

Medicaid Secondary Claims User Guide



Georgia Department of Community Health

April 1, 2023

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added D=Deleted M=Modified	(Revision required by Regulation, Legislation, etc.)
None	N/A	No updates for April 1, 2023		
1/2023	Chapter 1, Pg. 13, Pg. 14,	Removed reference to PES (Provider Electronic Solution).	M, D	
1/2023	Chapter 4, Pg. 21	Removed reference to PES (Provider Electronic Solution).	M, D	
7/2021	Pg. 28	Peach State and WellCare Merger (WellCare Removed)	M, D	

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Overview

The purpose of this guide is to assist Georgia Medicaid Fee-For-Service providers with submitting Medicaid secondary claims. A Medicaid secondary claim is a claim where there is potentially another payer with primary responsibility for payment. The guide accompanies Part I Policies and Procedure Manual, primarily chapter 300.

NOTE: Billing for members who are enrolled in a Care Management Organization (CMO) must follow the billing requirements of the member's CMO. The policies in this guide do not apply to members in a CMO.

Provider Access to Georgia Medicaid Forms

Providers can access any of the forms that are needed by going to the Georgia Medicaid Provider Portal. Find the menu at the top of the Provider Portal. Select “Provider Information”. From the Provider Information menu, select “Forms” to access the listing of forms available for the provider community. Click on the form name to view and/or print the form.

Some of the procedures covered in the guide are how to:

-  Complete an Adjustment Request Form (DMA-501) for Crossovers and COB
-  Complete a COB Notification Form (DMA-410)
-  Complete a Medicare Notification Form (DMA-460)
-  Complete a Coordination of Benefits/Third Party Liability Accident Information Form (DMA-312) via the web portal.
-  Correctly submitted claim attachments

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CHAPTER 1

INTRODUCTION

WHAT IS COORDINATION OF BENEFITS (COB)?

By federal law, Medicaid is the “payer of last resort” in most circumstances. Medicaid considers payment on a claim after a third party resource is billed. A third party resource is any individual, entity or program that is or may be liable for payment of part or all of the expenses for medical care furnished to a Medicaid member. It is the obligation of any legally liable third party other than Medicaid or the member to pay the primary cost of the member’s medical care. COB is the process of determining the primary payer.

When an individual applies for Medicaid in Georgia he/she automatically assign his/her rights to medical payments from a third party resource to the Department of Community Health (DCH).

Third party resources for members generally come from two sources:

- COB (commercial, individual and group health plans; government sponsored plans such as Tri-care; supplemental policies; casualty related coverage’s; Federal Employees Health Benefit Plan (FEHBP); and Workmen’s Compensation; to name a few); and
- Medicare Part A, B and/or C.

Pricing and processing methodologies for these two types of claims are very different.

Since Medicaid is most often the “payer of last resort”, providers must, with limited exceptions, submit an initial claim for reimbursement of services to the member’s primary plan (See NOTE below). Once the primary plan processes the claim, providers can submit a claim to Medicaid with information showing how the primary plan processed the claim. The claim processing information from the primary plan is usually provided on an Explanation of Benefits (EOB) form or, for Medicare, on an Explanation of Medicare Benefits (EOMB) form. Medicaid will coordinate the primary plan’s payment, if any, with the Medicaid maximum allowable amount for the service. If the primary plan paid more than the Medicaid maximum allowable amount, no additional payment will be made by Medicaid. If the primary plan paid less, in most cases Medicaid will pay the difference.

Rev. 10/19

NOTE: Providers are not *required* to initially file claims with the primary insurance carrier if the services are for preventive and pediatric care services under the Health Check program (also known as EPSDT).

However, providers may choose to bill the primary plan initially for these types of services.

WHEN SHOULD I SUBMIT A COB CLAIM?

Filing a Medicaid/PeachCare for Kids Claim

When a member has other insurance coverage that is potentially legally liable for payment of a claim, a COB claim is *usually* required prior to billing Medicaid. A COB claim submitted to Medicaid will be processed in one of two ways: cost avoid or pay-and-chase.

Cost avoid – Requires providers to bill the primary payer before billing Medicaid. If a COB claim is required to cost avoid, Medicaid will deny the claim until the primary payer processing information is included on the claim.

Pay-and-chase – This method of claims processing is limited to certain claims. Claims that pay-and-chase are claims for preventive and pediatric services under Health Check (formerly EPSDT). For these claims, Medicaid processes the member's medical claim and then attempts to recover from the liable third party. Thus, providers are allowed to bill Medicaid first and then *Medicaid, not the provider*, will seek reimbursement from the primary payer. If a provider chooses to bill Medicaid for these services instead of the primary payer, the provider must *not* bill the third party resource/primary payer if Medicaid pays the claim. *NOTE:* Even though Medicaid will pay these claims initially, Medicaid *is not* the primary payer on these charges. Medicaid will pay the maximum allowable amount and then Medicaid will bill the primary payer for reimbursement of the payments for the services.

Identification of Other Insurance

Providers must make reasonable efforts to collect funds from any insurance/benefit plan that is the primary payer to Medicaid. Reasonable efforts include, but are not limited to:

- Questioning the member to identify any other insurance so that a claim to the primary payer can be filed;
- Checking www.mmis.georgia.gov (GHP) Web site for insurance coverage on the member so that a claim to the primary payer can be filed;
- Questioning the member regarding any updates to the coverage(s) shown on www.mmis.georgia.gov Web site;
- Filing a claim with the known primary insurance(s) prior to filing with Medicaid.
- The discount amount reported on the EOB from the primary payer

HOW ARE COB CLAIMS REIMBURSED?

DCH takes into account many factors when determining the amount of payment on a Medicaid COB claim. Factors include, but are not limited to:

- the payment amount from a primary payer,
- The Medicaid maximum allowable amount for a specific covered service.
- the discount amount reported on the EOB from the primary payer

Rev. 04/10

Medicaid Reimbursement When another Insurer's Payment is involved

Any items or services for which another insurance carrier's reimbursement amount is equal to or greater than the Medicaid maximum allowable amount will be paid at zero by Medicaid. Claims that "pay" at zero are considered to be paid claims, not denied claims.

When the payment from another insurance carrier is less than the Medicaid maximum allowable amount, Medicaid can pay up to the Medicaid maximum allowable amount. The sum of the Medicaid payment and the other insurance payment(s) will not exceed the Medicaid maximum allowable amount.

Medicaid will *consider* making full payment for a covered service(s) when the primary insurance carrier denies payment for any reason or when there is no payment by the primary carrier because of the member's coinsurance and/or deductible. Full payment means an amount up to the Medicaid maximum allowable amount. The reason for the primary insurance carrier denial or non-payment is part of the consideration of payment by Medicaid.

When a Managed Care Plan is the Primary Insurer

- It is a member's responsibility to remain abreast of the physicians, pharmacies, hospitals and other providers who participate in his or her managed care plan. When a member's claim is denied by the managed care plan for failure to comply with the rules, policies, and procedures of the plan, the member, not DCH, is responsible for payment to the provider. Providers should inform members if they are not a network provider in the member's managed care plan.

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- Some services denied by a primary managed care plan may be paid by Medicaid up to the Medicaid maximum allowable amount. Whether or not Medicaid will pay depends on the reason for the denial by the primary plan. Examples of services denied by the primary payer that Medicaid may pay include, but are not limited to, the following situations:
 - Have provisions that allow Medicaid to cover the service when the primary plan will not pay. Claims denied by the primary plan because of a recommendation unique to Medicaid may be covered by Medicaid; however, the service must be a Medicaid covered service in order for Medicaid to pay.
 - The primary plan does not provide appropriate services. For example, a child needs pediatric therapy services, but the plan does not have a network

- pediatric therapist and a network adult therapist does not have the specific skills needed to provide the therapy. This forces the member to go out-of-network to receive the appropriate care. If the primary plan will not pay the out-of-network pediatric therapist, Medicaid will consider payment.
- The member's annual or lifetime service limitations have been exhausted so the primary plan will not pay.

Tort/Casualty (Personal Injury) Liability

In certain situations, the cause of a member's medical condition may invoke a third party's legal liability. These situations might include, but is not limited to injuries resulting from an automobile accident, injuries suffered on-the-job, medical malpractice, or "slip and fall" injuries. In such situations and pursuant to O.C.G.A §49-4-148, DCH is subrogated or substituted for the member or his/her representative's right to recovery against the person or entity legally liable for the injury and subsequent treatment of the member (i.e., the Department has the right to recover any Medicaid payments from settlement awards).

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

- 1) Filing claims with Medicaid and subsequently billing the third party carrier (or the member) for the same service, even if the provider refunds Medicaid; and
- 2) Billing Medicaid, the third party carrier, or member for the difference between the amounts Medicaid has paid and the amount the provider charged.

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

If a provider chooses not to initially bill Medicaid, the provider may submit a DMA-312 "Coordination of Benefits/Third Party Liability Accident Information online form," within six (6) months of the date of service to request an extension within the timely filing limits, if necessary in order to pursue the liable third party. By completing and submitting the online DMA-312 form, an extension of 12 months may be granted if the submitted form is approved.

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

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

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

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

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

If the DMA-312 form is returned to a provider for additional information, the provider must complete the unanswered questions on the form and resubmit to DCH online via the web portal.

Approval of the DMA-312 form grants the requesting provider an additional twelve (12) months in which to file their Medicaid claim. This extension will not exceed twenty four (24) months from the month of service for tort related claims.

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

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

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

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

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

To access the online DMA-312 form, you must log into the Georgia Medicaid Management information system (GAMMIS) web portal at www.mmis.georgia.gov using your username and password. The online DMA-312 form is located under the TPL.

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

MEDICARE

What is Medicare?

Medicare is a federal health insurance program for:

- People age 65 or older.
- People under age 65 with certain disabilities, and
- People of all ages with End-Stage Renal Disease (ESRD).

Original Medicare has two parts: Part A and Part B

- Part A (Hospital Insurance) – Included services are Hospital Inpatient care, Hospice, Skilled Nursing Facility and blood pints.
- Part B (Medical Insurance) - Included services are Outpatient Services provided in a doctors' office, outpatient facility or inpatient facility.

Medicare Advantage plans / Medicare Part C: This combines parts Part A and Part B and sometimes the Medicare prescription program (Medicare Part D).

- These plans cover the same benefit as the Original Medicare plans; however, they are administered by private health insurance payers.
- Some of these plans offer additional services beyond what the Original Medicare plans offer.
- These claims do not automatically cross-over to Medicaid; the provider must submit the claim to Medicaid.

WHAT IS A CROSSOVER?

A crossover (x-over) claim is any claim that is approved by Medicare and then forwarded or sent to Medicaid for consideration of payment not to exceed the sum of the Medicare deductible, co-payment and/or coinsurance. There are three very important implications made by this definition.

1. The claim must be *approved by Medicare* in order to be considered a crossover claim. "Approved" means that the charges are covered by the Medicare program, are provided by an appropriately enrolled Medicare provider, and are provided to a Medicare entitled beneficiary. "Approved" does not necessarily mean paid; sometimes all of the charges *approved* by Medicare are applied to the deductible. In these situations, the claim is approved, but no payment is made by Medicare. ***It is important to remember that claims that are not approved by Medicare, in other words, denied claims, are not crossover claims.*** If a member is Qualified Medicare Beneficiary (QMB) (aid categories 460 or 660) and Medicare denies the claim, *do not* bill Medicaid. QMB members are only eligible for crossover claims.
2. The claim must be sent to Medicaid. There are two ways this can occur: Medicare's Coordination of Benefits Contractor (COBC) can automatically send the claim to Medicaid (called an auto-crossover claim) or the provider can file a crossover claim through the GAMMIS web portal at www.mmis.georgia.gov or electronic that includes the Medicare payment information.

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3. The receipt of a crossover claim by Medicaid does not mean that Medicaid will make a payment on the claim. If Medicaid approves the claim, a payment of the sum of the coinsurance and deductible may be made *up to the Medicaid maximum allowable amount* for the provider type and/or procedure code. If the Medicare payment on a claim is equal to or greater than the Medicaid maximum allowable amount, Medicaid will not pay anything on the claim, but the claim will still be a paid Medicaid claim.

NOTE: Effective for dates of service on and after May 11, 2012, payments for Medicare coinsurance and deductible obligations for dual eligible Medicare/Medicaid members, including Qualified Medicare Beneficiaries (QMB), will be limited to the Medicaid maximum allowable amount.

Medicare Crossover Claims - Helpful Information

Providers should bill Medicaid in the same manner in which they bill Medicare. Do not change any codes to match the Medicaid requirements. The system has been adapted to Medicare's coding for crossover claims.

Providers identified in the Department's external audits, who repeatedly change their crossover claims to match Medicaid billing requirements may be subject to adverse action by the Department (i.e. changes made or additions made to a detail line billing or changed value codes, changed provider ID numbers or changed procedure codes or any changes made on a COBRA/COBA claim).

Exceptions:

- Medicaid **does** require National Drug Codes (NDC's) for outpatient injectable drugs. Medicare **does not** require NDC codes for outpatient services

Medicare Part D Plan

Georgia Medicaid members are automatically enrolled in a Medicare Part D plan for prescription drug coverage. Medicaid does not pay any cost share amounts for Part D plans so Part D claims do not crossover to Medicaid.

Medicare Part A, B and C Plans

Medicaid pays the Medicare medical cost share portion for members enrolled in a Part A, B and C plan up to the Medicaid maximum allowable amount for that service or procedure. The member is still responsible for the Georgia *Medicaid* co-payment amount, where applicable. Exceptions:

- Members who live in a long-term care nursing facility and are enrolled in Medicare Part D *and* Medicaid, but do not have a Medicaid co-payment.

MEDICARE COVERED SERVICES

Part A Medicare covered services that Medicaid *also* covers:

- semiprivate room

- meals
- regular nursing services
- rehabilitation services
- drugs
- medical supplies
- lab tests
- x-rays
- operating room
- recovery room
- intensive care
- coronary care
- blood pints
- medically necessary services and supplies

Part A Medicare covered services that Medicaid *does not* cover:

- telephone
- television
- private duty nurses
- amount between a semiprivate and private room rate unless it is medically necessary

Part B Medicare covered services:

- doctor services (including surgery) provided at a hospital, a doctor's office, or home
- mammograms, pelvic exams, bone density tests, and PAP smears for women
- an annual flu shot
- a one-time physical exam (called a "wellness exam") done within six months of the patient's enrollment date for Medicare Part B
- medical services provided by nurses, surgical assistants, or laboratory or X-ray technicians
- outpatient hospital treatment, such as emergency room or clinic charges, X-rays, injections, and lab work an ambulance, if required for a trip to or from a hospital or skilled nursing facility
- drugs or other medicine administered at a hospital or doctor's office medical equipment and supplies, such as splints, casts, prosthetic devices, body braces, heart pacemakers, corrective lenses after a cataract operation, glucose monitoring equipment, therapeutic shoes for diabetics, and equipment (such as ventilators, wheelchairs and hospital beds)
- some types of oral surgery
- some costs for outpatient physical and speech therapy
- a limited number of services by podiatrists and optometrists
- some care and counseling by psychologists, social workers, and daycare personnel

- some preventative screening exams if the doctor says the patient is at risk
- manipulation of out-of-place vertebrae by a chiropractor
- Alzheimer's-related treatments
- scientifically proven obesity therapies and treatments, and
- Part-time skilled nursing care, physical therapy, and speech therapy provided in your home.
- Ancillary services for inpatient hospital care

Medicare Payment Guidelines

The original Fee-for-Service Medicare Part A:

- For Skilled Nursing Care, Medicare pays for the first 20 days if the patient goes directly from the hospital to the skilled nursing care facility. Medicare will pay a portion of the care for the 21st through the 100th day. Medicare will not pay any benefit after the 100th day.
- For Inpatient Hospital Care during the first 60 days, Medicare will pay all covered costs except the deductible. For days 61 – 150, Medicare pays a set dollar amount.

After the 150th day, Medicare will not pay any of the costs. Bill Medicaid for any costs that Medicare does not pay.

- For Dually eligible members utilizing their Medicare benefits in a nursing home, Medicare should be the primary payer until the Member no longer meets the requirements of skilled services under the Medicare guideline.

The original Medicare Part B:

Pays only 80% of approved charges; Medicaid will pay the remaining 20% (coinsurance) up to Medicaid's maximum allowable amount for the service. Medicare pays 50% of outpatient psychiatric care.

Medicare Advantage Plans (MAP), Part C:

Previously known as Part C or Medicare Health Maintenance Organizations (HMO's), these Medicare replacement plans now include several different types of plans including HMO's, Preferred Provider Organizations (PPO's) or private fee-for-service (FFS) plans with a variety of co-payments and benefit packages. Plans vary so the allowed services and payments for each plan will not always be the same. Medicaid will pay eligible cost share amounts up to the Medicaid maximum allowable amount for the service.

Negative Paid Medicare Crossover Claims:

Medicare crossover claims with a negative Medicare paid amount will not be reimbursed by GA Medicaid.

CROSSOVER BILLING CONSIDERATIONS:

- Crossover claims must be received by the Department within 12 months of the month of service.
- Medicaid providers must accept Medicare assignment in order to submit claims to Medicaid for consideration of payment.
- Medicare denied claims: File a Medicare claim that was denied by Medicare via the web portal (www.gammis.com) or EDI as a Medicaid claim and attach the Medicare denial or the DMA 460. The claim is not a crossover since Medicare denied the charges, which changes the timely filing limitation from 12 months to 6 months from the month of service or 3 months from the of denial whichever is the later. NOTE: Medicare denied claims are straight Medicaid claims, *not* crossovers. All Medicaid billing requirements must be followed.

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Claims submitted to Medicare Carriers or Fiscal Intermediaries will be forwarded to the Department's Third Party Administrator by automatic transfer via the COBC. When claims automatically crossover to Medicaid, providers do not have to submit a Medicaid secondary claim to the Department. Medicare identifies claims selected for automatic crossover from eligibility files that Medicaid forwards to the COBC monthly. The provider's Medicare number must be on file with the Department and associated with only one Medicaid location in order for the automatic crossover of claims to occur. If the Remittance Advice (RA) indicates Remark Code "MA07", the claim has been forwarded to (crossover) Medicaid for adjudication. If the forwarded claims is not processed by the Department within forty-five (45) days from the receipt of Medicare payment, a claim may be submitted directly to the Department's third party administrator via the GAMMIS web portal at www.mmis.georgia.gov or electronic). NOTE: There is no 45 day waiting period if the RA does not show the MA07.

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Claims will not crossover automatically if any of the following situations exist:

- The Medicare rendering provider number is not on file with the Department or is not associated with an active Medicaid provider number;
- The Medicare provider number is associated with more than one Medicaid location - it can only be associated with one. If you use your Medicare ID# when billing for multiple locations, you must choose one Medicaid location for all your crossover claims;
- The member was not listed on the eligibility file sent to Medicare for the month the claims were processed;
- The provider did not include the beneficiary's Medicaid ID number when billing Medicare;
- The provider did not correctly show Medicaid as the secondary payer;
- Medicare denied the claim;
- The member is enrolled in MAP- The DMA-460 is also an acceptable attachment for

these claims, but do not use both on the same claim.

- When Medicare adjusts a Medicare claim, the adjusted claim does not automatically crossover. Thus, when Medicare adjusts a claim and Medicaid has *not yet paid* on it, submit a claim to Medicaid using the adjusted EOMB information. If Medicaid *has already paid* on the claim that Medicare adjusted, submit an Adjustment Request Form, DMA-501, to Medicaid using the new Medicare payment information. See Part I of the Policies and Procedures Manual, for additional information on adjustments; and
- Medicaid is the tertiary payer: Another insurer/third party made a payment on the claim. Medicare is primary, the other insurer/payer is secondary, and Medicaid is tertiary.

Medicare Eligibility Discrepancies

Occasionally a member will be shown as eligible for Medicare benefits in Medicaid's system when they are not eligible or the member may be shown as not eligible when they are eligible. The DMA-460 can be used by providers to notify Medicaid of these discrepancies. The notice only begins the validation process. Medicaid cannot update the Medicare eligibility files in the MMIS. Medicare eligibility data can only be updated in the MMIS by the monthly interface with the Centers for Medicare & Medicaid Services (CMS). Information from the Common Working File (CWF) *cannot* be used to update the MMIS. Claims may remain suspended until Medicare eligibility issues are resolved.

ADDITIONAL INDUSTRY STANDARDS AFFECTING COB AND CROSSOVER CLAIMS

National Provider Identifier

In accordance with federal regulations Georgia Medicaid is accepting the National Provider Identifier NPI as the provider identifier on **all standard HIPAA electronic transactions**. The NPI is a 10-digit national identifying number assigned to health care providers that is required to be used in all electronic claims submission in Georgia. Providers must ensure that their NPI number is on file with Georgia Medicaid.

NOTE: Providers who do not offer medical services are excluded from having a NPI. Contact Provider Enrollment at the DCH if you are not sure if you need a NPI number for Georgia Medicaid. Other provider-based activities will continue to be managed with the Provider Medicaid ID. These activities include:

- Web Portal submissions
- IVR system inquiries
- Telephone inquiries
- Prior authorization requests

National Drug Code and Injectable Drug for Outpatient Services

In order to comply with the Deficit Reduction Act (DRA) of 2005, section 6002, Georgia Medicaid requires providers to bill an accompanying NDC code with a HCPCS code for outpatient claims with service dates on or after January 1, 2007.

PLEASE DO NOT PLACE A NDC ON THE CLAIM FOR NON- OUTPATIENT INJECTABLE HCPCS CODES.

Georgia Medicaid providers must submit claims with the 11 digit NDC code that corresponds with the HCPCS code for the injectable drugs that are administered in an outpatient setting. Provide the NDC number with claims for the below medias:

- 837 P- Electronic Professional Claims Submission
- 837 I – Electronic Institutional Claims Submission
- GAMMIS Web Portal

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CHAPTER 2

ADJUSTMENTS INVOLVING COB AND CROSSOVER CLAIMS

WHEN SHOULD I FILE AN ADJUSTMENT ON A CLAIM?

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When a primary payer such as a commercial plan or Medicare adjusts a claim and a new EOB or EOMB is received, determine if that adjusted claim has been filed with Medicaid and ***paid***. If yes, review the paid claim for a possible adjustment. To adjust a Medicaid claim, complete an Adjustment Request Form (DMA-501). Remember, only Medicaid ***paid*** claims can be adjusted. Submit the Adjustment Request through the GAMMIS web portal at www.mmis.georgia.gov. Attach a copy of the EOB or RA/EOMB showing the primary payer's adjustment.

If the primary payer adjusts a claim that Medicaid ***denied***, no adjustment is needed. If the primary payer's adjustment results in a claim that Medicaid will possibly pay, file a new claim to Medicaid and include the corrected EOB or RA/EOMB as an attachment.

HOW TO COMPLETE AN ADJUSTMENT?

Adjustment Request Form (DMA-501)

The Adjustment Request Form is on the following page. Specific instructions are included following the form.

Please Return To:
GHP
P.O. Box 105208
Tucker, GA 30085-5208

ADJUSTMENT REQUEST FORM

Adjustment Requests must be received within 3 months from the month of Medicaid payment.

1. Internal Control Number (ICN) of the paid claim to be adjusted as shown on the Remittance Advice	3. Provider Name/Address Provider Number: Phone Number () Contact Person
Member Medicaid Information 2. Medicaid Number Member Name (Last, First, Initial)	
4. Reason for adjustment (check one box) ☐ A. Apply COB (indicate amount in Block #5D) ☐ B. Change information as indicated in Block 5 below ☐ C. Void claim ☐ D. Medicare adjustment (attach all EOMB's that apply to this adjustment)	

5. Please list the information to be corrected in Blocks 5A-5D. If the information to be corrected does not have a line number enter zero in the line number field. COB applied should always be line #0.

5A	5B	5C	5D
Line to be Corrected	Information to be Changed	From (Current) Information	To (Corrected) Information

6. Explanation for Adjustment

7. FOR DCH USE ONLY CCN _____ FS Line Amount \$ _____
--

Provider Signature _____ Date _____

DMA 501 Rev. (07/10)

COB or Crossover claim adjustments –specific instructions using the Adjustment Request Form (DMA-501):

1. **Blocks 1 - 3** must be completed for each claim adjusted.
2. **In Block 4**, check Box “B” for a COB adjustment or check Box “D” for a Medicare adjustment.
3. **In Block 5A** (Line to be Corrected), enter zero (0) if you are adjusting the *total* paid or the *total* patient liability for the claim. If you are only adjusting a line number, enter the line number corresponding to the claim that Medicaid has processed.
4. **In Block 5B** (Information to be Changed), show what data field of the *paid* claim is changing. For example, on a facility claim, if the prior payment is changing, enter “Box 54 A - prior Payments.”
5. **In Block 5C** (From (Current) Information), enter the incorrect information that was submitted on the original claim processed by Medicaid. This will be the same information that appears on the RA from Medicaid or Medicare.
6. **In Block 5D** (To (Corrected) Information), enter the corrected amount from the adjusted EOB or RA/EOMB.

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NOTE: See Part I Policies and Procedures for Medicaid/PeachCare for Kids manual, Section 204 for additional information regarding the individual provider Adjustment process.

NOTE: The DMA- 410 form is used *only* for COB claims; the DMA- 460 is used *only* for Medicare claims.

CHAPTER 3

COB and MEDICARE NOTIFICATION FORMS

TIPS FOR SUBMITTING THE DMA-410 AND THE DMA-460 FORMS

When completing the COB Notification Form (DMA-410) and the Medicare Notification Form (DMA-460), follow these instructions:

1. The form must be signed and dated. The signature date must be within 12 months of the date of service. Forms with older dates will not be valid attachments for COB or crossover claims. The date must be the month, day and year.
2. The member name and Medicaid ID number must be on the form. If either is missing, the form is an invalid attachment to the claim and the information submitted will not be used in processing the claim. This could result in the claim denying.
3. Enter the Medicaid provider ID number in the space provided. The ID number is required for all information being reported. If the number is not shown, the form is not a valid attachment and will not be used for claims processing.
4. Complete separate forms for each insurance card if the member has multiple cards, such as a medical card, a pharmacy card or a Medigap/Medicare supplemental insurance policy. Changes to coverage's can be reported on the forms also. New coverage and change information is recorded in Part III of the forms.
5. *Do not* attach the COB Notification Form *and* the EOB to the claim – attach only one. If the information on the EOB does not clearly show why the primary claim processed as it did, use the DMA-410 to clarify. If the EOB clearly shows how the claim was processed, attach the EOB. *Do not* attach the Medicare Notification Form *and* the RA/EOMB to the claim – attach only the one that most clearly explains the claims processing.
6. When there is no EOB and the provider is billing for a managed care co-payment, complete Section I on the DMA-410 showing the insurance carrier and the co-payment amount. When there is no EOMB and the provider is billing for a Medicare Advantage Plan co-payment, complete Section I of the DMA-460 showing the plan and the copayment amount.
7. When the EOB shows the carrier denied the claim due to “Out-of-Network”, but in reality the service is not covered even with a network provider, check the line on the DMA-410 showing “Service is non-covered” and use the DMA-410 as the attachment rather than the EOB. Document the patient’s file to show how it is known that the service is not covered.
8. When the COB information is in the form of a letter, include the information from the letter on the DMA-410 and keep the letter in the patient’s file. When the

Medicare information is in the form of a letter, include the information from the letter on the DMA-460 and keep the letter in the patient's file. NOTE: When the letter is used as the COB or Medicare attachment rather than the DMA-410 or the DMA-460, it might not be recognized as a COB or Medicare attachment and as a result be coded incorrectly. This incorrect coding could cause the claim to deny.

9. Always use the most current versions of the forms. The most current versions are available on the GHP Web Portal. If the most current versions are not used, the attachments will be invalid for processing the claims.

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10. Section III of the DMA-410 COB Notification form must be filed electronically, via the GAMMIS Web Portal at www.mmis.georgia.gov. To provide this information, upload a scanned image of the member's insurance card for COB updates by logging into the GAMMIS Web Portal at www.mmis.georgia.gov, perform an eligibility request for the member in question, select the new "Member Transactions" button and follow the instructions provided on the member transactions page. Please note that Providers will need to continue using the paper format of the DMA 410-Form for sections I: Co-Payment Notification and Section II: COB Non-Coverage Affidavit.

Copies of the COB Notification Form (DMA- 410) and the Medicare Notification Form (DMA- 460) are shown on the following pages

**DEPARTMENT OF COMMUNITY HEALTH – DIVISION OF MEDICAL ASSISTANCE
COB NOTIFICATION FORM****Member Name:** _____ **Medicaid ID#:** _____**I. CO-PAYMENT NOTIFICATION**

No EOB Available. Coverage is through: _____
Insurance / benefit plan. The co-payment for their service is _____

II. COB NON-COVERAGE AFFIDAVIT

I submitted my claim(s) to _____ (Insurance Carrier) on _____ (date) for payment. After

receiving no response, I contacted the carrier on _____ (date) for confirmation.

Insurance Representative: _____ Telephone #: _____

☐ Insurance was cancelled on _____ (date)☐ Service is non-covered, annual/lifetime service limits exceeded.☐ Member not covered under this policy.☐ Out-of-Network Provider, No In-Network provider available to provide Medicaid covered services (explain below).☐ Other (explain) _____

By signing, I certify that, to the best of my knowledge, the information above is verified and accurate, and that this notification form applies to any associated claim(s) and is made a part thereof.

Signature of Patient Account Representative_____
Date_____
Provider #

Note: This statement must be in accordance with the provisions of Part 1, Policies and Procedures, Chapter 200 – Timely Submission, Section 202.2(b).

Attach this form to your claim(s) for paper claim submission, or if claim submitted electronically, indicate the associated ICN above and forward to HPE for processing.

III. COB INFORMATION UPDATE

When completing only this portion of the form, upload member's information and a scanned image of the member's insurance card via the GAMMIS Web Portal at www.mmis.georgia.gov.

THIS FORM MAY BE PHOTOCOPIED

DMA-460: EB-EOMB

ICN:

DEPARTMENT OF COMMUNITY HEALTH – DIVISION OF MEDICAID MEDICARE NOTIFICATION FORM

Member Name: _____ Medicaid ID # _____

I MEDICARE CO-PAYMENT NOTIFICATION

NO EOMB/RA AVAILABLE. COVERAGE IS THROUGH: _____
MEDICARE HMO Plan. The co-payment for their service is _____

II. MEDICARE NON-COVERAGE AFFADIVIT

These services are not covered by Medicare Part A, Medicare Part B, or the Medicare HMO in which this member is enrolled.

- ☐ Medicare Part A was terminated on _____ (date)
☐ Medicare Part B was terminated on _____ (date)
☐ Service is non-covered by Medicare;
☐ Annual/Lifetime service limits exceeded; and/or
☐ Other (explain) _____

By signing, I certify that, to the best of my knowledge, the information above is verified and accurate, and that this notification form applies to any associated claim(s) and is made a part thereof.

Signature of Patient Account Representative

Date

Provider #

Submit this form with your claim(s) electronically via the GAMMIS web portal or EDI, indicate the associated ICN above.

III. MEDIGAP/MEDICARE SUPPLEMENTAL INSURANCE INFORMATION UPDATE

When a provider has knowledge that a member is enrolled in any other insurance or health benefit plan, other than Medicare and Medicaid, the provider is obligated to notify the department of that coverage. The provider can do so by completing only this portion of the form. It may be faxed to DXC Technology, ATTN: TPL Unit at 1-866-483-1044. If there are multiple cards, e.g., a medical card and a pharmacy card, please complete separate forms or make copies of all cards (front and back) to submit with this form.

COORDINATION OF BENEFITS (COB) INFORMATION: Please complete in full or attach a copy of the Insurance card(s), front and back.

Policyholder: _____ Patient Relationship to Policyholder: _____

Employer: _____ Group # _____

Subscriber/Member ID #: _____ Effective Date: _____

Coverage Type (s) (circle all that apply): Medicare Part A Supplement Medicare Part B Supplement
Pharmacy Long Term Care Dental Vision

Other (Specify): _____

THIS FORM MY BE PHOTOCOPIED

DMA 460 Rev.

Chapter 4

SUBMITTING COB AND CROSSOVER ATTACHMENTS

SPECIFIC GUIDELINES FOR SUBMITTING COB AND CROSSOVER ATTACHMENTS

There are specific guidelines that must be followed in order for claims submitted with attachments to process smoothly.

1. *Do not* highlight any areas on a COB or Crossover attachment or on the claim. When imaged, the highlighted areas will appear blacked out and unreadable.
2. Complete the Electronic Claim Attachment Coversheet. Fax or mail the completed coversheet and associated claim attachments to fax number or address identified on the coversheet to ensure that attachment is associated with the claim. The fax number on the Electronic Claim Attachment sheet is 1-866-483-2044. The mailing address for TPL Claims attachments is: DXC, P.O. Box 105209, Tucker, GA 30085-5209
3. When submitting an RA/EOMB attachment for a Medicare denial, write **MEDICARE DENIAL** clearly at the top of the RA/EOMB and submit as a straight Medicaid claim.
4. HIPAA privacy rules require that you cover up (redact) the names of other patients listed on the EOB or RA/EOMB prior to submission. Do not redact the column headings on these forms.
5. When the COB or Medicare information is received in the form of a letter, memo or any other communication instead of an EOB or EOMB, include the information from these documents on the DMA-410 or the DMA-460 and maintain the documents in the patient's file for audit purposes.
6. If an electronic RA (835) is received from Medicare and you translate that into a proprietary format as your EOMB, it should clearly indicate that the information contained is from Medicare. The following fields must be included:
 - Provider Name (pay to provider, rendering provider)
 - Provider Medicare ID: pay to provider ID; rendering provider ID
 - Medicare Plan Name
 - Medicare pay date
 - Beneficiary name and HIC (health insurance coverage) number

- Date of service
- Procedure code
- Billed charges
- Medicare allowed amount
- Medicare deductible, coinsurance and Medicare payment

CHAPTER 5

SPECIAL BILLINGS FOR CERTAIN COB AND CROSSOVER CLAIMS

SPECIAL BILLINGS FOR CROSSOVER CLAIMS

Inpatient Part B only hospital claims

Rev. 7/15
Rev. 4/16

The purpose of this section is to assist with submitting a claim for inpatient hospital claims when the member has no Medicare Part A coverage or the Medicare Part A coverage is exhausted, but the member still has an effective Medicare Part B coverage. *Inpatient hospital admissions for “Part B Only” members must be pre-certified.* All Medicare Part B ancillary charges must be submitted to Medicare first and crossed over/adjudicated through Medicaid’s system prior to submitting the Inpatient charges to Medicaid.

Following is the sequence for Medicare Part B only Inpatient Hospital claims when there is no Part A coverage:

- Submit the Part B ancillary charges to Medicare.
- The Part B ancillary charges are paid by Medicare and then crossover to Medicaid.
- If Medicaid approves the claim, a payment of the lesser of the coinsurance and deductible up to the Medicaid maximum allowable amount for the claim will be made on the Part B charges.
- Submit the Part A Inpatient Charges with the EOMB from Medicare Part B along with the Medicaid Remittance Advice showing the amount that Medicaid paid for the coinsurance and deductible electronically through the GAMMIS web portal, www.mmis.georgia.gov.
- Medicaid will process the Inpatient claim as a COB Hybrid claim by deducting the paid ancillary charges from the Diagnosis Related Grouper (DRG) amount to be paid.

Example:

The Inpatient Hospital charges are \$50,000 (\$6,000 of these charges are for ancillary services). The member has Medicare Part B only and Medicaid.

The provider submits ancillary charges of \$6,000 to the Medicare Part B fiscal agent. Medicare allows \$5,000 and there is a \$1,000 contractual discount. Medicare pays \$3912; the deductible is \$110, and the member’s coinsurance is \$978).

The Medicaid paid charges for the Part B crossover claim are: deductible \$110 and the member’s coinsurance of \$978 = \$1088 total.

The inpatient claim is submitted to Medicaid with the EOMB. Enter the prior payments using MB (Medicare B) and MC (Medicaid). Ancillary paid charges of \$5,000 (MB-Medicare paid \$3912 and MC- Medicaid paid \$1088). Charges submitted for the inpatient claim are \$50,000.

The Medicaid allowed charges for the inpatient DRG rate is \$20,000. Medicaid pays the inpatient claim for \$15,000 (DRG allowed amount is \$20,000 minus the ancillary amount of

\$5000 previously paid.

Note: If benefits are exhausted for Part A claims, the following attachments are acceptable:

8. DMA-460
9. If a Letter of Benefits Exhausted is received from CMS, enter this information on the DMA-460 and retain the letter in the patient's file.
10. The denial EOMB from Medicare Part A.

Understanding the edits that denied the Part B only claim

- ☐ ☐ Prior-Authorization Required – Edits 3001, 3003, 3047 ☐ ☐ PA units exceeded – Edit 3052 (The ancillary changes for the Part B claim should not have a PA#. Crossovers do not require pre-certification.)
- ☐ ☐ Patient Status code in Field Locator 17 is not billable to Medicaid. (The Inpatient Claim will process as a primary Medicaid claim. Providers must use the 'Patient Status' code billable under the Hospital Services Program.)
- ☐ ☐ Billing value codes with no amount in Field Locator 40 (1st or 2nd value code amounts missing – an amount wasn't included with the value code.) – Edit 462 or 463
- ☐ ☐ Missing/invalid covered days – Edits 282, 283, 518, or 573
- ☐ ☐ Admit date missing or invalid – Edits 275 or 276
- ☐ ☐ Value Code visits do not correspond to the revenue code units billed – Edit 384

Reasons the claim will be denied:

- No Medicaid payment for the Part B services
- Total Charges or billed amount must match the amount on EOMB.
- EOMB does not contain an outpatient crossover bill type.
- Medicare coinsurance, deductible, and payment amounts cannot be identified on provider's EOMB.
- No Letter of Benefits Exhausted or Medicare EOMB denial for benefits attached.
- The 'From Date' does not begin with the date after the benefits have exhausted.

Note: Medicaid will pay on services up to the Medicaid maximum allowable amount. The inpatient DRG rate is all inclusive (includes ancillary charges). Therefore, the previous paid ancillary charges are deducted from the inpatient DRG rate to prevent a double payment.

Medicare Part B – Retail Drugs

Medicare crossover claims are transmitted to DCH directly from the COBC. Pharmacies who bill Georgia Medicaid for Medicare Part-B Rx drugs must submit claims via X12 837 Professional format. Presently, Georgia Medicaid does not support the NCPDP Version 5.1 Batch format for **Crossover Claims**. To submit claims via the X12 837P format, providers must contact DXC-EDI at 877-261-8785.

Please note: If the COBC receives a Medicare Part B pharmacy claim in the NCPDP 5.1 format for Georgia Medicaid, they must send it out in the NCPDP 5.1 format. Since Georgia Medicaid does not support this format, the claim will not crossover and we will not receive it.

SPECIAL BILLINGS FOR COB CLAIMS

Mother and Baby billed as One to the Health Insurance Carrier

SCENARIO:

“B” Health Insurance is primary for this Georgia Medicaid Member. “B” Health Insurance required at the time of service a combined billing for the Mother and Baby claim. “B” Health Insurance adjudicates the claim and pays the claim for the Mother and Baby charges.

Georgia DCH processes all claims for individuals based upon determined eligibility for the Medicaid class of assistance. *Each individual must have an eligibility segment* in our claims processing system. Therefore, the provider must first insure that the child has eligibility information in the system.

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 Benefits (COB) payment should be prorated between the mother and the 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. Please see the below example:

<u>Combined EOB</u>		<u>Mother's EOB</u>	<u>Child's EOB</u>
Charges	\$6000	\$5000	\$1000
Paid by Primary plan	\$3000	\$2500	\$ 500
Patient's Liability	\$ 500	\$ 417	\$ 83

The mother's charges are \$5000 and the baby's charges are \$1000. The COB payment and Patient liability should be 5/6 to the mother's claim and 1/6 to the baby's claim.

Partial Hospital Stay

Scenario 1

The member was admitted into the hospital as a Medicaid member and the member's other insurance effective date occurred *after* the member was admitted.

The Medicaid eligibility effective date was 2/01/2003. The member's other insurance with XYZ Health was effective 12/03/2003. The member was admitted into the hospital on

12/01/2003 and discharged as of 12/17/2003.

The claim to Medicaid should have the following:

- Precertification for the entire stay
- DOS should be from 12/01/2003 to 12/17/2003, the exact dates that the member was eligible for Medicaid
- The amount paid by XYZ health insurance should be in the Prior Payments field of the UB-04.

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Scenario 2

The member was admitted into the hospital as a XYZ Health member and the Medicaid eligibility became effective *after* the member was admitted.

The member had XYZ Health eligibility as of 12/01/2003. Medicaid coverage was effective 12/07/2003. The member was admitted into the hospital on 12/01/2003 and discharged on 12/17/2003.

The claim to Medicaid should have the following:

- Precertification for DOS 12/07/2003 to 12/17/2003.
- DOS on claim should be from 12/07/2003 to 12/17/2003, the exact dates the member was eligible for Medicaid.
- The amount paid by XYZ health insurance should be prorated and entered in the Prior Payments field of the UB-04.

Prorating DOS for Scenario 2 XYZ Days: 12/01/2003 to 12/17/2003 = 16 days DMA Days: 12/07/2003 to 12/17/2003 = 10 days XYZ Paid: \$50,000 XYZ daily paid rate: \$50,000/16 = \$3,125.00 Prior Payment field on UB-04 for DMA is: \$3125.00 = \$31,250.00

CO-PAY ONLY CLAIMS

Medicaid will process claims for the manage care co-pay (co-pay only) under the following circumstances:

- The rendered services are covered by Medicaid
- The rendering provider is an in-network provider for the member's manage care plan.
- An EOB is received as an attachment to the claim or a DMA-410 is received as an attachment to the claim.

○ If an EOB is received:

- The member's information on the EOB matches the information on the claim. (For example, member name, member ID, etc).
- The dates of service and the procedure codes on the EOB match those on the claim.

- The billed amount on the claim must match the co-payment amount on the EOB.

○ **If a DMA 410 is received:**

- The member's information on the EOB matches the information on the claim. (For example, member name, member ID, etc.)
- In Section I, CO-PAYMENT NOTIFICATION, of the DMA-410, the co- pay dollar amount must be indicated.
- The DMA-410 must have a valid signature, signature date, and Provider number.

Please note: When completing the claim for co-pay only, the claim should be billed the same as the actual service rendered, with the exception of the billed amount. You should enter the amount of the co-payment instead of the amount of the service; and the paid amount field (**the field where you enter the amount paid by the primary payer**) should be left blank. All other data, such as procedure code, diagnosis code, etc., should be the same.

Rev. 4/17
Rev. 7/18
Rev. 7/21

Appendix A

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

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children’s Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women’s Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

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

benefits, and health and wellness education. **All three CMOs are State-wide.**

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

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

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

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

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

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC – LIM
183	P4HB ROMC – ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM – Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB <= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)

876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola – Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola – Disabled
221	Disabled Widower 1984 Cola – Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle – Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child – Aged
227	Disabled Adult Child – Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled

239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto – Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind

426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

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

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

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

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact GAINWELL TECHNOLOGIES at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

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

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

Participating in a Georgia Families' health plan:

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

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

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

Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

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

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

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid

provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

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

Health plans payment of clean claims:

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

Amerigroup Community Care	CareSource	Peach State Health Plan
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for clean claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. Dental: Checks are mailed weekly on Thursday for clean claims. Vision: Checks are mailed weekly on Wednesday for clean claims (beginning June 7th) Pharmacy: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for <u>clean</u> claims that have been adjudicated. <u>Pharmacy:</u> 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:	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

	• 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.	every six months. There are a few exclusions that apply and would warrant an immediate PCP change.
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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 24 th day of the month and are effective for the current month. PCP changes made after the 24 th 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 B



Information for Providers Serving Medicaid Members in the Georgia Families 360SM Program

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

DCH, Amerigroup, and partner agencies -- the Department of Human Services (DHS) and DHS' Division of Family and Children Services (DFCS), the Department of Juvenile Justice (DJJ) and the Department of Behavioral Health and Developmental Disabilities (DBHDD), as well as the Children's and Families Task Force continue their collaborative efforts to successfully rollout this new program.

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 360SM 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 360SM Every member in Georgia Families 360SM 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.

(Refer to the Part 1 Medicaid and Peachcare for Kids Manual, Appendix J, ICD-10 Overview policy)

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Affordable Care Act

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.

ACRONYMS

ADA-AMERICAN DENTAL ASSOCIATION

AFC-AFFORDABLE CARE ACT

CBAY-COMMUNITY BASED ALTERNATIVE FOR YOUTH

CIC- CUSTOMER INTERACTION CENTER

CMO-CARE MANAGEMENT ORGANIZATION

CMS- CENTERS FOR MEDICARE AND MEDICAID SERVICES

COB –COORDINATION OF BENEFITS

COBC-COORDINATION OF BENEFITS CONTRACTOR

COE-CATEGORIES OF ELIGIBILITY

CWF- COMMON WORKING FILE

RA-REMITTANCE ADVICE

RTP-RETURN TO PROVIDER

SSI-SOCIAL SECURITY INCOME

TPL-THIRD PARTY LIABILITY

UB-UNIFORM BILLING

VFC-VACCINE FOR CHILDREN

WHM-WOMEN’S HEALTH MEDICAID

NDC-NATIONAL DRUG CODE

NPI-NATIONAL PROVIDER IDENTIFIER

PPO-PREFERRED PROVIDER ORGANIZATION

QMB-QUALIFIED MEDICARE BENEFICIARY

DCH-DEPARTMENT OF COMMUNITY HEALTH

DMA-DIVISION OF MEDICAL ASSISTANCE

DOS-DATES OF SERVICE

DRA- DEFICIT REDUCTION ACT

DRG-DIAGNOSIS RELATED GROUPS

DXC-DXC Technology (Gainwell Technologies)

EDI-ELECTRONIC DATA INTERCHANGE

EOB-EXPLANATION OF BENEFITS

OMB-EXPLANATION OF MEDICARE BENEFITS

EPSDT-EARLY & PERIODIC SCREENING DIAGNOSIS & TREATMENT
ESRD-END STAGE RENAL DISEASE

FEHBP-FEDERAL EMPLOYEES HEALTH PARTNERSHIP

GF- GEORGIA GAMILIES

GAPP-GEORGIA PEDIATRIC PROGRAM

GRITTS-GEORGIA IMMUNIZATION REGISTRY

HIPPA-HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

HMO-HEALTH MAINTENANCE ORGANIZATION

LIM-LOW INCOME MEDICAID

MAP-MEDICARE ADVANTAGE PLANS

NCPDP-NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAM

Rev. 7/2020