

PART II

POLICIES AND PROCEDURES for INDEPENDENT LABORATORY SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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Part II Policies and Procedures Manual for INDEPENDENT LABORATORY SERVICES

2024

Revision Date	Section	Revision Description	Revision Type A= Added D = Deleted M = Modified	Citation (Revision required by Regulation, Legislation, etc.)
01/01/2024	802	Removed procedure code 81407 from chapter 800		
01/01/2024	802	Added procedure codes 0094U, 0340U and 81425		
04/01/2024	802	Added procedure codes 81400, 81402 and 80407 to chapter 800	A	
05/08/2024	802	Added procedure codes 0243U, 0247U and 0390U	A	

**PART II – POLICIES AND PROCEDURES
FOR
INDEPENDENT LABORATORY SERVICES**

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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, Section 106, providers in the Independent Laboratory Program must meet the following conditions:
- 601.1 Agree to operate independent of both the attending or consulting physician's office and of a hospital which meets at least the requirements specified in section 1861(e) and (j) of the Act to qualify for payment for emergency hospital services under Section 1814(d) of the Act.
 - 601.2 Be established as a single facility for the biological, microbiological, serological, immunological, chemical, hematological, radiobioassay, cytological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition. Facilities that only collect specimens and do not perform testing are excluded from participation in the Medicaid Laboratory program.
 - 601.3 Agree to bill the Division only for services rendered in those specialty areas for which current certification has been granted by the Department of Health and Human Services (DHHS).
 - 601.4 Agree to maintain current State licensure (if required by the state in which the laboratory is located), and to supply the Division with copies of such, and to immediately notify the Division in writing of revocation, suspension or change in licensure.
 - Rev. 10/21 601.5 Agree to bill the Division for only those laboratory services and/or procedures that are completed within that facility. The Division will also cover laboratory services performed at one location within the same hospital system even though the specimen was collected at another location within the same hospital system. Under certain circumstances laboratory services may be rendered by outside laboratory that are **NOT** within the same hospital system or laboratory site, physician or group practice be billed to the Division. Independent laboratories must comply with all Conditions of Participation outlined in Chapter 600 and Part II of the Policies and Procedures of the Independent Laboratory Services Manual.
 - 601.6 Be certified for participation in the Title XVIII, Part B, Medicare Program.

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- 601.7 Agree to bill only for laboratory services requested by an attending or Consulting Physician, Physician Assistant, Advance Nurse Practitioner, Nurse Midwife and Podiatrist.
- 601.8 Agree to maintain copies of the requesting physician's request slip and the test results for a period of five (5) years. The records for pathology test reports must be maintained for a period of ten years and records of blood product testing and immunology for a period of not less than five (5) years, according to federal law. Records shall be retained in the laboratory in such a manner that permits ready identification and accessibility.

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- 601.9 Agree to bill the Division the lowest rate charged to private patients, other third-party payers and insurance carriers, HMOs or other members of the general public for comparable services. The lowest rate includes any special price or discounts offered to such patients.
- 601.10 Agree to notify the Division's Provider Enrollment/Reference Data Base Unit in writing should any change in enrollment status occur such as: new address or telephone number, additional locations, or voluntary termination. Each notice of change must include the date on which the change shall be effective.
- 601.11 Comply with the existing regulatory programs covered by federal, state, and local laws for fire safety, environment and health-related matters.
- 601.12 Enroll and successfully participate in a proficiency testing program approved by DHHS for each specialty and subspecialty in which the laboratory seeks Medicare approval or licensure under the Clinical Laboratory Improvement Amendments (CLIA) of 1988 or both. Failure to successfully participate in a proficiency testing program will result in the termination of the laboratory from the Medicaid program.
- 601.13 Submit to the Division Provider Enrollment/Reference Data Base Unit a completed copy of the Disclosure of Ownership Form (CMS 1513).

PART II - CHAPTER 700

SPECIAL ELIGIBILITY CONDITIONS

- 701.** In addition to those eligibility conditions described in Part I, Section 102, members receiving services under this Program must be referred, in person or by delivery of specimen, by a physician or podiatrist. The laboratory must have a valid laboratory request slip from the referring provider indicating the tests to be performed.

PART II - CHAPTER 800

PRIOR APPROVAL

- 801.** Some services covered in this manual do not require prior approval. However, the Division will require prior approval for certain procedures performed by a laboratory 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 Licensing Agent. This action may be invoked by the Commissioner as an administrative recourse in lieu of or in conjunction with an adverse action described in Chapter 400. In such instances, the Department will serve written notice to the provider of this requirement and the grounds for such action.

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802. Procedures for Obtaining Prior Approval

The physician is responsible for obtaining the prior authorization before rendering the laboratory test. Requests for prior approvals may be submitted online via the Web portal at www.mmis.georgia.gov. For further information, contact the Gainwell Technologies at (800) 766-4456 (Toll free). Laboratory tests listed below require a PA regardless to age or place of service.

A request for prior approval must be submitted at least one week prior to the planned laboratory test. Laboratory tests performed prior to receipt of an approved request may risk denial of reimbursement. Failure to obtain required prior authorization shall result in denial of reimbursement.

The documentation that **must** be submitted to substantiate the request for a genetic testing PA should include:

- Physician/ Nurse Practitioner/ Physician Assistant Order
- Clinical Notes from the Medical Chart belonging to the provider signing the order which should include appropriate history, physical exam, etc.
- Additional Supporting Clinical Documents which may include related testing and genetic counseling.

CPT CODE	DESCRIPTION
81400	Molecular Pathology Procedure Level 1
81401	Molecular Pathology Procedure Level 2
81402	Molecular Pathology Procedure Level 3
81403	Molecular Pathology Procedure Level 4
81404	Molecular Pathology Procedure Level 5
81405	Molecular Pathology Procedure Level 6
81406	Molecular Pathology Procedure Level 7
81407	Molecular Pathology Procedure Level 8
81408	Molecular Pathology Procedure Level 9
81415	Test for Detecting Exome, Sequence Analysis
81417	Revaluation Test of Previously Obtained Exome Sequence
81425	Test for detecting genes associated with disease, genome sequence analysis.
81479	Unlisted Molecular Pathology
81445	Targeted Genomic Sequence Analysis Panel of DNA Or Combined DNA And RNA 5-50 Associated with Solid Organ Neoplasm
81449	Targeted Genomic Sequence Analysis Panel of RNA of 5-50 Genes Associated with Solid Organ Neoplasm
81451	Targeted Genomic Sequence Analysis Panel of RNA of 5-50 Genes Associated with Blood and Lymphatic System Disorders
81455	Targeted Genomic Sequence Analysis Panel of DNA or Combine DNA and RNA of 51 or Greater Genes Associated with Blood and Lymphatic System Disorders
81456	Targeted Genomic Sequence Analysis Panel of RNA of 51 or Greater Genes Associated with Blood and Lymphatic System Disorders
0037U	DNA gene analysis of 324 genes in solid organ tumor tissue

0094U	Rapid sequence gene testing.
0172U	DNA gene analysis (BRCA1, DNA repair associated and BRCA2, DNA repair associated) for detection of mutations associated with breast cancer.
0239U	Gene analysis of 311 or more genes associated with solid organ cancer in cell-free DNA, targeted sequence panel.
0243U	Time-resolved fluorescence immunoassay of placental-growth factor in maternal serum to evaluate risk of preeclampsia.
0247U	Quantitative measurement of insulin-like growth factor-binding protein 4 and sex hormone-binding globulin (SHBG) in maternal serum by LC-MS/MS to evaluate risk of premature birth.
0340U	DNA assays for detection of minimal residual disease in cancer.
0345U	Genomic analysis panel of 15 genes for detection of abnormalities associated with mental health disorders.
0390U	Immunoassay of serum for proteins, reported as a risk score for preeclampsia.

SCOPE OF SERVICES

PART II - CHAPTER 900

901. General

The Independent Laboratory program reimburses for most pathological and clinical laboratory tests, subject to the service limitations described in Section 903 and the non-covered services described in Section 904. All services are subject to these limitations without regard to diagnosis, type of illness, or condition.

902. Coding

Provider coding of both diagnosis and procedures is required for all claims. The coding schemes acceptable by the Division are the ICD-10-CM (International Classification of Diseases - 10th Edition - Clinical Modification) for diagnoses and the CPT (Current Procedural Terminology- 4th Edition) for procedures. Copies of the CPT and ICD-10-CM code books are available for purchase from the following organizations:

CPT

American Medical Association
Order Department OP341-6
Post Office Box 10946
Chicago, Illinois 60610

ICD-10-CM

ICD-10-CM
Post Office Box 991
Ann Arbor, Michigan

Certain codes from these coding schemes are not accepted by the Division and are discussed in the following sections:

902.1 ICD-10-CM

Codes deleted from previous editions of the ICD 10 are not accepted by the Division. The provider must select the diagnosis codes from the ICD 10 CM expert which most nearly describes the diagnosis of the patient.

In coding the diagnosis on your claims, the code must be placed on the claim form using the identical format (including the decimal point) as shown in the ICD-10-CM codes (examples: I11, I11.0 and I11.9). Coding must be to the lowest level.

It is the responsibility of the laboratory to obtain the member's diagnosis from the prescribing practitioner at the time the referral is made.

902.2 CPT

Laboratory procedures are defined in the CPT in the ranges 80047 through 89356. Providers must select the procedure code(s) that best describes the procedure(s) performed. The following instructions apply to the use of the CPT procedure codes on laboratory claims:

- a) Codes deleted from previous editions of the CPT are not reimbursable;
- b) Most of the codes for "Unlisted Procedures" which end in "99" are not accepted by the Division;
- c) The 26 and TC modifiers should be used only when necessary; other modifiers used for clarifying circumstances are not accepted by the Division.
- d) The appropriate "Place of Service" codes located on the back of the CMS-1500 claim form must be used.
- e) Updates to the CPT are effective as soon as possible after the month of publication. This applies to deletions, additions and/or revisions. It is the laboratory staff's responsibility to maintain an up-to-date CPT publication.

903. Service Limitations

903.1 Specimen Conveyance to another Laboratory

Specimen conveyance from one independent laboratory to another independent laboratory or to one of the Public Health Laboratories is not reimbursable.

903.2 Automated Chemistries (Bundling and Unbundling)

Individual components of automated, multi-channel tests must be billed separately. These tests must be billed using codes in the ranges 80047 through 89356 and 80047 through 80076.

- a. When any of the twenty-three automated tests are performed:
 - 1. Bill the CPT for each individual test, or
 - 2. Bill the CPT for the Organ Disease Panel (OD) plus the individual CPT code for any automated tests not included in the panel.

- b. When several panels are ordered that contain some or all of the same automated chemistries, payment will be equal to the total number of different automated chemistries in all of the panels (minus any duplicate tests). Multiples of OD panels may be denied.
- c. When any of the twenty-three automated chemistries are part of an OD panel, payment for the OD panel will be made if the panel contains only the automated tests for that date of service for that member.
- d. When other automated chemistries are ordered along with the OD panel, the panel will be unbundled, and a fee based on the least expensive method of grouping the automated chemistries and OD panel.

903.3 Public Health Laboratory Services

The following policies and procedures on Public Health Laboratory services must be followed:

Effective October 1, 2010, Fee for Service (FFS) Medicaid will begin reimbursing providers the \$10 lab handling fee assessed by the GPHL. The \$10.00 reimbursement is limited to CPT lab codes:

CPT 83655—Assay of lead

CPT 86803—Hepatitis C AB test

Providers are also required to continue to submit all other specified lab tests to the GPHL, as outlined in the Part II Policy and Procedure for Independent Laboratory Services, Section 903. Only CPT codes 83655, 86403, 86689 and 86803 are subject to reimbursement.

To ensure accurate reimbursement, providers must submit CPT codes 83655, 86403, 86689 and 86803 with modifier 90 or 91, on the CMS 1500 claim form per established billing guidelines.

Modifier 90—Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

Modifier 91—Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same

laboratory test on the same day to obtain subsequent (multiple) test results.

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Referring Laboratory- is a laboratory that receives a specimen to be tested and then refers the specimen to another laboratory for performance of the laboratory test.

Reference Laboratory- is a laboratory that referring specimen from another, referring laboratory for testing and that actually performs the test.

Newborn Screens

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

Procedure Codes 82017 82127 82131 82261 84150
 82775 82776 83020 83498
 84030 84436 84437 84442 84443

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

Hemoglobin Testing

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

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

All blood specimens with a sickle cell indicator must be forwarded in an appropriate sickle cell outfit to the Waycross Regional Public Health Laboratory.

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

Gonorrhea and Syphilis Testing

Rev 04/14

The Department will not provide reimbursement for diagnosis ICD 10 CM A54 through A64 with the following procedure codes:

Procedure codes 87070, 87081, and 87205

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

Tuberculosis Testing

Rev 04/14

The following procedures are for tuberculosis diagnosis ICD 10 CM A15.0 through A15.9 & A18.4 testing:

87116 and 87118

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

Salmonella and Shigella Testing

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Diagnoses included are ICD 10 CM A02.0 – A03.9.

The procedures are: 87045 and 87081.

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

903.4 Hemodialysis Related Testing

Laboratory procedures performed as part of routine hemodialysis services rendered in a dialysis center will not be separately reimbursed without medical documentation.

The following list identifies laboratory tests that can be reimbursed routinely without documentation of medical necessity when the diagnosis code is end stage renal disease. If the procedures are

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performed at a frequency greater than that specified below, they are covered only if accompanied by medical documentation. For reimbursement of procedure codes performed outside of the frequencies below, the provider must send to the Medical Review Unit a copy of the remittance advice notice with the denied service, a completed CMS-1500 claim form, and documentation from the ordering provider 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.

- (a) Testing for hepatitis B Surface Antigen (Hbsag), procedure code 87340 is limited to one month for patients who are identified as seronegative.
- (b) Hepatitis B Surface Antibody or Hepatitis B Core Antibody testing is limited to one but not both, once a year. Procedures included are: 86704, 86705, 86706, and 87350; and
- (c) Serum aluminum (82108) and Serum Ferritin (82728) are limited to one every 3 months.

903.5 Laboratory Test Included In The Dialysis Fee

The tests listed below are restricted when the procedures are performed in conjunction with dialysis. The procedures listed below are included in the dialysis fee and are not directly reimbursable to the laboratory.

82042 Albumin, Urine
82247 Bilirubin, total
82248 Bilirubin, direct
82310 Calcium, total
82330 Calcium, iodized
82734 CO2 Combining Power
82435 Chloride, Serum
82436 Chloride, Urine
82540 Creatine, Blood
82565 Creatinine, Blood
82575 Creatinine, Clearance
82947 Glucose, Serum
83615 LDH, Blood

83735 Magnesium, Serum, Chemical
84075 Alk, Phosphatase
84100 Phosphorus (phosphate), Serum

84105 Phosphorus (Phosphate), Urine
 84132 Potassium; Serum, plasma or whole blood
 84133 Potassium, Urine
 84155 Protein, total, except by refractometry; serum, plasma or whole blood
 84295 Sodium; Serum, plasma or whole blood
 84300 Sodium, Urine
 84450 SGOT
 84460 SGPT
 84520 BUN
 84550 Uric Acid, Blood
 84560 Uric Acid, Urine
 85014 Hct.
 85018 Hgb.
 85025 CBC
 85027 CBC with platelet count
 85041 RBC
 85048 WBC
 85610 Prothrombin Time

Note: Procedures codes shown above include any <u>other</u> lab code with similar descriptions.
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903.6 Specimen Collecting Fee (Venipuncture or Catheter Urine)

The collection of specimens associated with dialysis laboratory tests is included in the dialysis fee and is non-covered.

Rev. 01/19 903.7 Drug Testing

We are implementing the following changes for drug testing for Calendar Year (CY) 2017:

For **presumptive testing**, create three codes, **80305**, **80306** and **80307**. Only **one** of the three presumptive codes may be billed per day.

For **definitive testing**, create five G codes, **G0480**, **G0481**, **G0482**, **G0483** and **G0659**. Only **one** of the five definitive G codes may be billed per day.

For definitive testing, the unit used to determine the appropriate definitive code to bill is “drug class.”

Each drug class may only be used **once per day** in determining the appropriate definitive code to bill.

Drug classes are listed below and are consistent with their usage in the AMA CPT Manual.

The AMA CPT Manual may be consulted for examples of individual drugs within each class.

- Alcohol(s)
- Alcohol Biomarkers
- Alkaloids, not otherwise Specified
- Amphetamines
- Anabolic steroids
- Analgesics, non-opioid
- Antidepressants, serotonergic class
- Antidepressants, Tricyclic and other cyclicals
- Antidepressants, not otherwise specified
- Antiepileptics, not otherwise specified
- Antipsychotics, not otherwise specified
- Barbiturates
- Benzodiazepines
- Buprenorphine
- Cannabinoids, natural
- Cannabinoids, synthetic
- Cocaine
- Fentanyl
- Gabapentin, non-blood
- Heroin metabolite
- Ketamine and Norketamine
- Methadone
- Methylenedioxyamphetamines
- Methylphenidate
- Opiates
- Opioids and opiate analogs
- Oxycodone
- Phencyclidine
- Pregabalin
- Propoxyphene
- Sedative Hypnotics (nonbenzodiazepines)
- Skeletal muscle relaxants
- Stereoisomer (enantiomer) analysis
- Stimulants, synthetic

- Tapentadol
- Tramadol
- Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified;

Presumptive Drug Class Screening (PDSC):

Code: 80305 Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, capable of being read by direct optical observation only (eg utilizing immunoassay eg. dipsticks, cups, cards, or cartridges), includes sample validation when performed, per date of service. **Report this procedure once, irrespective of the number of procedures or drugs tested on any date of service.**

Code: 80306 Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures,) read by instrument-assisted direct optical observation (eg, immunoassay eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service. **Report this procedure once, irrespective of the number of procedures or drugs tested on any date of service.**

Code: 80307 Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures by instrument chemistry analyzers (eg,utilizing immunoassay, eg EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA) chromatography, (eg. GC, HPLC) and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, ML- MS/MS, LDTD, MALDI, TOF) including sample validation when performed, per date of service.

Definitive Drug Testing:

Code: G0480 Drug test(s) definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(s), including metabolite(s) if performed.

Code: G0481: Drug test(s) definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic

methods (e.g., alcohol dehydrogenase). (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day, 8-14 drug class(s), including metabolites(s) if performed.

Code: G0482: Drug test(s) definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day, 15-21 drug classes, including metabolites(s) if performed.

Code: G0483: Drug test(s) definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day, 22 or more drug classes, including metabolites(s) if performed.

Code G0659: Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes.

Specimen outfits for testing to be done in the Regional Laboratories should be ordered directly from those laboratories at the below listed address.

The State Laboratory locations and telephone numbers are listed below:

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

Waycross Public Health Laboratory
Georgia Department of Public Health
1751 Gus Karle Parkway
Waycross, Georgia 31503
(912) 338-7050 FAX (912) 338-7061

903.8 HIV Screening Testing

The Division reimburses for screening tests when ordered by the member's physician or practitioner within the context of a healthcare setting and performed by an eligible Medicaid provider.

The following procedures are for HIV screenings:

- 86701 Analysis for antibody to HIV -1 virus
- 86702 Analysis for antibody to HIV- 2 virus
- 86703 Analysis for antibody to HIV – 1 and HIV- 2 virus
- 87389 Detection test for HIV-1 and HIV-2
- 87390 Detection test for HIV-1
- 87391 Detection test for HIV-2

903.9 HIV Resistance Testing

- (A) The Division reimburses for genotype assay and phenotype assay tests for the management of Human Immunodeficiency Virus (HIV) type I. These tests will help determine drug resistance or drug sensitivity and are useful for patients who are not improving on a specific drug regimen.

Genotype analysis identifies mutations that are associated with drug resistance and phenotype analysis measures the ability of the virus to grow in the presences of drugs under consideration by the physician.

Reimbursement will be made when resistance testing is recommended in the following situations:

- When a patient presents with virologic failure during Highly Active Antiretroviral Therapy; and
- When the patient has suboptimal suppression of viral load after initiation of antiretroviral therapy.

Reimbursement will not be considered:

- When the patient's plasma viral load is <1000 HIV copies/mL;
- After the discontinuation of drugs; and
- With chronic HIV infection prior to initiation of therapy.

The following procedures are for HIV resistance testing:

- 87901 – Genotype analysis
- 87903 – Phenotype analysis up to 10 drugs
- 87904 – Each additional drug, up to 5 drugs; use this code in conjunction with 87903
- 87900-Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics

The following procedure is for HIV detection testing:

87536 – Detection test for HIV-1 virus

Molecular Diagnostic Testing

Procedure codes in the range 81500-81512, 87481 and 87798 when greater than one unit of service is required and when medical necessity supports the procedures that normally receive a National Correct Coding Initiative exception will be considered for payment.

904. Non-Covered Services

The list below represents common procedures and settings in which services are non-covered. This list is not meant to be exhaustive but is indicative of non-covered services:

- a) Procedures completed in laboratories operated as a part of a physician's private office (described in the Policies and Procedures for Physician Services);

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- b) Procedures completed in laboratories providing services to hospital patients, operating on the premises of a hospital that meets the definition of an emergency hospital (described in the Policies and Procedures for Hospital Services);
- c) Experimental services or procedures or those not recognized by the United States Public Health Service as universally accepted procedures;
- e) Procedures deleted from previous and current editions of the CPT and those shown as "Unlisted Procedure" which end in "99";
- f) Professional interpretation for procedures normally interpreted by an attending practitioner;
- g) Services and/or procedures performed without regard to the policies contained in this manual;
- h) Services provided free-of-charge to Medicaid members by state or public laboratories;
- i) The collection and handling of specimens sent to an independent laboratory for further distribution to another testing facility;
- j) Laboratory test procedures included in the dialysis facility's composite rate;
- k) Specimen collection and or handling fee (Venipuncture or Catharized Urine);
- l) Services for which the performing provider does not have appropriate CLIA certification;
- m) Reimbursement for more than twenty-five multiple drug screens per member per fiscal year;

PART II - CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001. Reimbursement Methodology

The Division will pay the lower of the laboratory's usual and customary charge, or the statewide maximum allowable amount for the procedure rendered. This maximum allowable amount is derived from an analysis of the usual and customary fees submitted for a given procedure. The Division cannot exceed the prevailing reimbursement rate that has been established for Medicare reimbursement for the same clinical laboratory procedure

Rev 07/16

The Schedule of Maximum Allowable Payments is not a fee schedule. As required in Section 601.8, providers must bill the Division their usual and customary fees. 'Usual and customary' means the lowest rate charged to private patients, other third-party payers and insurance carriers, HMO's or other members of the general public for comparable services. The lowest rate includes any special price or discounts offered to such patients. Providers must not change their fees to the rates in this Schedule, even if their fees are higher than those listed for the service rendered. Usual and customary fees are recorded and used by the Division when the Schedule of Maximum Allowable Payments is updated.

Multiple laboratory procedures billed for the same member should be submitted on one claim for that date of service.

Rev 04/22

Note: Reimbursement of the clinical laboratory CPT codes is based on Medicaid's pricing methodology for Outpatient Lab services which reimburses the lesser of the following:

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

1002. Co-payment

Members receiving services are not subjected to co-payment requirements. Independent Laboratory Services are exempt.

1003. CLIA Requirements

All providers that bill for laboratory services must have CLIA certification equal to the procedure code being billed. If a provider bills for a procedure without appropriate CLIA certification, reimbursement will be denied.

If multiple providers share a location that has a laboratory for that office/practice, all of the Medicaid providers at that location must have the CLIA number for that location on his/her individual provider file for billing. Please send all CLIA and provider information to the Provider Enrollment Unit.

It is not necessary to send procedure codes and certification areas to the Department anymore.

If a procedure code is excluded from CLIA requirements, the provider will not be required to have any type CLIA certification.

Rev 04/13

1004. 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/>.

1005. General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

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

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

For the NEW CMS-1500 claim form:

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

For claims entered via the web:

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

For claims transmitted via EDI:

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

1006: Tests Performed More Than Once on the Same Day

When it is necessary to obtain multiple results in the course of treatment, the modifier 91 is used to indicate that a test was performed more than once on the same day for the same patient. The 91 modifier is used for laboratory tests paid under the clinical laboratory fee schedule. This modifier may be used to indicate that a test was performed more than once on the same day for the same patient, only when it is necessary to obtain multiple results in the course of treatment. This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens and equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when there are standard HCPCS codes available that describe the series of results (e.g., glucose tolerance tests, evocative/suppression testing, etc.).

Improper use of modifiers is likely to indicate a fraudulent or abusive circumstance.

APPENDIX A

Sample Georgia Medicaid Card

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Member ID #: 123456789012

Member: Joe Q Public

Card Issuance Date: 12/01/02

Primary Care Physician:

Dr. Jane Q Public

285 Main Street

Suite 2859

Atlanta, GA 30303

Phone: (123) 123-1234 X1234

Plan: Georgia Better Health Care

After Hours: (123) 123-1234 X1234

Verify eligibility at www.mmis.georgia.gov

300 OERSTED

If member is enrolled in a managed care plan, contact that plan for specific claim filing and prior authorization information.

Payor: For Non-Managed Care Members

Customer Service: 1-800-766-4456 (Toll Free)

HP Enterprise Services

Member: Box 105200

Provider: Box 105201

Tucker, GA 30085

Prior Authorization: GMCF

1455 Lincoln Parkway, Suite 800

Atlanta, GA 30346

SXC, Inc.

Rx BIN-001553

Rx PCN-GAM

SXC Rx Prior Auth

1-866-525-5827

Mail RX Drug Claims to:

SXC Health Solutions, Inc.

P.O. Box 3214

Lisle, IL 60532-8214

Rx Provider Help Line

1-866-525-5826

This card is for identification purposes only, and does not automatically guarantee eligibility for benefits and is non-transferable.

BP 75

APPENDIX B

STATEMENT OF PARTICIPATION

**The new Statement of Participation
is available in the Provider Enrollment Application Package via the web at
www.mmis.ga.gov.**

Phone your request to:

1 (800) 766-4456

APPENDIX C

BILLING INSTRUCTIONS AND CLAIM FORMS

Detailed information and instructions for completion and submission of claim forms can be found in this section. Claims must be filed on the required form with appropriate information in specific blocks for payment. Claim forms for Independent Laboratory Services are:

- Health Insurance Claim Form (CMS–1500)

Claims must be submitted within (6) months from the month of service. Claim(s) with third party resource(s) must be submitted within (12) months from the month of service. Please refer to the Medicaid Secondary Claims User Guide for additional instructions.

- Medicaid-Medicare Crossover (CMS–1500)

A special crossover claim form is no longer required when billing Medicaid/Medicare crossover. Claims must be submitted using the CMS–1500 format. This claim must have an Explanation of Medicare Benefits (EOMB) from Medicare for Medicaid payment. Claim (s) must be submitted within twelve (12) months from the month of service. Please refer to the Medicaid Secondary Claims User Guide for additional instructions.

The only significance differences using the new CMS-1500 claim form are items 20 and 23. For item 20, Georgia Medicaid does not allow Reference Lab billing or Outside Lab charges. Item 23, the CLIA number does not need to be inserted on the line item as CLIA information must be submitted to the Provider Enrollment Unit to be placed on the provider file.

PLACE OF SERVICE CODES

02 - Telemedicine

11 – Office

12 – Home

17 - Walk-in Retail Health Clinic

19 – Off Campus - Outpatient Hospital

21 – Inpatient Hospital

22 – On Campus - Outpatient Hospital

23 – Emergency Room - Hospital

24 – Ambulatory Surgical Center

25 – Birthing Center

26 – Military Treatment Facility (Not a covered

POS for Georgia Medicaid)

31 – Skilled Nursing Facility

32 – Nursing Facility

33 – Custodial Care Facility

34 – Hospice

41 – Ambulance – Land
Maintenance

42 – Ambulance Air or Water

51 – Inpatient Psychiatric Facility

52 – Psychiatric Facility Partial Hospitalization

(Not a covered POS for Georgia Medicaid)

53 – Community Mental health

TYPE OF SERVICE CODES

1 – Medical Care

2 - Surgery

3 – Consultation

4 – Diagnostic X-Ray

5 – Diagnostic Laboratory

6 – Radiation Therapy

7 – Anesthesia

8 – Assistance at Surgery

9 – Other Medical Service

0 – Blood or Packed Red Cells

A – DME

F – Ambulatory Surgical Center

H – Home Health

M – Alternate Payment For
Dialysis

N – Kidney Donor

R – Rural Health/Community
Health Center

W – Nurse Midwife

Y – Second Opinion on Elective
SurgeryZ – Third Opinion on Elective
Surgery

PLACE OF SERVICE CODES CONT.

54 – Intermediate Care Facility/Mentally Retarded

(Not a covered POS for Georgia Medicaid)

56 – Psychiatric Residential Treatment Center

(Not a covered POS for Georgia Medicaid)

61 – Comprehensive Inpatient Rehabilitation Facility

62 – Comprehensive Outpatient Rehabilitation Facility

65 – End Stage Renal Disease Treatment Facility or Office

71 – State or Local Public Health Clinic

72 – Rural Health Clinic/Community Health Center

81 – Independent Laboratory

99 – Other

NEW CMS 1500 Claim Form (version 02/12) & FLD Locator Instructions



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 ☐ (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)					1a. INSURED'S LD. NUMBER (For Program in Item 1)								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY		SEX M ☐ F ☐		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		8. RESERVED FOR NUCC USE				
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		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.				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO		a. INSURED'S DATE OF BIRTH MM DD YY		SEX M ☐ F ☐				
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? ☐ YES ☐ NO		b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? ☐ YES ☐ NO		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO <i>If yes, complete items 9, 9a, and 9d.</i>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described 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.				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY										15. OTHER DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? ☐ YES ☐ NO		21. PRIOR AUTHORIZATION NUMBER	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD-9-CM		22. RESUBMISSION CODE	
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	
B. PLACE OF SERVICE										C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
E. DIAGNOSIS POINTER										F. \$ CHARGES		G. DAYS OR UNITS	
H. ICD-9-CM										I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1										2		3	
2										3		4	
3										4		5	
4										5		6	
5										6		7	
6										7		8	
25. FEDERAL TAX ID. NUMBER										26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govts. districts, see back) ☐ YES ☐ NO	
28. TOTAL CHARGE										29. AMOUNT PAID		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()	
SIGNED										DATE		34. NPI	

NUCC Instruction Manual available at: 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 “RESERVED FOR NUCC USE.”
Item Number 9b	Deleted “OTHER INSURED’S DATE OF BIRTH, SEX.” Changed title to “RESERVED FOR NUCC USE.”
Item Number 9c	Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “RESERVED FOR NUCC USE.”
Item Number 10d	Changed title from “RESERVED FOR LOCAL USE” to “CLAIM CODES (Designated by NUCC).” Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC. FOR DCH/Gainwell Technologies FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “OTHER CLAIM ID (Designated by NUCC).” Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed “If yes, return to and complete Item 9 a-d” to “If yes, complete items 9, 9a, and 9d.” (Is there another Health Benefit Plan?)
Item Number 14	Changed title to “DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP).” Removed the arrow and text in the right-hand side of the field. Added “QUAL.” with a dotted line to accommodate a 3-byte qualifier.” FOR DCH/Gainwell Technologies: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date).
Item Number 15	Changed title from ‘IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE’ to “OTHER DATE.” Added “QUALIFIER.” with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a

	Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date]); 091 (Report End [Relinquished Care Date]); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – Used by Medicare for identifiers for provider roles: Ordering, Referring and Supervising. FOR DCH/Gainwell Technologies: Use the following Ordering Provider, Referring, Supervising Qualifiers (effective 4/01/2014): Ordering = DK; Referring = DN or Supervising = DQ.
Item Number 19	Changed title from “ RESERVED FOR LOCAL USE ” to “ADDITIONAL CLAIM INFORMATION (Designated by NUCC).” FOR DCH/Gainwell Technologies: Remove the Health Check logic from field 19 and add it in field 24H.
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from “(Relate Items 1, 2, 3 or 4 to Item 24E by Line)” to “Relate A-L to service line below (24E).”
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added “ICD Indicator.” and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. Diagnosis Code ICD Indicator - new logic to validate ICD - 10 diagnoses (CM) codes = value 0.
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from “MEDICAID RESUBMISSION” to “RESUBMISSION.” The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. FOR DCH/Gainwell Technologies Item numbers 24A & 24G are used to capture Hemophilia drug units. 24H (EPSDT/Family Planning).
Item Number 30	Deleted “BALANCED DUE.” Changed title to “ RESERVED FOR NUCC USE. ”
Footer	Changed “APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)” to “APPROVED OMB-0938-1197 FORM 1500 (02/12).”

APPENDIX D

GEORGIA HEALTH PARTNERSHIP (GHP)

Electronic Data Interchange (EDI)

1-877-261-8785

- Asynchronous
 - Web portal
 - Physical media
 - Network Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol/Internet Protocol (TCP/IP)

Provider Inquiry Numbers:

800-766-4456 (Toll free)

The web contact address is www.mmis.georgia.gov

Appendix E

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 medical care or services covered by Medicaid, you can contact a transportation broker for transport to and from your appointment. The member must contact the Broker to request NEMT services as 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 Verida, formerly 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 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.

Region	Broker / Phone number	Counties served
North	Verida (formerly Southeastrans) Toll free 1-866-388-9844	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

	Local 678-510-4555	
Atlanta	Verida <i>(formerly Southeastrans)</i> Local 404-209-4000 Note: For Georgia Families 360 1-866-991-6701	Fulton, DeKalb and Gwinnett
Central	ModviCare <i>(formerly LogistiCare)</i> Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup and Wilkinson
East	ModivCare <i>(formerly LogistiCare)</i> Toll free 1-888-224-7988 Note: For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities 1-800-486-7642 Ext. 461 or 436	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treulen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	ModivCare <i>(formerly LogistiCare)</i> Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pilaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

APPENDIX F

Rev 10/18

Rev 07/21

Georgia Families

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

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

The three licensed CMOs:

 Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	 Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	 CareSource 1-855-202-1058 www.caresource.com
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Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

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

Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

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

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

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

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

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

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

Included Categories of Eligibility (COE):

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

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

Excluded Categories of Eligibility (COE):

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

223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled

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

HEALTH CARE PROVIDERS

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

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

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

Registering immunizations with GRITS:

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

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

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

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

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

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

Participating in a Georgia Families' health plan:

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

Billing the health plans for services provided:

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

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

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

Credentialing

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

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

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

The CVO's one-source application process:

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

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

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

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

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

Billing the health plans for services provided:

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

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

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

Receiving payment:

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

Health plans payment of clean claims:

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

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

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as:	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and

	• Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	would warrant an immediate PCP change.
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Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

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

PHARMACY

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

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

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

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

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

Health Plan	PBM	BIN #	PCN #	GROUP #	Helpdesk
Amerigroup Community Care	IngenioRx	020107	HL	WKJA	1-833-235-2031
CareSource	Express Scripts (ESI)	003858	MA	RXINN01	1-800-416-3630

Peach State Health Plan	RxAdvance	020545	RXA379	RXGMCGA01	1-800-518-5973
	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. GAINWELL TECHNOLOGIES will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

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

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

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

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

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

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

Who to call to request a PA:

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



APPENDIX G

Information for Providers Serving Medicaid Members in the Georgia Families 360⁰ SM Program

. Georgia Families 3600 SM, the state's (took out "new") managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system. launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible, through its provider network, for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 3600SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 3600 SM Every member in Georgia Families 3600 is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

**To learn more about DCH and its dedication to A Healthy Georgia, visit
www.dch.georgia.gov**

Appendix H

Reconsideration Requests

Submitting Reconsideration Requests

From the Provider Workspace, providers may submit a reconsideration of a denied PA and attach supporting documentation. When a Reconsideration Request is processed, a no-reply email and a 'Contact Us' message are sent to the provider. The notifications inform the provider that the reconsideration was processed and to check the Provider Workspace for details. The process used to view reconsideration details is the same as the process used to view change request details. The reconsideration request details are available on the PA Review Request page accessed from PA Search. The reviewer's comments display in a tool tip made visible by holding the mouse pointer over the reconsideration status.

Reconsideration Request Guidelines and Restrictions

Reconsideration requests may only be submitted if the PA is denied or at least one procedure code line is denied. The acceptable denial types are: Withdrawn, Nurse Denied, Initial Tech Denied, Peer Consultant Denied (1st Peer Consultant review only), or System Denied. A reconsideration request cannot be submitted if the request has already undergone a reconsideration review. Reconsideration requests must be submitted within 30 calendar days of the denial decision date.

Reconsideration Submission Instructions

1. Open the Provider Workspace and select [Submit Reconsideration Request](#).
2. On the search page, enter the PA number in the Request ID box.
3. Click [Search](#).
4. Click the Request ID on the search results list to open the Review Request page.
Note: When the Review Request page is opened for a request which does not meet the reconsideration request criteria, a message will appear at the top of the page indicating that reconsideration cannot be entered.
5. Click Enter a [Reconsideration Request](#) at the bottom of the page.
6. The Reconsideration Request Information form opens.
7. At the top of the form, the contact information for the requesting provider is inserted by the system. Verify that the information is correct. If not correct, edit the information. This is important because a no-reply email and contact message is sent to the email address noted on the reconsideration form when the reconsideration is processed.
8. In the first text box, indicate why the reconsideration is being requested and how you would like the PA to be changed as a result of the reconsideration.
9. In the second text box, provider additional clinical information that supports the request for reconsideration review, and specifically addresses the reason for the denial. If additional supporting documentation is to be attached, it is acceptable to not 'see attached' in the text box.

Request ID: [REDACTED]

Please make sure that the information submitted addresses the reason for denial. You may attach documents to this request. After you click Submit, a confirmation page will display. Use "Create an Attachment" on that page to attach documents.

You will receive an email once this Change Request/Reconsideration Request is processed. Please check All contact information (name, phone and email address) and make sure that the information is correct. If not correct, edit the information.

Contact Name: [REDACTED] Phone: [REDACTED] Ext: [REDACTED] Fax: 444-444-4444 Email: [REDACTED]

Describe what you want changed.
Describe what is being requested.

Provide your rationale for changing the Prior Authorization Request.
Provide rationale or attach to the reconsideration.

[Submit](#) [Close Window](#)

10. Click [Submit](#).

11. If the submission is successful, a page displays confirming that the reconsideration has been entered successfully; and the attachment panel is available.

Reconsideration Request Information

Your Reconsideration Request has been successfully entered into the system. Should a review staff member have any questions, you will be contacted.

To attach documents, use Create an Attachment below. You may attach files that are no more than approximately 20 pages.

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

[Browse...](#) [Attach File](#)

12. Additional supporting documentation should be attached at this point. Click [Browse](#) to find the file to be attached. To select a file, highlight the file and click [Open](#), or double click the file. The file name will appear in the box next to [Browse](#). Click [Attach File](#). If the file is uploaded, the 'File uploaded successfully' message displays, and a link to the attachment will display in the **Attached Files** table.

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