not be approved by the Department include without limitation:

- Restricting coverage to emergency services only
- Restricting coverage to non-emergency services only
- Restricting coverage in a way that could have the effect of discriminating against a particular group or groups of individuals
- Restricting coverage in a way that could have the effect of discriminating against individuals with particular types of conditions, provided that the needed services are within the scope of those ordinarily provided by the facility
- Geographic limitations

4. **Variances.**

The Department may approve a hospital's plan containing one or more variances from this Manual for the purpose of allowing the hospital to coordinate its program with an existing program of care for the medically indigent sponsored by the local government. The Department will not approve a variance that permits a program to operate in a manner inconsistent with the Rules, nor that renders ineligible those persons who would have been eligible for free or reduced-charge services if the variance had not been granted. For additional information or to request a variance from a requirement of this Manual, contact the Department. Any variance granted by the Department must be approved in writing by the Chief of the Medical Assistance Plans prior to its implementation, and will become part of the Letter of Agreement.

E Public Notification about the ICTF Program

Each hospital is required to give adequate notification to the public regarding services that are hospital must provide forms and instructions to assist those who may be eligible to apply for services. Utilization of the methods listed below is required. The hospital shall provide the Department, upon request, with other methods of public notification that it utilizes.

1. The Notice shall include the following:

   (a) The availability of free and reduced-charge services.

   (b) The patient's ability to gain admittance without pre-admission deposits.

   (c) The right not to be transferred solely or insignificant part for economic reasons.

   (d) The availability of services provided.

   (e) The terms of eligibility for free and reduced-services.

   (f) The application process for free and reduced- charges services.

   (g) The person or office to which complaints or questions about the hospital's participation in or operation of the program may be directed.

2. Publish notices in newspapers of general circulation in the area and distribute notices through other organizations and mechanisms to reach the population in need of free or reduced-charge services.

3. Provide similar individual written notices to each patient potentially eligible for free or reduced charged care under the Trust Fund program. Also, include these notices with bills to the patient. Include in the notice the Department's toll-free telephone number 1-877-261-3117 or local 404-463-5827 for individuals to call if they are unable to resolve any problems they experience with the Trust Fund program at the facility.

4. Place easily readable signs in the emergency room, business office and the admissions area that include the appropriate program information. Refer to page R-23 for a sample sign entitled "Help Getting Health Care Services and Help with Your Hospital Bills" for posting in various areas of the facility.

5. Provide notices in English, Spanish and any other languages as appropriate.

6. Instruct staff to communicate the content of the notices to people who are unable to read and to assist individuals who have difficulty applying for available services.

The hospital's business office staff, social workers and others having contact with patients regarding the payment of bills should receive adequate training about the hospital's ICTF program. The staff shall also make appropriate efforts to refer inpatients and outpatients needing financial assistance to the local county office of the Department of Family and Children Services (DFCS) for Medicaid eligibility determinations.

F. Financial Reporting

The hospital must provide appropriate data to the Department on the use of Trust Funds. The hospital must institute written policies and procedures by which patients are determined to be medically indigent. Adoption of and compliance with this manual shall satisfy the requirement to institute written policies and procedures.

Each participating hospital must submit an annual financial report documenting its expenditures for services to medically indigent patients. A hospital must use the Hospital Financial Survey

form issued by the Division of Health Planning of the Department to report this information and must file the report within the time period specified by the Division.

G. Hospital's Resolution Processes

(1) Free and Reduced-Charge Services. Hospitals in the ICTF program shall inform persons who have been denied free or reduced-charge services under the hospital's ICTF program that they have an opportunity for reconsideration by the hospital. Refer to subsection D in this manual entitled **Free and Reduced- Charge Care**. The hospital shall maintain written evidence verifying that its reconsideration process has been utilized.

Each hospital shall implement and maintain a process that includes the following mechanisms for tracking and documenting requests for reconsideration:

A. Keep an application on file for each person applying for free or reduced-charge services.

B. Issue written notice to the applicant that approves or denies free or reduced-charge services from the hospital within five (5) working days from the date of application information is complete. Notices that deny free or reduced-charge services or that only approve reduced-charge services must include a provision informing the applicant that the request can be reconsidered. The hospital must appoint someone to reconsider applications other than the personnel issuing the original notice. Notices must include specific contact information to hospital personnel. The formats for these notices are included in this manual as follows:

(5) Eligible and approved for free services: Page R-26 (no reconsideration required)

(6) Eligible and approved for reduced-charge services: Page R-27

(7) Ineligible for free or reduced-charge services: Page R-28

C. Issue written notice to the applicant of the hospital's final decision after reconsideration is made by the appropriate hospital personnel. The formats for final notices are included in this manual as follows:

A) Reconsidered and approved for free services: Page R-30 (no reconsideration required)

B) Reconsidered and confirmed original denial of eligibility for free or reduced-charge services: Page R-29

C) Reconsidered and approved for reduced-charge services: Page R-31

(2) **All Other Complaints**. The hospital shall seek to resolve complaints in a timely manner regarding its compliance with the Rules, Policies and Procedures of the Department, including this Manual, or with the maintenance of the hospital's ICTF program as required by the Department.

H. Compliance

1. In the event that a hospital fails to comply with the Rules, the Department's Policies and Procedures or this Appendix Q, the Department may, in addition to any legal remedies, assess liquidated damages against the hospital under its Letter of Agreement in an amount(s) established by the Department for each calendar day in which the hospital is non-compliant. These liquidated damages are not, and shall not be construed to be penalties and shall be in addition to every other remedy now or hereinafter enforceable at law, in equity, by statue, under contract.

2. In the event that a disproportionate share hospital knowingly and willfully makes or causes to be made any false statement or misrepresentation of material fact with respect to the hospital's use of funds from the Trust Fund or in response to any request for information from the Department related to the Trust Fund, including without limitation the submission of any report required pursuant to these Rules, the Department may, in addition to any other legal remedies available, assess liquidated damages against the disproportionate share payment or the year in which the false statement or misrepresentation occurred. These liquidated damages are not, and shall not be construed to be penalties, and shall be in addition to every other remedy now or hereinafter enforceable at law, inequity, by statue, or under contract.

SAMPLE

[Sample sign to be posted in facility. The signs should be printed in large format (at least 14" by 17"). Signs should be placed as specified in the required areas in a prominent spot so that patients can easily read it.]

Assistance Information for Health Care Services or your Hospital Bills:

This hospital participates in the Georgia Indigent Care Trust Fund. As our patient, you receive certain benefits under the Trust Fund.

You have a right to:

- The availability of free and reduced-charge services.
- The ability to gain admittance without pre-admission deposits.
- Not be transferred solely or insignificant part for economic reasons.
- The availability of services provided.
- The terms of eligibility for free and reduced services.
- The application process for free and reduced-charges.
- The person or office to which complaints or questions about the hospital's participation in or operation of the program may be directed.

Help with your hospital bills:

You may be eligible for financial help with your bills for inpatient and outpatient services at this hospital. Under the Trust Fund, we offer a certain amount of free and reduced-charge care each year. Apply at __.

If you have problems:

If you have any concerns about how we operate programs under the Trust Fund rules, please let us try to work with you to resolve them. However, if you are not satisfied with our handling of your situation, you may call the Department of Community Health toll-free at _____, or write to:

_____

SAMPLE

[Sample Individual Notice of Availability for Free or Reduced-Charged Services]

Do you need help with your hospital bill?

If you do not have insurance to cover your hospital bill, and you have low income, you may qualify for help under Georgia's Indigent Care Trust Fund.

This hospital participates in the Georgia Indigent Care Trust Fund. We receive special funding to assist qualified patients with their medical bills. This year we will provide a certain amount of services to patients free or at a reduced charge.

Apply at
(office address and telephone number). We will make a
decision on whether you are eligible within 5 working days. We will give you a written notice of our decision.

The income guidelines are as follows:

Free Services:

Family Size	Income/Mo.
1	
2	
3	
4	
Each additional	

Reduced-Charge Services:

Family Size	Income/Mo.	20%	Income/Mo.	40%	Income/Mo.	60%
1						
2						
3						

4						
Each additional						

SAMPLE

APPLICATION FOR
FREE AND REDUCED-CHARGE SERVICES
UNDER THE ICTF PROGRAM
_____HOSPITAL

Name of patient: Date(s) of service:

Amount of charges: $

Name of applicant: Relationship to patient:
Address:_____

_____

Telephone:_____

Lost member of household, birth date, relationship to patient, and income from each source; state whether income is per week, month, or year:

Name	Birth Date	Relationship	Income (wk/mo/yr)	Income (wk/mo/yr)	Income (wk/mo/yr)	TOTAL INCOME

If income of any member is from self-employment, you may give information on business costs so that we can determine actual income to be counted. Write details on the back of this sheet.

(Note to applicant: You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size. For example, if you have a brother or sister who lives with you, that person is not responsible for paying your medical bills, and would not have to be counted or report income.)

Signature of Applicant: _____
Date: _____

For Hospital Staff Use:

NUMBER COUNTED IN HOUSEHOLD: _____ _____

TOTAL COUNTABLE INCOME:
(Average monthly income for last year or past 3 months, whichever is more favorable.)
Verification of income supplied (if requested)? Yes _____ No _____
Determination: Eligible for free services _____ _____
Conditional?

Pending:

_____
Eligible for discount
Ineligible _____

_____ _____ _____ _____

Reason:
(%)
Conditional?

Pending:

_____

Date notice mailed: Date: _____ _____
Staff Signature: ___
Reconsideration: Result:
_____ Date: _____

SAMPLE

[Letter to applicant with income below 125% of poverty who qualifies for ICTF Funding]

[Hospital letterhead]

Date

Name of applicant
Address

Patient account number

Dear

Thank you for your application for assistance with your hospital bills under the Georgia Indigent Care Trust Fund. We are pleased to tell you that you are eligible for free services because of your income. We are therefore writing off a hospital bill of [$] for services received by [name of patient] on [date(s)]. You should not receive any further bills from us for these services. Please call if you have any questions.

Sincerely,

Name
Title, Telephone

[For hospital without physicians who are on salary at the facility or who have agreed to treat patients without charge, add the note below.]

Note: If you received services from physicians not employed by this hospital, you may receive bills for treatment they provided to you unless you have made arrangements with them.

SAMPLE

[Letter to applicant with income between 125% and 200% of poverty who qualifies for reduced price services]

[Hospital letterhead]

Date

Name of applicant
Address

Patient account number

Dear

Thank you for your application for assistance with your hospital bills under the Georgia Indigent Care Trust Fund. We are pleased to tell you that you are eligible for reduced charge services because of your income.

We have determined that your income is [$ per] for your family size of [#], which qualifies you to pay only [%] of our usual charge. A hospital bill of [$] for services received by [name of patient] on [date(s)] is being reduced to [$]. We will contact you about arrangements for payment on this bill. We will send you a detailed bill if you request it.

Please call _____ at

If you have any questions. If you disagree _____ with this decision and believe that you should qualify for a further reduction in your payment, you may ask for another review of your application. Please contact [person / office / telephone number].

Sincerely,

Name
Title, Telephone

[For hospitals without physicians who are on salary at the facility or who have agreed to treat patients without charge, add the note below:]

Note. If you received services from physicians not employed by this hospital, you may receive bills for treatment they provided to you unless you have made arrangements with them.

SAMPLE

[Letter to applicant determined ineligible for free or reduced-charge services]

[Hospital letterhead]

Date

Name of applicant
Address

Patient account number

Dear

Thank you for your application for assistance with your hospital bills under the Georgia Indigent Care Trust Fund. We are sorry to tell you that we have determined that you are not eligible for free services or a reduction in our charges based on your income.

We have determined that your income of [$ per] for your family size of [#] is more than the limit of [amount that is 200% of the federal level for this family size].

If you disagree with this decision and believe that you should qualify for free services or a reduction in your payment, you may ask for another review of your application. Please contact [person/office/telephone number].

Sincerely,

Name
Title, Telephone

SAMPLE

[Letter to applicant after reconsideration - no change in decision]

[Hospital letterhead]

Date

Name of applicant
Address

Patient account number

Dear

We have reconsidered our original decision on your application for assistance with your hospital bills under the Georgia Indigent Care Trust Fund. We are sorry to tell you that we still find that you are not eligible for free services or a reduction in our charges based on your income.

We have determined that your income of [$ per] for your family size of [#] is more than the limit of [amount that is 200% of the federal poverty level for this family size].

If you still disagree with this decision and believe you should qualify for free services or a reduction in your payment, you may contact the Department of Community Health by writing to the address below or by calling local 404-463-5827 or toll-free 1-877-261-3117

Indigent Care Trust Fund
Medical Policy Unit, Hospital Services
Division of Medicaid
2 Peachtree Street, NW, 37th Floor
Atlanta, Georgia 30303-3159

You may be eligible for free legal assistance. You may contact your local office of Georgia Legal Services or Atlanta Legal Aid.

Sincerely,

Name
Title, Telephone

SAMPLE

[Letter to applicant after reconsideration --
Change in decision to free care eligibility]

[Hospital letterhead]

Date

Name of applicant
Address

Patient account number

Dear

We have reconsidered our original decision on your application for assistance with your hospital bills under the Georgia Indigent Care Trust Fund. We are pleased to tell you that you are eligible for free services because of your income. We are therefore writing off the hospital bill of [$] for services received by [name of patient] on [date(s)]. Please call _____ if you have any questions.

Sincerely,

Name
Title, Telephone

[For hospitals without physicians who are on salary at the facility or who have agreed to treat patients without charge, add the note below:]

Note: If you received services from physicians not employed by this hospital, you may receive bills for treatment they provided to you unless you have made arrangements with them.

SAMPLE

[Letter to applicant after reconsideration -
Change in decision to reduced charge eligibility]

[Hospital letterhead]

Date

Name of applicant
Address

Patient account number

Dear

We have reconsidered our original decision on your application for assistance with your hospital bills under the Georgia Indigent Care Trust Fund. We are pleased to tell you that you are eligible for reduced charges for our hospital services based on your income.

We have determined that your income of [$ per] for your family size of [#] qualifies you to pay only [%] of our usual charge. A hospital bill of [$] for services received by [name of patient] on [date(s)] is being reduced to [$]. We will contact you about arrangements for payment on this bill. We will send you a detailed bill if you request it.

Please call _____ at

if you have any questions. If you still _____
disagree with this decision and believe that you should qualify for free services or a further reduction in your payment, you may contact the Department of Community Health by writing to the address below or by calling local 404-463-5827 or toll-free 1-877-261-3117.

Indigent Care Trust Fund
Medical Policy Unit, Hospital Services
Division of Medicaid
2 Peachtree Street, NW, 37th Floor
Atlanta, Georgia 30303-3159

You may be eligible for free legal assistance. You may contact your local office of Georgia Legal Services or Atlanta Legal Aid.

Sincerely,

Name
Title, Telephone

[For hospitals without physicians who are on salary at the facility or who have agreed to treat patients without charge, add the note below:]

Note: If you received services from physicians not employed at the facility by this hospital, you may receive bills for treatment they provided to you unless you have made arrangements with them.

Log of Patient Accounts											
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Patient Name or Acct. No	Date(s) of Application	Date Eligibility Determined	Eligible (E) or Conditionally Eligible (CE)	Date of Application	Annual Family Income	Family Size	Total Charges ($)	3rd Party Payment ($)	Pt. Liability if income 125-200% of poverty ($)	Uncompensated Service ($) (Col.8 minus Cols. 9 & 10	Total $ Reportable (Col. 10 x .65)

TOTAL REPORTABLE UNCOMPENSATED SERVICES FROM COLUMN 12: $_____

Year _____ Page _____ of _____

APPENDIX R

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/GeorgiaMedicaid	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 due to moral or religious objections • PCP moves, retires, etc.	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.

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 S

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

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

Amerigroup is responsible, through its provider network, for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 3600SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

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

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

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

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

APPENDIX T

LIST OF CMS' 28 NEVER EVENTS

A. Surgery or other invasive procedure performed on the wrong site

B. Surgery or other invasive procedure performed on the wrong patient

C. Wrong surgical or other invasive procedure performed on a patient

D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure

E. Intraoperative or immediately postoperative/ post-procedure death in an ASA Class 1 patient

2. Product or Device Events

A Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting

B Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended

C Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

3. Patient Protection Events

A Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person

B Patient death or serious injury associated with patient elopement (disappearance)

C Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting

4. Care Management Events

A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)

B Patient death or serious injury associated with unsafe administration of blood products

C Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting

D Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy

E Patient death or serious injury associated with a fall while being cared for in a healthcare setting

F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting

G. Artificial insemination with the wrong donor sperm or wrong egg

H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen

I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

5. Environmental Events

A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting

B Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances

C Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting

D Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

6. Radiologic Events

A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

7. Potential Criminal Events

A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider

B. Abduction of a patient/resident of any age

C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting

D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

APPENDIX U

PROVIDER PREVENTABLE CONDITIONS, NEVER EVENTS, and HOSPITAL ACQUIRED CONDITIONS

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

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

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

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

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

APPENDIX V

Early Elective Deliveries (EED) and Elective Inductions Policy

Effective October 1, 2013, the Medicaid Division within the Department of Community Health changed its benefit coverage for non-medically necessary cesarean deliveries prior to 39 weeks gestation. Claims submitted for ANY labor inductions or cesarean sections on or before 39 weeks gestation that are not properly documented as medically necessary will be denied in the Georgia Medicaid Management System (GAMMIS). Gainwell Technology's current MMIS will be updated later for claims processing of this benefit coverage for early elective deliveries (EED) including non-medically necessary cesarean deliveries and early inductions. This policy was approved as a mandate by the 2013 Georgia legislature in Georgia's SFY 2014 budget bill.

Hospital UB 04 Claims

There are no proposed changes to the current billing process of inpatient claims for induction/delivery services when processed through the claims adjudication process for payment. Hospitals are strongly encouraged to collaborate with their physicians privileged to provide obstetric services in order to develop guidelines and protocols (i.e., a scheduling protocol or Hard Stop Policy and/or establish documentation standards) for deliveries prior to 39 weeks gestation. Hospitals are also encouraged to enforce those guidelines and protocols.

Professional 1500 Claims

Practitioners are to continue billing obstetric procedure codes on their professional 1500 claim forms for payment: 59400, 59409, 59410, 59514, 59510, 59515, 59610, 59612, 59614, 59618, 59620, and 59622, along with one of the three (3) modifiers (UB, UC, or UD) appended to the billed delivery procedure code. GAMMIS will be configured with system edit(s) for the delivery claims that do not append one of the required EED modifier and/or that do not meet the approved guidelines of billing certain clinical indications. Delivery claims that are submitted with medical conditions that do not warrant an exception prior to 39 weeks gestation will post the EED edit requiring medical review by our state's peer review organization, Georgia Medical Care Foundation (GMCF). Clinical justification and the proper documentation must be submitted to GMCF for review of the denied obstetric delivery claim. Also, **ALL Medicaid practitioners' claims for elective inductions/C-sections must include EITHER the last menstrual period (LMP) or the estimated date of confinement (EDC) or the estimated delivery date (EDD) in field locator 14 of the CMS 1500 paper/electronic form.**

Delivery Modifiers for Professional 1500 Claims

One of the following modifiers is required when billing obstetric services for payment:

UB—Medically-necessary delivery prior to 39 weeks of gestation

- For deliveries resulting from members presenting in labor, or at risk of labor, and subsequently delivering before 39 weeks, or
- For inductions or cesarean sections that meet the ACOG or approved medically necessary guidelines, the appropriate ACOG Patient Safety Checklist must be completed and maintained for documentation in the GA enrolled member's file, or

- For inductions or cesarean sections that do not meet the ACOG or approved guidelines, the appropriate ACOG Patient Safety Checklist must be completed. Additionally, the enrolled provider must obtain approval from the state's peer review organization, Georgia Medical Care Foundation (GMCF), and maintain this checklist in the enrolled member's file. The practitioner must submit to GMCF the clinical justification and documentation for review along with the Patient Safety Checklist.

UC—Delivery at 39 weeks of gestation or later

- For all deliveries at 39 weeks gestation or more regardless of method (induction, cesarean section or spontaneous labor).

UD—Non-medically necessary delivery prior to 39 weeks of gestation (Elective non-medically necessary deliveries less than 39 weeks gestation)

- For deliveries less than 39 weeks gestation that do not meet ACOG or approved guidelines or are not approved by the Georgia Medical Care Foundation as medically necessary with clinical justification. Examples of unacceptable medical reasons include patient choice, physician going out of town, history of a fast labor, etc.

NOTE: Obstetric delivery claims that are submitted without one of the required modifiers listed above will be denied. To avoid claim denials, the two-digit modifier is required whenever billable obstetrical procedure codes are submitted for payment either for vaginal deliveries or cesarean sections.

Documentation Requirements

Providers should utilize medical standards before performing cesarean sections, labor inductions, or any delivery following labor induction. The documents required for peer review are the member's history and physical, admission notes for the delivery, operative report, if applicable, for cesarean sections, physician progress notes, labor and delivery report, discharge summary, and the ACOG Patient Safety Checklist or an appropriate checklist that meets national guidelines. There are medically necessary conditions that may warrant clinical justification with the proper documentation for an early induction or cesarean section (refer to links in references) for some approved exceptions of medical conditions for deliveries prior to 39 weeks. The list of conditions is not meant to be exclusive.

References

http://www.acog.org/~/media/Patient%20Safety%20Checklists/psc005.pdf?dmc=1&ts=20130911T1426455280 (Scheduling Induction of Labor Checklist)

http://www.acog.org/~/media/Patient%20Safety%20Checklists/psc003.pdf?dmc=1&ts=20130911T1426455290 (Scheduling Planned Cesarean Delivery Checklist)

https://manual.jointcommission.org/releases/TJC2013A/AppendixATJC.html#Table_Number_11_07_Conditions_Po (Joint Commission Conditions)

Appendix W

Screening, Brief Intervention, and Referral of Treatment (SBIRT) Services
On July 1, 2017, SBIRT services codes were opened and allowed for reimbursement from Georgia Medicaid. SBIRT is an evidence-based approach to identifying individuals who use alcohol and other drugs at risky levels and providing intervention before more serious long term effects occur. The goal is to reduce and prevent related health consequences, disease, accidents and injuries.
Why SBIRT?

- Provides for uniformity/consistency of language, questions, and methods.
- More than twenty years of research supports screening and brief intervention as effective approaches in reducing substance use.
- The majority of U.S. states use SBIRT and are having positive results. Georgia covers the SBIRT codes effective July 1, 2017 in listed categories of services below.
- Early intervention results in decreased long term, intensive substance abuse services which saves lives and money.
- Used by paraprofessionals as well as clinicians, SBIRT is non-confrontational and positive and can be utilized in multiple settings.
- States like Wisconsin and Texas have built on its clinical success and have demonstrated its cost-effectiveness, reducing hospital costs and emergency room visits.
- The SBIRT screening tool has been successfully implemented during a five-year pilot project in two hospitals in Georgia, resulting in a decrease in substance use among participants.

The SBIRT procedure codes are open in GAMMIS in the following areas:

010	Inpatient Hospital	070	Outpatient Hospital
080	Swingbed	200	Home Health
430	Physician	431	Physician Assistant
740	Adv. Nurse Practitioners		

Procedure Codes	Definition	Time	Reimbursement
99408	Alcohol and/or substance abuse structured screening and brief intervention services:	15-30 Minutes	$33.41
99409	Alcohol and/or substance abuse structured screening and brief intervention services:	greater than 30 Minutes	$65.51

These services may be provided by the following practitioner levels:

- Physicians
- Physician Extenders
- Advanced Nurse Practitioners

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(Refer to the Part 1 Medicaid and Peachcare for Kids Manual, Appendix J, and ICD-10 Overview policy).