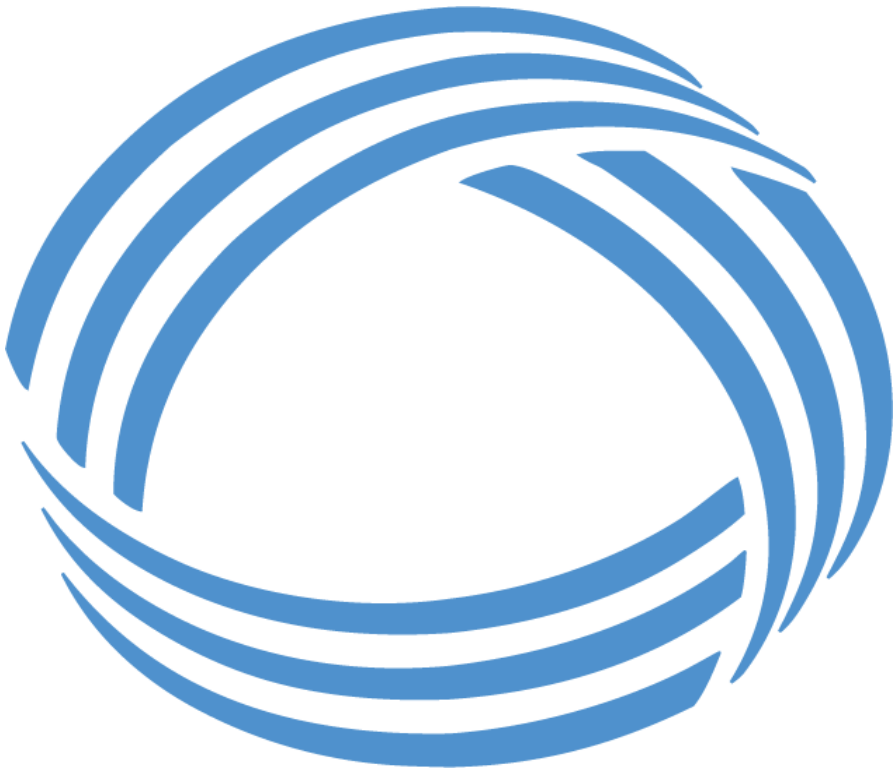
PART II

POLICIES AND PROCEDURES
for
DIALYSIS SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: July 1, 2023

Policy Revisions Record
Part II Policies and Procedures Manual for Dialysis Services
2023

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
1/1/2023		There are no revisions for January 1, 2023.		
4/1/2023		There are no revisions for April 1, 2023		
7/1/2023	Appendix G, page 2 & 3	Update the NEMT Regions and Counties Served	M	

PART II - POLICIES AND PROCEDURES
FOR
DIALYSIS SERVICES

CONTENTS

CHAPTER 600	SPECIAL CONDITIONS OF PARTICIPATION			VI
CHAPTER 700	SPECIAL ELIGIBILITY CONDITIONS			VII
CHAPTER 800	PRIOR APPROVAL			VIII
CHAPTER 900	SCOPE OF SERVICES			IX
	SECTION	901	General	
	SECTION	902	Coding Of Claims	
		902.1	ICD-9-CM/ICD-10-CM Diagnosis Coding	
		902.2	Procedure and Revenue Codes	
		902.3	General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers	
	SECTION	903	Service Limitations	
		903.1	Services Included In the Facility Composite/Treatment Rate	
		903.2	Laboratory Tests Included In Dialysis Composite/Treatment Rate	
		903.3	Ancillary Services Rendered	
		903.4	Home Dialysis	
		903.5	Professional Services	
		903.6	Dialysis Training	
		903.7	Kidney Transplant	
		903.8	Medicare Coverage	
		903.9	Telemedicine	
	SECTION	904	Non-Covered Services	
CHAPTER 1000	BASIS FOR REIMBURSEMENT			X
APPENDIX A	MEDICAL ASSISTANCE ELIGIBILITY CERTIFICATION			
APPENDIX B	Page Intentionally Left Blank			
APPENDIX C	GEORGIA MEDICIAID ESRD ENROLLMENT APPLICATION			

- COMPLETION OF THE GEORGIA MEDICAID ESRD ENROLLMENT APPLICATION

APPENDIX D BILLING INSTRUCTIONS AND CLAIM FORMS

- CMS-1500 CLAIM FORM
- COMPLETION OF THE CMS-1500 CLAIM FORM
- MEDICAID-MEDICARE CROSSOVER (CMS-1500)
- UB-04 CLAIM FORM
- COMPLETION OF THE UB-04 CLAIM FORM
- MEDICAID-MEDICARE CROSSOVER (UB-04)

APPENDIX E GEORGIA FAMILIES (GHF)

APPENDIX F GEORGIA 360°

APPENDIX G NON-EMERGENCY TRANSPORTATION

APPENDIX H National Correct Coding Initiative (NCCI)

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NOTE:
DIALYSIS PROVIDERS SHOULD REFER TO SPECIFIC BILLING INSTRUCTIONS PROVIDED IN APPENDIX D.

PART II - CHAPTER 600
SPECIAL CONDITIONS OF PARTICIPATION

601. In addition to the general conditions of participation identified in Part I, providers in the Dialysis Services Program must meet the following conditions:

601.l The Facility must be Medicare-certified to provide End Stage Renal Disease (ESRD) services.

601.2 Both hospital-based and non-hospital-based dialysis facilities must be enrolled in the Dialysis Services Program. The physician responsible for the provision of the professional component of dialysis services also must enroll in the Dialysis Services Program. ESRD dialysis services will not be reimbursed in the Hospital or Physician program of Medicaid.

601.3 The ESRD facility must furnish all necessary equipment, supplies and dialysis services.

601.4 Each facility must bill its usual and customary composite/treatment rate on the UB-04 claim form. The professional component must be billed under the physician's unique Dialysis Services Program provider number on the HCFA-1500 (CMS-1500) claim form.

601.5 The facility must notify the Division of any changes in the member's Medicare status or eligibility. The ESRD lock-in period will not be adjusted without such notification being made in writing.

601.6 Submit to the Provider Enrollment Unit a completed copy of the Disclosure of Ownership Form (CMS-1513) with the provider enrollment application.

601.7 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 Laboratory Services and the Schedule of Maximum Allowable Payments for Clinical Laboratory and Anatomical Pathology Services

PART II - CHAPTER 700
SPECIAL ELIGIBILITY CONDITIONS

701. In addition to any eligibility conditions listed in Part I, Section 102, members receiving services under this program must have a diagnosis of chronic renal failure [end stage renal disease (ESRD)]. Coverage of eligible ESRD members is limited to:

- Services provided by providers enrolled in the Dialysis Services Program;

Rev. 10/15

- members enrolled in this program

PART II - CHAPTER 800
PRIOR APPROVAL

801. The services covered in this Policy Manual do not require approval by the Division prior to the provision of such services. However, the Division may require prior approval of all or certain procedures rendered in certain dialysis facilities based on the findings or recommendations of the Division, its authorized representatives or agents, the Secretary of the U.S. Department of Health and Human Services or the applicable State Examining Board. In such instances, the Division will serve written notice to the dialysis facility of this requirement and the grounds for such action.

PART II - CHAPTER 900
SCOPE OF SERVICES

901. General

Dialysis services include those services and procedures designed to promote and maintain the functioning of the kidney and related organs. Dialysis services are covered only when provided by an enrolled Dialysis Services provider.

902. Coding of Claims

All claims for dialysis services must be completed as instructed in Appendix D. Procedure codes are required on the CMS-1500 claim form and revenue codes with the procedure/hcpcs code are required on the UB-04 claim form. Appropriate diagnosis codes are required on each. Procedure codes and revenue codes assigned for the services are presented in Section 902.2 of this manual. Diagnosis codes are discussed in Section 902.1.

Rev.04/14
Rev.07/14

902.1 ICD-10-CM Diagnosis Coding

The diagnosis coding scheme accepted by the Division for diagnosis for dates of service on or before September 30, 2015 is the ICD-9-CM (International Classification of Diseases -9th Edition) and for dates of service October 1, 2015 and after is the ICD-10-CM (International Classificationof Diseases – 10th Edition. Codes deleted from previous editions of the ICD-9 are not accepted by the Division. The ICD-9-CM coding scheme consists of three volumes. Only Volumes I and II are needed. Further, the special categories of codes which begin with alphabetic characters “E” (E800 - E999) and “M” (M800 M9970/1) are not accepted by the Division. The remaining special category of codes which begin with “V” are acceptable only if the “V” codes describe the primary diagnosis. The principle diagnosis for claims submitted through the dialysis program must be chronic renal failure (end stage renal disease ESRD).

Copies of the ICD-10-CM codebook are available for purchase from the following organization:

Superintendent of Documents

U.S. Government Printing Office

Washington, D.C. 20402

ICD-10-CM codebooks are available for purchase from various organizations. There are a number of industry resources available for a fee.

902.2 Procedure and Revenue Codes

Only the Procedure and Revenue Codes listed in this section can be used to bill for dialysis services for Medicaid primary members. No other codes will be accepted. Please see Appendix D for specific billing instructions.

A) Codes for Professional Services

Code	Description
90951	End Stage Renal Disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to- face physician visits per month
90954	End Stage Renal Disease (ESRD) related services monthly, for patients two (2) - eleven (11) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to-face physician visits per month
- 90955	End Stage Renal Disease (ESRD) related services monthly, for patients two (2) -eleven (11) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with two (2) or three (3) face-to-face physician visits per month
90956	End Stage Renal Disease (ESRD) related services monthly, for patients two (2) - eleven (11) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with one (1) face-to-face physician visit per month
90957	End Stage Renal Disease (ESRD) related services monthly, for patients twelve (12) - nineteen (19) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to-face physician visits per month
90958	End Stage Renal Disease (ESRD) related services monthly, for patients twelve (12) - nineteen (19) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with two (2) -three (3) face-to-face physician visits per month

Code	Description
90959	End Stage Renal Disease (ESRD) related services monthly, for patients twelve (12) - nineteen (19) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month
90960	End Stage Renal Disease (ESRD) related services monthly, for patients twenty (20) years of age and older, with four (4) or more face-to-face physician visits per month
90961	End Stage Renal Disease (ESRD) related services monthly, for patients twenty (20) years of age and older, with two (2) - three (3) face-to-face physician visits per month
90962	End Stage Renal Disease (ESRD) related services monthly, for patients twenty (20) years of age and older, with one (1) face-to-face physician visit per month

B) Home Dialysis Patients

Code	Description
90963	End Stage Renal Disease (ESRD) related services for home dialysis per full month, for patients younger than two (2) years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents
90964	End Stage Renal Disease (ESRD) related services for home dialysis per full month, for patients two (2) -eleven (11) years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	End Stage Renal Disease (ESRD) related services for home dialysis per full month; for patients twelve (12) - nineteen (19) years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	End Stage Renal Disease (ESRD) related services for home dialysis per full month, for patients twenty (20) years of age and older

C) Codes for Professional Services (less than full month)

Code	Description
90967	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients younger than two (2) years of age
90968	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients two (2) - eleven (11) years of age
90969	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients twelve (12) - nineteen (19) years of age
90970	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients twenty (20) years of age and older

D) Training Codes

Code	Description
90989	Dialysis training, patient, including helper where applicable, any mode, completed course
90993	Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session

E) Facility Revenue Codes

Code	**Description**
821	Hemodialysis/Composite/Treatment Rate
831	Peritoneal Dialysis/Composite/Treatment Rate
259 634 635 636	Injectable Drugs

F) Facility Procedure Codes

Rev. 07/09

Code	**Description**
90999	Hemodialysis
90945	Home Dialysis

Rev. 07/13
Rev. 04/14

902.3 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.

Also, 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**.

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.

903. Service Limitations

The procedures in Section 902.2 are covered with the limitations described below. Documentation may be requested in prepayment or post-payment review, and

lack of appropriate medical justification or documentation may be grounds for denial, reduction or recoupment of reimbursement.

903.1 Services Included In The Facility Composite/Treatment Rate

Services included in the facility composite/treatment rate and professional monthly capitation payment are not separately reimbursable. The composite/treatment rate includes technical services, routine laboratory work, and cost of supplies and equipment as outlined in the sections below. All facility and professional charges are reimbursed at an all-inclusive rate for all modes of dialysis treatment. These services include but are not limited to:

- IV fluids and supplies;
- Drugs administered into dialysis delivery systems;
- Oral medications;
- Injections - including but not limited to: B-12, liver, steroids, antiarrythmics, heparin, protamics, mannitol, saline, pressor drugs, glucose, dextrose, antihistamines, antihypertensives, vitamins;
- All hospital, emergency room, office or home visits and consults;
- Specimen collection fee;
- Blood Pressure Apparatus and Weight Scales;
- Insertion or removal of catheters, shunt declotting;
- ESRD services that are provided to dialysis patients by a non-Medicare certified facility; and
- Laboratory tests listed in Section 903.2.

903.2 Laboratory Tests Included In Dialysis Composite/Treatment Rate

The procedures listed below are included in the facility's composite/treatment rate and are not separately reimbursable.

82040	Albumin, Serum	84295	Sodium, Serum
82042	Albumin, Urine	84300	Sodium, Urine
82247	Bilirubin, Total	84450	SGOT
82248	Bilirubin, Direct	84460	SGPT
82310	Calcium, Serum	84520	BUN
	Calcium, Urine		

82374	CO2 Combining Power	84550	Uric Acid, Blood
82435	Chloride, Blood	84560	Uric Acid, Blood
82436	Chloride, Urine	85014	Hct.
82540	Creatine, Blood	85018	Hgb.
82565	Creatinine, Blood		
82575	Creatinine Clearance	85025	CBC
82947	Glucose, Serum		
83615	LDH, Blood	85027	Hgm. with platelet count
83735	Mag., Serum Chemical	85041	RBC
84075	Alk. Phosphatase	85048	WBC
84100	Phosphorus (Phosphate), Serum	85610	Prothrombin Time
84132	Potassium, Serum		
85014	Hct		
84133	Potassium, Urine		
84105	Phosphorus (Phosphate), Urine		
84155	Total Protein, Serum		

The composite/treatment rate includes any other laboratory code(s) with similar descriptions and panels of laboratory tests (multiple test panels that contain routine lab tests).

903.3 Ancillary Services Rendered

The following procedures and services listed below in a, b, and c are recognized as medically necessary and are not included in the facility composite/treatment rate or physician professional monthly capitation payment (MCP).

A) Separately Billable Laboratory Tests for Dialysis Patients

Any laboratory tests not listed in Section 903.2 and not actually performed by the dialysis facility must be billed by the outside testing facility, e.g., independent laboratory or hospital laboratory.

The following are covered procedures that may be billed separately and are not included in the monthly composite/treatment rate:

- Hepatitis B Surface Antigen (HBsAg) or testing for (sero-negative) patients (including those who have received Hepatitis B Vaccine and still have a negative response) is limited to one test procedure (87340) per month;

- Either Hepatitis B Surface Antibody or Hepatitis B Core Antibody testing is limited to one test procedure per year. Procedures included are: 86704, 86705, 86706, and 87350.Out of these procedure codes, only one will be reimbursed per calendar year.

- Serum Aluminum - one every 3 months: 82108;

- Serum Ferritin - one every 3 months: 82728;

Rev. 01/11
Rev. 07/15
Rev. 10/18

If the procedures are performed at a frequency greater than that specified above, they are covered only if accompanied by medical documentation. For reimbursement of procedure codes performed outside of the frequency, the provider must submit a DMA-520A to Alliant Health Solutions (AHS) - Medical Review Unit via the Provider Workspace on the GAMMIS Web portal, www.mmis.georgia.gov, under the link Prior Authorization/Provider Workspace/Provider Inquiry Form. a copy of the remittance advice notice with the denied service, a completed CMS-1500 claim form, and documentation from the ordering provider of the medical necessity to support the need for the tests. This documentation must include information other than the physician's order and medical diagnosis of the member. The diagnosis code indicating ESRD alone is not sufficient.

B) Separately Billable Medical Procedures for Dialysis Services

Rev. 10/13
Rev. 01/18

- Bone Survey - one per year: 78300 - 78306;

- Nerve Conduction Velocity test (NCV) - one every three months: 95907 - 95909.

- Chest X-Ray - one every six months: 71045, 71046, 71048;

- Bone Mineral density - one every 6 months: 77074, 77075.

C) Separately Billable Drugs for Dialysis Patients

Rev. 04/19

The injectable drugs listed below are separately billable for dialysis patients. These drugs are contained in the Provider Administered Drug List (PADL) and may be billed by the Dialysis facilities. Details for billing are presented in Appendix D.

- Antibiotics

- Hematinics

- Anabolics

- Muscle relaxants
- Analgesics
- Sedatives
- Tranquilizers

Billable covered oral medications must be obtained by the patient through the Medicaid Pharmacy Program and are subject to Pharmacy Program limitations.

903.4 Home Dialysis

The Social Security Administration does not require a delay period for home dialysis services; therefore, Medicare will reimburse from the initiation of services. As a result, Medicaid will not reimburse for home dialysis if an application submitted to Medicare is still pending or if the member is Medicare covered. If the patient is denied Medicare benefits, Medicaid will reimburse retroactively.

Home dialysis services for Medicaid-only patients will be reimbursed at the same facility and professional services rate paid for in-center dialysis services. See Section 903.1 for a list of services included in the reimbursement fee.

903.5 Professional Services

Professional services are defined as monthly supervision of medical care, dietetic services, social services and procedures directly related to ESRD. The rate of reimbursement is the same for all patients regardless of mode of treatment or location.

The Monthly Capitation Payment (MCP) for professional services cannot be billed in the same month as Professional Training codes (90989 - 90993). Care provided to patients in acute renal failure is not a part of this program and must be billed through the Medicaid Physician Program according to the Physician Policies and Procedures manual.

903.6 Dialysis Training

The Division will reimburse only one unit of service for hemodialysis (90989) training or peritoneal dialysis training during a lifetime. The monthly capitation payment will not be allowed for the month in which the training code is billed. The MCP is included in the training reimbursement for that month. The training is to be billed in the month of completion only.

Retraining for hemodialysis is limited to fifteen sessions per lifetime. Retraining for peritoneal dialysis may be billed under code 90993. It is also limited to fifteen sessions per lifetime. Each day of retraining will be reimbursed up to the current maximum allowable rate. Professional services (MCP) will be billed using the appropriate CPT-4 procedure code for per day and will be reimbursed up to the maximum allowable rate.

903.7 Kidney Transplant

Kidney transplant services are not covered in the Dialysis Services Program. They are covered under the Hospital and Physician Services Programs. Please see the appropriate policy manual for details.

903.8 Medicare Coverage

Rev. 01/11

Medicare is the primary payor for ESRD with Medicaid as a secondary payor. Medicaid will reimburse as primary for the ninety (90) day waiting period required for Medicare eligibility (other than home dialysis) or if the individual has been denied Medicare coverage. In order for reimbursement to occur during the ninety (90) day waiting period, the facility must submit an ESRD Enrollment Application (DMA-615) to, P.O. 105200, Tucker, Georgia 30085-5200. Please refer to Appendix C for further instructions regarding completion of the ESRD Enrollment Application (DMA-615). Reimbursement will not be made after 90 days of treatment if a Medicare determination is still pending. Reimbursement made on behalf of members later determined to be retroactively eligible for Medicare will be recouped and both professional and technical fees must be billed to Medicare.

Please refer to Part I, Policies and Procedures for Medicaid/Peachcare for Kids for more details regarding reimbursement for Medicare co-insurance and deductible crossover claims.

Rev. 04/17
Rev. 04/2020

903.9 Telemedicine

The Centers for Medicaid and Medicare Services (CMS) has added Dialysis Services to the list of services that can be provided under Telehealth.

The originating facility/site (Dialysis Facility) will bill with the revenue code and procedure codes listed below.

Revenue Code	Description	Procedure Code	Modifier
780	Telemedicine, General Classification	Q3014	GT

The distant site/physician providing the service via a telecommunications system will bill using Place of Service 02 to indicate Telehealth. For a list of the procedure codes used for Telemedicine services please refer to the Telemedicine Guidance manual on the GAMMIS web portal at www.mmis.georgia.gov.

The term "distant site" means the site where the physician or practioner providing the professional service, is located at the time the service is provided via a telecommunications system.

Please refer to the Telemedicine Guidance manual for specific information regarding services, coverage, and limitations for Telemedicine Services. Paper copies of the manual may be obtained from the Division's fiscal agent by contacting Gainwell Technologies at 1 (800) 766-4456.

904. Non-Covered Services

The services listed below are non-covered under this program. This list is representative of non-covered services and is not meant to be exhaustive.

A) Services provided for acute renal failure;

B) Services not listed as separately billable in this manual;

C) Experimental services or procedures or those which are not recognized by the profession, the Division, or the United States Public Health Service as universally accepted treatment;

Rev. 4/16

D) Services provided to members not enrolled in this program; and

E) Services provided to members enrolled in a CMO plan

PART II - CHAPTER 1000
BASIS FOR REIMBURSEMENT

1001. Reimbursement Methodology

Rev. 04/09

The Division will pay the lower of the submitted charge or the statewide facility treatment rate or the statewide Monthly Capitation Payment for the services rendered. The treatment rate includes payment for the maintenance, supplies and equipment required to provide ESRD services to eligible Medicaid members. This rate is comprehensive and applies to all modes of in-facility and home dialysis services. The statewide monthly capitation includes payment for monthly supervision of medical care, dietetic services, social services and procedures directly related to ESRD provided to eligible Medicaid members. The rate of reimbursement is the same for all patients regardless of mode of treatment or location.

1001.1 Technical Component Billing

Reimbursement for the technical component will be made to the enrolled dialysis facility under the appropriate assigned provider number for the location where services were rendered. The facility must bill the Division for the technical services using the UB-04 claim form. Detailed instructions for the completion of the UB-04 are contained in Appendix D.

1001.2 Professional Component Billing

The professional component must be billed under the physician's unique dialysis provider number on the CMS-1500 Claim form. Detailed instructions for the completion of the CMS-1500 claim form are contained in Appendix D.

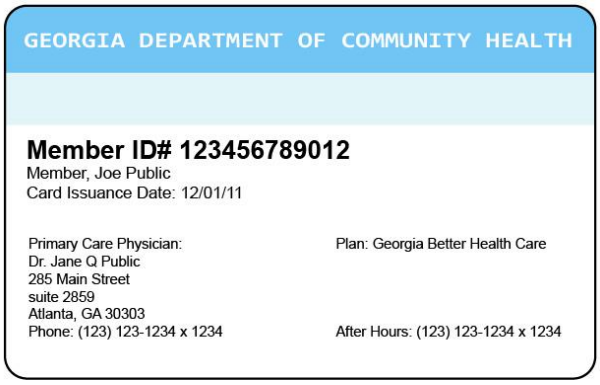
1001.3 Co-Payment

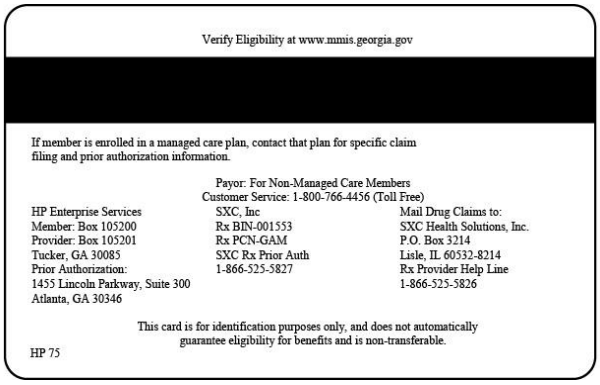
Patients receiving ESRD services are not subjected to co-payment.

1001.4 CMO

The Division will not make direct reimbursement to a dialysis facility for members enrolled in a CMO plan.

APPENDIX A
MEDICAL ASSISTANCE ELIGIBILITY CERTIFICATION





Appendix B

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APPENDIX C

STATE OF GEORGIA

DIVISION OF Medicaid

GEORGIA MEDICAID ESRD ENROLLMENT APPLICATION

PART I – PATIENT INFORMATION		
Name:	Date of Birth: / /	Social Security No.: ☐☐☐-☐☐-☐☐☐☐
Address:	Medicaid ID NO.:	Medicare Eligible: Yes ☐ No ☐
Medicare Application Submitted: Yes ☐ No ☐		
County:	Medicare No.:	Effective Date:	Medicare Denied: Yes ☐ No ☐
Reason for Denial		
DOCUMENTATION SHOWING MEDICARE DENIAL MUST BE ATTACHED TO THIS FORM		

PART II – TREATMENT INFORMATION - DIALYSIS		
Date of First Treatment:	Transplant Candidate: Yes ☐ No ☐	Place of Dialysis: Home ☐ Clinic ☐
Name of Facility Transferred from:		
Mode of Treatment: HEMODIALYSIS ☐ PERITONEAL DIALYSIS ☐ SELF DIALYSIS ☐		

PART III – TO BE COMPLETE BY PATIENT	
I have elected to receive dialysis services provided by the facility shown on this application	
Patient Signature	Date

PART IV – PROVIDER INFORMATION	
Clinic Name: Provider Number:	
Physician's Name:	Physician's Provider Number:

Form Completed by:	
Name:	Telephone No.:

Mail this form to:
Gainwell Technologies
P.O. Box 105200
Tucker, GA. 30085-5200

DMA 615 Rev. (04/2021)

COMPLETION OF THE GEORGIA MEDICAID ESRD ENROLLMENT APPLICATION (DMA-615-REV. 02/21)

Rev. 04/21

This section provides specific instructions for completing the Georgia Medicaid ESRD Enrollment Application (DMA-615 Rev. 02/21). A sample form is included for your reference.

Item 1 Member's Name
Enter the name exactly as listed on the Medicaid Eligibility Card (last name first).

Item 2 Member's Date of Birth
Enter the date of birth as month, day and year (April 15, 1994 would be listed as 04/15/94).

Item 3 Member's Social Security Number
Enter the Member's Social Security number exactly as it appears on the Social Security Card.

Item 4 Member's Address
Enter the street number, street name, post office box, county, state and zip code.

Item 5 Member's Medicaid I.D. No.
Enter the Member I.D. Number exactly as it appears on the Medicaid Eligibility Card.

Item 6 Medicare Eligibility
Enter "yes" if member is Medicare eligible.

Item 7 Medicare Application Submitted
Enter the date that the Medicare application was mailed.

Item 8 Medicare Number
Enter the Member's Medicare Number exactly as it appears on the Social Security Card.

Item 9 Effective Date
Enter the effective date of the Member's Medicare coverage.

Item 10 Medicare Denied
Check appropriate block indicating "Yes or No".

Item 11 Reason for Denial
Enter the reason for the Medicare denial.

Item 12 Date of First Treatment
Enter the date that the member was first treated in the dialysis facility.

Item 13 Transplant Candidate
Check the appropriate box indicating "Yes or No".

Item 14 Place of Dialysis
Check the appropriate block indicating the place of dialysis.

Item 15 Name of Facility Transferred From
Enter the name of the facility the member was transferred from.

Item 16 Mode of Treatment
Enter the appropriate mode of treatment.

Item 17 Clinic Name
Enter the facility providing treatment.

Item 18 Provider Number
Enter the facility's Medicaid provider number.

Item 19 Physician's Name and Provider Number
Enter the primary treating physicians name and Medicaid provider number on the first line. Add any additional physician's names and Medicaid provider numbers that belong to the same physician group and rotate at this facility.

Item 20 Form Completed By
Enter the name of the person completing this form.

Item 21 Telephone Number
Enter the telephone number (including Area Code) of the person completing the form.

Item 22 Title
Enter the title of the person completing the form.

Rev. 01/11

Item 23 **Date**
Enter the date the form is completed.

NOTES:

Part III requires that the member sign the ESRD Enrollment Application. This form *must* be signed to be a valid application. "Signature On File" is *not* acceptable.

You *must* attach to the Enrollment Form a copy of the Medicare Application Form (HCFA/CMS 2728) *or* show proof of Medicare denial for coverage *or* attach a copy of Medicare eligibility card with effective dates.

You must have proof of Medicare denial to extend enrollment beyond 90 days.

You must notify the DMA of clinic transfer or change of physician.

Mail to: Gainwell Technologies P. O. BOX 105200 Tucker, GA 30085-5200

APPENDIX D
CLAIM FORMS

Claims must be filed on the required form with appropriate information in specific blocks for payment. Claim forms for dialysis services are:

- **Health Insurance Claim Form (CMS-1500) New Version 02/12**

Rev. 04/14

  - 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.

- **Medicaid-Medicare Crossover (CMS –1500) New Version 02/12**

Rev. 07/12
Rev. 04/14

A special crossover claim form is no longer required when billing Medicaid/Medicare crossover. Claims must be submitted in the same format as they are submitted to Medicare. This claim must have an Explanation of Medicare Benefits (EOMB) from Medicare for Medicaid payment.

  - Claim (s) must be submitted within twelve (12) months from the month of service.

- **National Uniform Billing Form (UB-04)**
  - 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.

- **Medicaid-Medicare Crossover (UB-04)**

Rev. 07/12

A special crossover claim form is no longer required when billing Medicaid/Medicare crossover. Claims must be submitted in the same format as they are submitted to Medicare. This claim must have an Explanation of Medicare Benefits (EOMB) from Medicare for Medicaid payment.

  - Claim (s) must be submitted within twelve (12) months from the month of service.



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

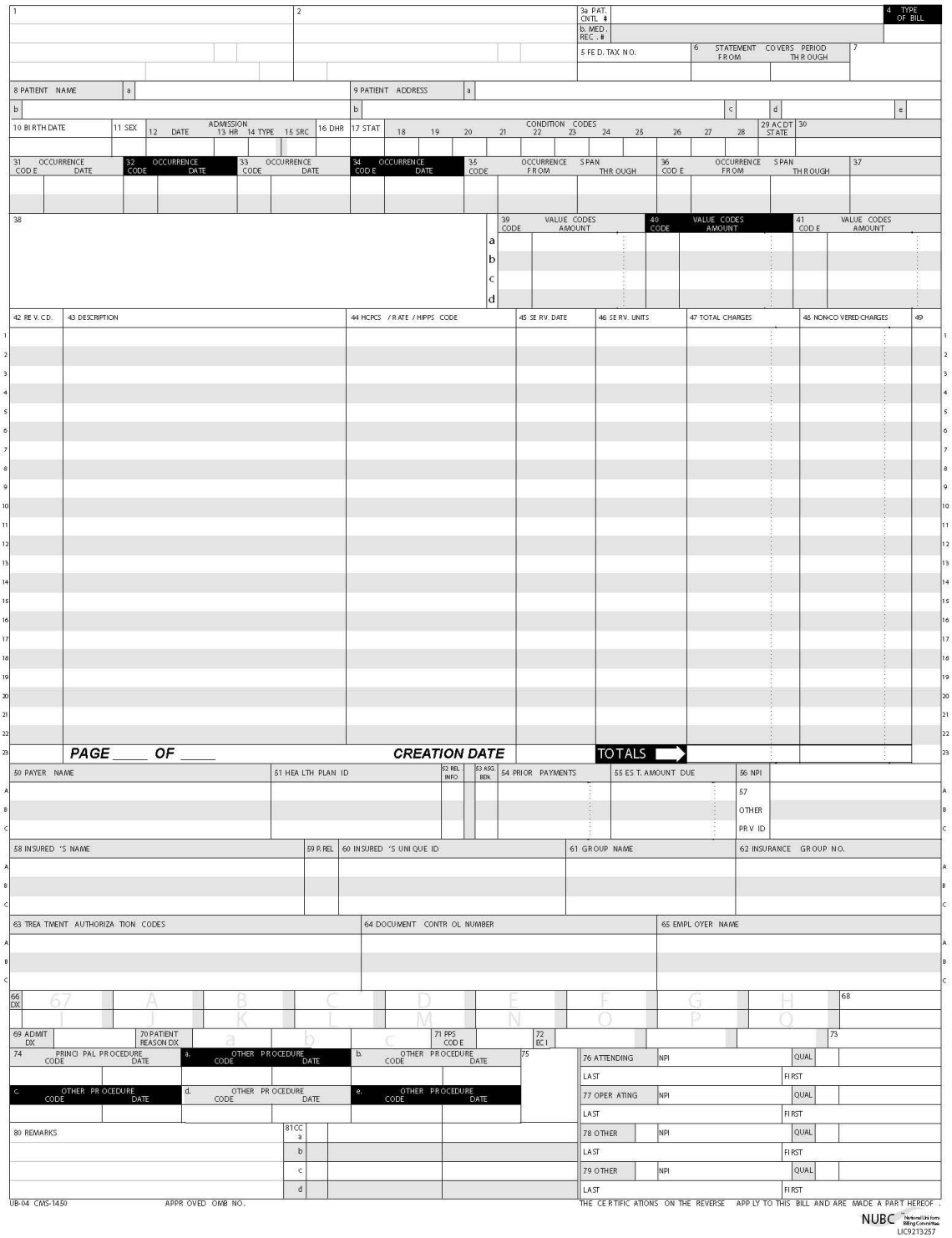
SAMPLE

The following table outlines the **revised changes** on the above CMS 1500 claim form version 02/12:

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

	(Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/Gainwell Technologies:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/Gainwell Technologies:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. **(Do not bill ICD 10 code sets before October 1, 2015.)**
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. **FOR DCH/Gainwell Technologies** : Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

UB-04 CLAIM FORM



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

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

FL1 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 3a Patient Control Number
Enter the patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual case records and posting of payment.

FL 3b Medical Record Number

Enter the number assigned to the patient's medical/health record by the provider.

NOTE:
The medical/health record number is typically used in auditing the history of Treatment and can expedite the processing of claims when medical records are required. It should not be submitted for the Patient Control Number (FL3), which is assigned by the provider to facilitate retrieval of the individual financial record.

FL 4 Type of Bill
Should be 72X

FL 5 Federal Tax Number

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

NOTE:
Monthly Technical Capitation Billing
If you are billing for the full capitation fee, the dates of service will be the first day of the month and the last day of the month.
If the patient was not under your care for the full month, you must bill only for the portion of the month the patient was under your care.

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

FL 9 Patient Address

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

FL 10 Patient Birthdate

Enter date of birth exactly as it appears on the Medicaid card. An unknown birthdate is not acceptable. If the date on the Medicaid card is incorrect, the member or the member's representative should contact the DFACS to have it corrected immediately.

FL 11 Patient Sex

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

FL 17 Patient Status

Enter a code indicating patient status as of the "Statement covers thru date".

FL 18 Thru 28 Condition Codes

The condition codes for dialysis services must be 71 through 76.

FL 42 Revenue Code

Enter the appropriate Revenue Code. Refer to the Uniform Billing Manual for a listing of revenue codes.

The last revenue code on each UB-04 should be 001 for the total submitted charges.

FL 43 Revenue Description

Enter a narrative description of the related revenue categories included on this bill. Abbreviations may be used.

Rev. 04/11
Rev. 07/11
Rev. 10/15

NOTE:

When billing injectable drugs on a UB04, the 11 digit NDC (National Drug Code) for the actual administered drug must be billed in Field Locator 43. Enter the 2 digit qualifier "N4" as a prefix to the 11 digit NDC number. Example: N455513028310. The associated code must be entered into Field Locator 44.

<u>For Medicaid-Medicare Crossover Claims:</u> When billing injectable drugs on a UB04, the 11 digit NDC (National Drug Code) for the actual administered drug must be billed along with revenue code 636, 634, or 635. Enter the 2 digit qualifier "N4" as a prefix to the 11 digit NDC number. Example: N455513028310. The associated code must be entered into Field Locator 44.

NOTE:
Currently, Venofer® NDC- 11s are marketed under two separate and specific labeler codes. The terms and license agreements, approved by the Federal Trade Commission, limits their marketing use to specific indications and distributors. Reimbursement for end stage renal dialysis use will require free-standing dialysis entities to submit the accurate and appropriate NDC code. The Department reserves the right to recoup all monies reimbursed for inaccurate and inappropriately submitted NDC codes.

FL 44 <u>CPT/HCPCS/Rates</u>
Enter the CPT/HCFA Common Procedure Coding System (HCPCS) code to describe ancillary services.

Rev. 07/09

NOTE:
All claims billing for hemodialysis sessions must report a Healthcare Common Procedure Code (HCPCS) code of 90999 (unlisted dialysis procedure, inpatient or outpatient) when billing revenue code 821

All claims billing for home dialysis sessions must report a Healthcare Common Procedure Code of 90945 (dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) with single physician evaluation) when billing revenue code 831.

Rev. 07/10
Rev. 01/11
Rev. 04/11
Rev. 07/11
Rev. 10/15

NOTE:

When billing using an electronic format (EDI, Web) the appropriate CPT/HCPCS code for the actual administered drug must be entered in FL 44. The NDC code for the actual administered drug must be billed in the field specified for the NDC. This applies to Medicaid primary and Medicaid-Medicare Crossover claims.

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).

NOTE:

When billing for drugs given on multiple dates, please bill a separate line for each date of service and the appropriate amount of units.

Rev. 04/11

NOTE:

Effective April 1, 2007 Dialysis Facilities will be required to line item bill. All ESRD claims with dates of service on or after April 1, 2007 are required to bill all services with line item date of service detail, excluding epoetin alfa (EPO).

Effective April 1, 2011 Dialysis Facilities will be required to line item bill all services with line item date of service detail.

FL 46 Units of Service

Enter the units of service or number of days associated with Revenue Codes in FL42

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.

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.

Note:
the "PAGE ____ OF ____" and CREATION DATE on line 23 should be reported on all pages of the UB-04.

FL 50 Payer

A, B, C Enter payer name and carrier code of any liable third party payer other than Medicare. (*Carrier codes are located in the Third Party Insurance Carrier listing). A reasonable effort must be made to collect all benefits from other third party coverage. Federal regulations require that Medicaid be the payer of last resort. (See Chapter 300 of the Policies and Procedures Manual applicable to all Medicaid providers.)

When a liable third party carrier is identified on the card, the provider must bill the third party.

FL 51 Health Plan ID

A, B, C Report the national health plan identifier when one is established; otherwise report the "number" Medicare has assigned.

FL 54 Prior Payments

A, B, C Enter the amount that the dialysis facility 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 60 Certification/SSN/HIC/ID No.

A, B, C Enter the Medicaid Member Client Number exactly as it appears on the Medicaid 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 which designates that the treatment covered by this bill has been authorized by the DMA. Enter the twelve (12) digit authorization number as required for inpatient hospital admissions and selected outpatient procedures, if applicable.

FL 64 Document Control Number (DCN)

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 FL 58.

FL 66 Diagnosis and Procedure code qualifier (ICD Version Indicator)

The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The qualifier 9 indicates Ninth Revision and the qualifier 10 indicates Tenth Revision.

FL 67 Principle Diagnosis Code

Enter the ICD-9-CM code for the *principal* diagnosis for dates of service on or before September 1, 2015. Enter the ICD-10-CM code for the *principal* diagnosis for dates of service on or after October 1, 2015.

Codes prefixed in 'E' or 'M' are not accepted by the Department. A limited number of 'V' codes are accepted.

(***The principle diagnosis for dialysis claims must be chronic renal failure (end stage renal disease ESRD).***

FL 67A-Thru 67Q — Other Diagnosis Codes

Enter the ICD-9-CM diagnosis codes for dates of service on or before September 30, 2015 and the ICD-10-CM diagnosis codes for dates of service on or after October 1, 2015 corresponding to additional conditions that co-exist at the time of admission/service, or develop subsequently, and which have an effect on the treatment received or the length of stay.

Codes prefixed in 'E' or 'M' are not accepted by the Department. A limited number of 'V' codes are accepted.

FL 69 — Admitting Diagnosis

Enter the ICD-9-CM diagnosis code for dates of service on or before September 30, 2015 and ICD-10-CM diagnosis code for dates of service on or after October 1, 2015 provided at the time of admission/service as stated by the physician.

FL 76 — Attending Provider Name and Identifiers (including NPI)

Enter the NPI /QUAL/ID and name ofnthe physician attending the patient. This is the physician primarily responsible for the care of the patient.

RENAL DIALYSIS SETTING
CONDITION CODES

71 Full Care in Unit	Code indicates the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72 Self-Care in Unit	Code indicates the billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
73 Self-Care Training	Code indicates the billing is for special dialysis services where a patient and his helper (if necessary) were learning to perform dialysis.
74 Home	Code indicates the billing is for a patient who received dialysis services at home, but where code 75 below does not apply.
75 Home – 100% Reimbursement	Code indicates the billing is for a patient who received dialysis services at home, using a dialysis machine that was purchased by Medicare under the 100 percent program.
76 Back-up in Facility Dialysis	Code indicates the billing is for a home dialysis patient who received back up.

TIPS FOR SUBMITTING MEDICARE CROSSOVER CLAIMS

UB-04

Rev. 01/11
Rev. 10/15

1. Enter valid data in all required fields on the claim form as if billing a Medicare Primary claim.
2. In field 50, enter name of all payers in this order:
    a. Primary Payer
    b. Secondary Payer
    c. Tertiary Payer
3. In field 51, enter the provider number used to bill each payer, see above for order.
4. In field 54, enter the amounts actually paid by each payer prior to billing Medicaid.
5. In field 55, enter the amount that you estimate is actually due from Medicaid. That amount should equal any patient liability listed on the RA/EOB.
6. In fields 58-66, enter valid data as it relates to each payer as listed in field 50.
7. Attach the Medicare EOB to the claim form.

NOTE:
Please refer to the Medicaid Secondary Claims User Guide for additional information regarding submission of secondary claims.

Rev. 10/16
Rev. 04/17
Rev. 10/18
Rev. 07/21

APPENDIX E

Georgia Families

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

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

The three licensed CMOs:

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

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

Eligibility Categories for Georgia Families:

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

Resource Mothers Outreach	

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

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

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

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

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

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

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child

510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged

225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind

306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

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

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

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

Registering immunizations with GRITS:

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

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

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

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

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

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

Participating in a Georgia Families' health plan:

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

Billing the health plans for services provided:

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

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

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

Credentialing

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

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

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

The CVO's one-source application process:

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

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

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

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

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

Billing the health plans for services provided:

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

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

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

Receiving payment:

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

Health plans payment of clean claims:

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

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

How often can a patient change his/her PCP?

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

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

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

Amerigroup Community Care	CareSource	Peach State Health Plan
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.

PHARMACY

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

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

Amerigroup Community Care	CareSource	Peach State Health Plan
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com

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

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

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

If a patient does not have an identification card:

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

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

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

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:

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

Will Medicaid cover prescriptions for members that the health plans do not?

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

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan
1 (800) 454-3730	1 (855) 202-1058 1 (866) 930-0019 (fax)	1 (866) 399-0929

Rev. 04/14

Appendix F

GEORGIA 360°



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

Georgia Families 360^{0}SM, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

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 360^{0}SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Rev. 7/18

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

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister

agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management will 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 G

Non-Emergency Medical Transportation

Non-Emergency Medical Transportation (NEMT) services are defined as medically necessary transportation for any eligible Medicaid member and companion, if required, who have no other means of transportation available to any Medicaid-reimbursable service for the purposes of receiving treatment, medical evaluation, obtaining prescription drugs or medical equipment.

How do I get NEMT services?

If you are a qualifying Medicaid recipient and have no other means of transportation for your medical care or services covered by Medicaid, you may contact a transportation broker for transport to and from your appointment. The member must contact the Broker to request NEMT services at least three (3) business days prior to a non-urgent, scheduled appointment. The three (3) day advance scheduling includes the day of the call but not the day of the appointment. Advance scheduling will be mandatory for all NEMT services except urgent care and follow-up appointments when the timeframe does not allow advance scheduling. Urgent care or same day reservations may require verification from your direct provider of service confirming you must be seen that day. Each broker has a toll-free telephone number to schedule transportation services, and available weekdays (Monday-Friday) from 7 a.m. to 6 p.m.

All counties in Georgia are grouped into five regions for NEMT services. A NEMT Broker covers each region. If you need NEMT services, **you must contact the NEMT Broker serving the county you live in** to ask for Non-Emergency Medical Transportation. Contact Southeastrans for Atlanta and North Regions and ModivCare, formerly LogistiCare, for Central, East and Southwest 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 NEMT provider or 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. If you have a question, comment, or complaint about a NEMT provider or broker that has not been resolved with the broker, you may contact the Georgia Department of Community Health, NEMT unit.

NEMT REGIONS & COUNTIES SERVED

Rev.
07/23

Region	NEMT Broker & Phone Number	Counties Served
North	**Verida** ***(formerly Southeastrans)*** *Toll free* 1-866-388-9844 *Local* 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	**Southeastrans** ***(formerly Southeastrans***) 404-209-4000 *Note: For Georgia Families 360°* 1-866-991-6701	Fulton, DeKalb and Gwinnett
Central	**ModivCare** ***(formerly 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	**ModivCare** ***(formerly LogistiCare)*** Toll free 1-888-224-7988 *Note: For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities* 1-800-486-7642 Ext. 461 or 436	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	**ModivCare** ***(formerly 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 H

National Correct Coding Initiative (NCCI)

The Centers for Medicare and Medicaid Services (CMS) has directed all State Medicaid agencies to implement the National Correct Coding Initiative (NCCI) as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010.

Georgia Medicaid uses NCCI standard payment methodologies. NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUEs) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

For additional questions regarding the NCCI or MUE regulations, please see the CMS website: http://www.cms.gov/.

APPENDIX I

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