

**PART II**

**POLICIES AND PROCEDURES**  
**for**  
**DIALYSIS SERVICES**



**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**

**DIVISION OF MEDICAID**

Revised: April 1, 2024

**Policy Revisions Record**  
**Part II Policies and Procedures Manual for Dialysis Services**  
**2024**

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## PART II - POLICIES AND PROCEDURES FOR DIALYSIS SERVICES

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| <p style="text-align: center;"><b>NOTE:</b></p> <p>DIALYSIS PROVIDERS SHOULD REFER TO SPECIFIC BILLING INSTRUCTIONS PROVIDED IN APPENDIX D.</p> |
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**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:**

- 601.1 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 the Dialysis ESRD program must have a diagnosis of chronic renal failure [end stage renal disease (ESRD)]. Coverage of eligible ESRD members is limited to:**

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- Services provided by providers enrolled in the Dialysis Services Program;
- 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/HCPSC 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.

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#### **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 Classification of Diseases – 10<sup>th</sup> 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 principal 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.

End Stage Renal Disease (ESRD) is defined as irreversible and permanent damage to the kidneys that requires either a regular course of dialysis treatment or kidney transplantation to maintain life.

### 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 |

| <b>Code</b> | <b>Description</b>                                                                                                                                                                                                                                                                                   |
|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 |
| 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

| <b>Code</b> | <b>Description</b>                                                                                                                                                                                                                                       |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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<br>634<br>635<br>636 | Injectable Drugs                             |

F) Facility Procedure Codes

| Code  | Description   |
|-------|---------------|
| 90999 | Hemodialysis  |
| 90945 | Home Dialysis |
|       |               |

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### 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 details were 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, antiarrhythmics, heparin, protamids, 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;

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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](http://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

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- 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

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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

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.

### 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](http://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.

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A) Services not listed as separately billable in this manual.

B) 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.

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

D) Services provided to members enrolled in a CMO plan

## **PART II - CHAPTER 1000 BASIS FOR REIMBURSEMENT**

### **1001. Reimbursement Methodology**

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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**

| GEORGIA DEPARTMENT OF COMMUNITY HEALTH                                                                                             |                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <b>Member ID# 123456789012</b><br>Member, Joe Public<br>Card Issuance Date: 12/01/11                                               |                                                                                        |
| Primary Care Physician:<br>Dr. Jane Q Public<br>285 Main Street<br>suite 2859<br>Atlanta, GA 30303<br>Phone: (123) 123-1234 x 1234 | Plan: Georgia Better Health Care<br><br><br><br><br>After Hours: (123) 123-1234 x 1234 |

| Verify Eligibility at <a href="http://www.mmis.georgia.gov" style="color: white;">www.mmis.georgia.gov</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                    |                                                                                                                                                                                                      |                                                                                                                                                                                                    |                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><small>If member is enrolled in a managed care plan, contact that plan for specific claim filing and prior authorization information.</small></p> <table style="width: 100%;"><tr><td style="width: 33%; vertical-align: top;"><p><small>HP Enterprise Services<br/>Member: Box 105200<br/>Provider: Box 105201<br/>Tucker, GA 30085<br/>Prior Authorization:<br/>1455 Lincoln Parkway, Suite 300<br/>Atlanta, GA 30346</small></p></td><td style="width: 33%; vertical-align: top;"><p><small>Payor: For Non-Managed Care Members<br/>Customer Service: 1-800-766-4456 (Toll Free)<br/>SXC, Inc.<br/>Rx BIN-001553<br/>Rx PCN-GAM<br/>SXC Rx Prior Auth<br/>1-866-525-5827</small></p></td><td style="width: 33%; vertical-align: top;"><p><small>Mail Drug Claims to:<br/>SXC Health Solutions, Inc.<br/>P.O. Box 3214<br/>Lisle, IL 60532-8214<br/>Rx Provider Help Line<br/>1-866-525-5826</small></p></td></tr></table> |                                                                                                                                                                                                    | <p><small>HP Enterprise Services<br/>Member: Box 105200<br/>Provider: Box 105201<br/>Tucker, GA 30085<br/>Prior Authorization:<br/>1455 Lincoln Parkway, Suite 300<br/>Atlanta, GA 30346</small></p> | <p><small>Payor: For Non-Managed Care Members<br/>Customer Service: 1-800-766-4456 (Toll Free)<br/>SXC, Inc.<br/>Rx BIN-001553<br/>Rx PCN-GAM<br/>SXC Rx Prior Auth<br/>1-866-525-5827</small></p> | <p><small>Mail Drug Claims to:<br/>SXC Health Solutions, Inc.<br/>P.O. Box 3214<br/>Lisle, IL 60532-8214<br/>Rx Provider Help Line<br/>1-866-525-5826</small></p> |
| <p><small>HP Enterprise Services<br/>Member: Box 105200<br/>Provider: Box 105201<br/>Tucker, GA 30085<br/>Prior Authorization:<br/>1455 Lincoln Parkway, Suite 300<br/>Atlanta, GA 30346</small></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <p><small>Payor: For Non-Managed Care Members<br/>Customer Service: 1-800-766-4456 (Toll Free)<br/>SXC, Inc.<br/>Rx BIN-001553<br/>Rx PCN-GAM<br/>SXC Rx Prior Auth<br/>1-866-525-5827</small></p> | <p><small>Mail Drug Claims to:<br/>SXC Health Solutions, Inc.<br/>P.O. Box 3214<br/>Lisle, IL 60532-8214<br/>Rx Provider Help Line<br/>1-866-525-5826</small></p>                                    |                                                                                                                                                                                                    |                                                                                                                                                                   |
| <p style="text-align: center;"><small>This card is for identification purposes only, and does not automatically guarantee eligibility for benefits and is non-transferable.</small></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                    |                                                                                                                                                                                                      |                                                                                                                                                                                                    |                                                                                                                                                                   |

## 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:<br>/ /        | Social Security No.:<br>[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]            |
| Address:                                                                                                                                        |                                                                                   | Medicaid ID NO.:             | Medicare Eligible:<br>Yes <input type="checkbox"/> No <input type="checkbox"/>      |
| Medicare Application Submitted: Yes <input type="checkbox"/> No <input type="checkbox"/>                                                        |                                                                                   |                              |                                                                                     |
| County:                                                                                                                                         | Medicare No.:                                                                     | Effective Date:              | Medicare Denied:<br>Yes <input type="checkbox"/> No <input type="checkbox"/>        |
| Reason for Denial                                                                                                                               |                                                                                   |                              |                                                                                     |
| DOCUMENTATION SHOWING MEDICARE DENIAL MUST BE ATTACHED TO THIS FORM                                                                             |                                                                                   |                              |                                                                                     |
| PART II – TREATMENT INFORMATION - DIALYSIS                                                                                                      |                                                                                   |                              |                                                                                     |
| Date of First Treatment:                                                                                                                        | Transplant Candidate:<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |                              | Place of Dialysis:<br>Home <input type="checkbox"/> Clinic <input type="checkbox"/> |
| Name of Facility Transferred from:                                                                                                              |                                                                                   |                              |                                                                                     |
| Mode of Treatment:<br>HEMODIALYSIS <input type="checkbox"/> PERITONEAL DIALYSIS <input type="checkbox"/> SELF DIALYSIS <input type="checkbox"/> |                                                                                   |                              |                                                                                     |
| 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:<br>Gainwell Technologies<br>P.O. Box 105200<br>Tucker, GA. 30085-5200                                                        |                                                                                   |                              |                                                                                     |

## 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:

Rev. 04/14

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

- o Claim (s) must be submitted within six (6) months from the month of service.
- o Claim (s) with third party resource (s) must be submitted within twelve (12) months from the month of service.

Rev. 07/12  
Rev. 04/14

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

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.

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

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

- o Claim (s) must be submitted within six (6) months from the month of service.
- o Claim (s) with third party resource (s) must be submitted within twelve (12) months from the month of service.

Rev. 07/12

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

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.

- o 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                                                                                                                                                                                                                                                     |  |  |  |  |                                        |  |  |                                                           |  | PICA                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|----------------------------------------|--|--|-----------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER                                                                                                                                                                               |  |  |  |  |                                        |  |  |                                                           |  | 1a. INSURED'S LD, NUMBER (For Program in Item 1)                                                                                                              |  |
| (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)                                                                                                                                                                                        |  |  |  |  |                                        |  |  |                                                           |  |                                                                                                                                                               |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)                                                                                                                                                                                                |  |  |  |  | 3. PATIENT'S BIRTH DATE                |  |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |  |                                                                                                                                                               |  |
|                                                                                                                                                                                                                                                          |  |  |  |  | MM DD YY M F                           |  |  |                                                           |  |                                                                                                                                                               |  |
| 5. PATIENT'S ADDRESS (No., Street)                                                                                                                                                                                                                       |  |  |  |  | 6. PATIENT RELATIONSHIP TO INSURED     |  |  | 7. INSURED'S ADDRESS (No., Street)                        |  |                                                                                                                                                               |  |
| CITY                                                                                                                                                                                                                                                     |  |  |  |  | Self Spouse Child Other                |  |  | CITY                                                      |  |                                                                                                                                                               |  |
| STATE                                                                                                                                                                                                                                                    |  |  |  |  | 8. RESERVED FOR NUCC USE               |  |  | STATE                                                     |  |                                                                                                                                                               |  |
| ZIP CODE                                                                                                                                                                                                                                                 |  |  |  |  | TELEPHONE (Include Area Code)          |  |  | ZIP 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)   |  |  | a. INSURED'S DATE OF BIRTH                                |  |                                                                                                                                                               |  |
|                                                                                                                                                                                                                                                          |  |  |  |  | YES NO                                 |  |  | MM DD YY M F                                              |  |                                                                                                                                                               |  |
| b. RESERVED FOR NUCC USE                                                                                                                                                                                                                                 |  |  |  |  | b. AUTO ACCIDENT?                      |  |  | b. OTHER CLAIM ID (Designated by NUCC)                    |  |                                                                                                                                                               |  |
|                                                                                                                                                                                                                                                          |  |  |  |  | YES NO                                 |  |  |                                                           |  |                                                                                                                                                               |  |
| c. RESERVED FOR NUCC USE                                                                                                                                                                                                                                 |  |  |  |  | c. OTHER ACCIDENT?                     |  |  | c. INSURANCE PLAN NAME OR PROGRAM NAME                    |  |                                                                                                                                                               |  |
|                                                                                                                                                                                                                                                          |  |  |  |  | YES NO                                 |  |  |                                                           |  |                                                                                                                                                               |  |
| 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.              |  |                                                                                                                                                               |  |
| 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. |  |  |  |  |                                        |  |  |                                                           |  | 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                                                                                                                                                                                                                                                   |  |  |  |  |                                        |  |  |                                                           |  | SIGNED                                                                                                                                                        |  |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)                                                                                                                                                                                                  |  |  |  |  |                                        |  |  |                                                           |  | 15. OTHER DATE                                                                                                                                                |  |
| MM DD YY QUAL                                                                                                                                                                                                                                            |  |  |  |  |                                        |  |  |                                                           |  | MM DD YY                                                                                                                                                      |  |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE                                                                                                                                                                                                           |  |  |  |  |                                        |  |  |                                                           |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES                                                                                                         |  |
| 17a. 17b. NPI                                                                                                                                                                                                                                            |  |  |  |  |                                        |  |  |                                                           |  | FROM TO                                                                                                                                                       |  |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)                                                                                                                                                                                                    |  |  |  |  |                                        |  |  |                                                           |  | 20. OUTSIDE LAB? \$ CHARGES                                                                                                                                   |  |
|                                                                                                                                                                                                                                                          |  |  |  |  |                                        |  |  |                                                           |  | YES NO                                                                                                                                                        |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate to A-L to service line below (24E) ICD Ind.                                                                                                                                                          |  |  |  |  |                                        |  |  |                                                           |  | 22. RESUBMISSION CODE ORIGINAL REF. NO.                                                                                                                       |  |
| A. B. C. D. E. F. G. H. I. J. K. L.                                                                                                                                                                                                                      |  |  |  |  |                                        |  |  |                                                           |  |                                                                                                                                                               |  |
| 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPICOT Family Plan I. ID, QUAL. J. RENDERING PROVIDER ID. #     |  |  |  |  |                                        |  |  |                                                           |  |                                                                                                                                                               |  |
| 1 2 3 4 5 6                                                                                                                                                                                                                                              |  |  |  |  |                                        |  |  |                                                           |  |                                                                                                                                                               |  |
| 25. FEDERAL TAX ID, NUMBER SSN EIN                                                                                                                                                                                                                       |  |  |  |  |                                        |  |  |                                                           |  | 26. PATIENT'S ACCOUNT NO.                                                                                                                                     |  |
|                                                                                                                                                                                                                                                          |  |  |  |  |                                        |  |  |                                                           |  |                                                                                                                                                               |  |
| 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.)                                                                                   |  |  |  |  |                                        |  |  |                                                           |  | 32. SERVICE FACILITY LOCATION INFORMATION                                                                                                                     |  |
| SIGNED                                                                                                                                                                                                                                                   |  |  |  |  |                                        |  |  |                                                           |  | a. NPI b.                                                                                                                                                     |  |
| DATE                                                                                                                                                                                                                                                     |  |  |  |  |                                        |  |  |                                                           |  |                                                                                                                                                               |  |
| 27. ACCEPT ASSIGNMENT? (For gov't claims, see back) YES NO                                                                                                                                                                                               |  |  |  |  |                                        |  |  |                                                           |  | 28. TOTAL CHARGE \$                                                                                                                                           |  |
|                                                                                                                                                                                                                                                          |  |  |  |  |                                        |  |  |                                                           |  | 29. AMOUNT PAID \$                                                                                                                                            |  |
|                                                                                                                                                                                                                                                          |  |  |  |  |                                        |  |  |                                                           |  | 30. Rsvd for NUCC Use                                                                                                                                         |  |
| 33. BILLING PROVIDER INFO & PH #                                                                                                                                                                                                                         |  |  |  |  |                                        |  |  |                                                           |  |                                                                                                                                                               |  |
|                                                                                                                                                                                                                                                          |  |  |  |  |                                        |  |  |                                                           |  |                                                                                                                                                               |  |

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

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

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 “ <b>RESERVED FOR NUCC USE.</b> ”                                                                                                                                                                                                                                                   |
| Item Number 9b  | Deleted “OTHER INSURED’S DATE OF BIRTH, SEX.” Changed title to “ <b>RESERVED FOR NUCC USE.</b> ”                                                                                                                                                                                                                                                    |
| Item Number 9c  | Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “ <b>RESERVED FOR NUCC USE.</b> ”                                                                                                                                                                                                                                                             |
| Item Number 10d | Changed title from “RESERVED FOR LOCAL USE” to “CLAIM CODES (Designated by NUCC).” <b>Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.</b><br><b>FOR DCH/Gainwell Technologies:</b> 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.” <b>Changed title to “OTHER CLAIM ID (Designated by NUCC).”</b> 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.”<br><b>FOR DCH/Gainwell Technologies: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date).</b>  |
| 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 – <b>Used by Medicare</b> for identifiers for provider roles: Ordering, Referring and Supervising.<br><b>FOR DCH/Gainwell Technologies:</b> Use the following Ordering Provider, Referring, Supervising Qualifiers (effective 4/01/2014): <b>Ordering = DK; Referring = DN or Supervising = DQ.</b>                                          |
| Item Number 19                                     | Changed title from “ <b>RESERVED FOR LOCAL USE</b> ” to “ADDITIONAL CLAIM INFORMATION (Designated by NUCC).”<br><b>FOR DCH/Gainwell Technologies:</b> Remove the Health Check logic from field 19 and add it in <b>field 24H.</b>                                                                                                                                                                                                     |
| 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.<br>Use the highest level of code specificity in FLD Locator 21.<br><b>Diagnosis Code ICD Indicator</b> - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0.<br><b>(Do not bill ICD 10 code sets before October 1, 2015.)</b> |
| 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:<br>7 (Replacement of prior claim)<br>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.<br><b>FOR DCH/Gainwell Technologies</b><br>: Item numbers <b>24A &amp; 24G</b> are used to capture Hemophilia drug units. <b>24H</b> (EPSDT/Family Planning).                                                                                                                                                   |
| Item Number 30                                     | Deleted “BALANCED DUE.” Changed title to “ <b>RESERVED FOR NUCC USE.</b> ”                                                                                                                                                                                                                                                                                                                                                            |
| Footer                                             | Changed “APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)” to “APPROVED OMB-0938-1197 FORM 1500 (02/12).”                                                                                                                                                                                                                                                                                                                                 |

# UB-04 CLAIM FORM

[illegible]

## 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     Condition Codes  
Thru 28    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.**

**For Medicaid-Medicare Crossover Claims:** 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 CPT/HCPCS/Rates

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 the 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 example: 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 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- Other Diagnosis Codes  
Thru 67Q

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 of the 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 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.**

## 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:

|                                                                                                                                                                                                      |                                                                                                                                                                                                    |                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <p>Amerigroup Community Care<br/>1-800-454-3730<br/><a href="http://www.amerigroup.com">www.amerigroup.com</a></p> |  <p>Peach State Health Plan<br/>866-874-0633<br/><a href="http://www.pshpgeorgia.com">www.pshpgeorgia.com</a></p> |  <p>CareSource<br/>1-855-202-1058<br/><a href="http://www.caresource.com">www.caresource.com</a></p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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](http://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):**

| <b>COE</b> | <b>DESCRIPTION</b>                      |
|------------|-----------------------------------------|
| 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<br>(general information)<br><a href="http://www.amerigroup.com">www.amerigroup.com</a> | 1-855-202-1058<br><a href="http://www.careSource.com/Georgia/Medicaid">www.careSource.com/Georgia/Medicaid</a> | 866-874-0633 (general information)<br>866-874-0633 (claims)<br>800-704-1483 (medical management)<br><a href="http://www.pshpgeorgia.com">www.pshpgeorgia.com</a> |

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

### How often can a patient change his/her PCP?

| Amerigroup Community Care | CareSource                                                                                                                                                                                                                                                                                                                          | Peach State Health Plan                                                                                                                                                                                                                                                                 |
|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Anytime                   | <p>Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as:</p> <ul style="list-style-type: none"><li>• Member requests to be assigned to a family member's PCP</li><li>• PCP does not provide the covered services a member seeks</li></ul> | <p>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.</p> |

|  |                                                                    |  |
|--|--------------------------------------------------------------------|--|
|  | due to moral or religious objections<br>• 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 24 <sup>th</sup> day of the month and are effective for the current month. PCP changes made after the 24 <sup>th</sup> 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<br><a href="https://providers.amerigroup.com/pages/ga-2012.aspx">https://providers.amerigroup.com/pages/ga-2012.aspx</a> | 844-441-8024<br><a href="https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod">https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod</a> | 866-874-0633<br><a href="http://www.pshpgeorgia.com">www.pshpgeorgia.com</a> |

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       |
|----------------------------------|-----------------------|--------|-------|---------|----------------|
| <b>Amerigroup Community Care</b> | IngenioRx             | 020107 | HL    | WKJA    | 1-833-235-2031 |
| <b>CareSource</b>                | Express Scripts (ESI) | 003858 | MA    | RXINN01 | 1-800-416-3630 |
| <b>Peach State Health Plan</b>   | Express Scripts (ESI) | 003858 | MA    | 2EFA    | 1-833-750-4403 |

**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](http://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<br>1 (866) 930-0019 (fax) | 1 (866) 399-0929        |



## Appendix F

### **GEORGIA FAMILIES 360°** *Information for Providers Serving Medicaid Members* in the Georgia Families 360°<sub>SM</sub> Program

**Georgia Families 360°<sub>SM</sub>**, 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°<sub>SM</sub> Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

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

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management 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](http://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.

## **Dialysis Transportation**

Non-Emergency Medical Transportation services are defined as medically necessary transportation for eligible Medicaid members (and escort, 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. **It is the responsibility of NEMT providers to provide transportation only.**

### **NEMT Driver and/or Attendant Responsibilities:**

- NEMT drivers and attendants are not required to assist the members beyond the scope of NEMT policy guidelines.
- NEMT drivers and/or attendants are not medical personnel and do not provide any direct medical services to the members at the dialysis facility.
- NEMT drivers and/or attendants are only responsible for transporting members within the NEMT guidelines which include:
  - Safely transporting the members to and from their designated locations.
  - Adhering to NEMT policies and procedures.
  - No driver and/or attendant shall touch any passenger except as appropriate and necessary to assist the passenger into or out of the vehicle, into a seat on the vehicle and to secure the seatbelt, or as necessary to render first aid or assistance in case of an emergency.
  - Transporting the members to and from their designated locations with the appropriate mobility as described below:
    - Ambulatory – Curb to Curb (Member can walk to and from the vehicle without assistance). If a member with ambulatory mobility needs special assistance, the member's escort or facility staff is responsible for providing the member with the needed assistance upon arrival.
    - Wheelchair – Door to Door (No lift assistance provided for member to the dialysis chair by the NEMT provider)
    - Stretcher – Bed to bed/treatment chair. The facility must have a bed/treatment chair ready for the Member to offload immediately upon arrival. A letter of medical necessity must be included with all stretcher mobility standing order requests.
- **Dialysis Facility Responsibilities:**
  - Upon arrival at the dialysis facility, the dialysis health care team assumes responsibility for the member's care.
  - This includes weighing the member, transferring the member to the dialysis chair, and any other duties outside of the scope of NEMT services.

**NEMT REGIONS & COUNTIES SERVED**

| <b>Region</b> | <b>NEMT Broker &amp; Phone Number</b>                                                                                                                                                                                          | <b>Counties Served</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>North</b>  | <b>Verida</b><br><i>(formerly Southeastrans)</i><br><br>Toll free<br>1-866-388-9844<br><br>Local<br>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       | <b>Southeastrans</b><br><i>(formerly Southeastrans)</i><br>404-209-4000<br><br><i>Note: For Georgia Families 360°</i><br><br>1-866-991-6701                                                                                    | Fulton, DeKalb, and Gwinnett                                                                                                                                                                                                                                                                                                                                                                                                           |
| Central       | <b>ModivCare</b><br><i>(formerly LogistiCare)</i><br><br>Toll free<br>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          | <b>ModivCare</b><br><i>(formerly LogistiCare)</i><br><br>Toll free<br>1-888-224-7988<br><br><i>Note: For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities</i><br><br>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     | <b>ModivCare</b><br><i>(formerly LogistiCare)</i><br><br>Toll free<br>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).