

PART II

POLICIES AND PROCEDURES
for
INDEPENDENT LABORATORY SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

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Policy Revision Record
[from October 2024 to January 2025¹

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added D=Deleted M=Modified	(Revision required by Regulation, Legislation, etc.)
07/01/2025	802.4.1	Genetic Counselor	A	
07/01/2025	802.3	All Genetic prior authorization requests can be submitted up to thirty days after specimen collection.	A	
07/01/2025	800	Procedure code 81595	A	
04/01/2025	800	Procedure codes 0242U 0326U 0334U 81450 81459 and 81463	A	
01/01/2025	800	New HCPCS codes update	A	
10/2024		Appendix F Georgia families and Appendix G Georgia Families 360 has been combined to Appendix E with Non-Emergency Transportation	M	
10/2024	800	Procedure code 0411U	A	

¹ The revisions outlined in this Table are from October 1, 2024, to current. For revisions prior to July 1, 2024, please see prior versions of the policy.

Independent Lab Services
Chapter 600: Special Conditions of Participation

601. General

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, radio bioassay, 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.
- 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.
- 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.

- 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).

Chapter 700: Special Eligibility Conditions

701. Eligibility Conditions

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.

Chapter 800: Prior Approval

801. General

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 give written notice to the provider of this requirement and the grounds for such action.

802. Procedures for Obtaining Prior Approval

- 802.1. 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 Gainwell Technologies at (800) 766-4456 (Toll free). The laboratory tests listed below require a PA regardless of age or place of service.
- 802.2. 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.
- 802.3. All Genetic prior authorization requests can be submitted up to thirty days after specimen collection.
- 802.4. The documentation that must be submitted to substantiate the request for a genetic testing PA should include:
- 802.4.1. Physician/ Nurse Practitioner/ Physician Assistant /Genetic Counselors Order
 - 802.4.2. Clinical Notes from the Medical Chart belonging to the provider signing the order which should include appropriate history, physical exam, etc.
 - 802.4.3. Additional Supporting Clinical Documents which may include related testing and genetic counseling.

803. CPT Code Description

Code	Description
81195	Optical Genome Mapping for Hematologic Malignancy
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.
81426	Test for detecting genes associated with disease, genome sequence analysis, each additional comparator genome.
81432	Test for detecting genes associated with inherited breast cancer-related disorders, genomic sequence analysis at least 5 genes
81435	Test for detecting genes associated with inherited colon cancer-related disorders, genomic sequence analysis at least 5 genes
81437	Test for detecting genes associated with inherited neuroendocrine tumor-related disorders, genomic sequence analysis at least 5 genes
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
81450	Genomic sequence analysis panel of DNA or Combined DNA and RNA of 5-50 genes associated with blood and lymphatic system disorders
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 of 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
81459	Genomic sequence analysis panel of DNA or Combined DNA and RNA for copy number variants, microsatellite instability, tumor mutation burden, and rearrangements in solid organ abnormal growth of tissue
81463	Genomic sequence analysis of DNA in plasma for copy number variants and microsatellite instability on solid organ abnormal growth of tissue
81479	Unlisted Molecular Pathology
81558	Test for Detecting 139 Genes Associated with Kidney Transplant Rejection
81595	Test for detecting genes associated with heart diseases.
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	DNA gene analysis (BRCA1, DNA repair associated and BRCA2, DNA repair associated) for detection of mutations associated with breast cancer.
0242U	Gene analysis of 55-74 genes associated with solid organ cancer in cell-free circulating DNA, targeted genomic sequencing analysis 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.
0326U	Targeted genomic sequencing analysis of 83 or more genes in cell free circulating DNA for detection of abnormalities associated with solid organ cancers

0334U	Targeted genomic sequencing analysis of 84 or more genes for detection of abnormalities associated with cancer of body organ
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.
0411U	Genomic Analysis of genes to evaluate for psychiatric disorders.

Chapter 900: Scope of Services

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 916. 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	ICD-10-CM
American Medical Association Order Department OP341 6 Post Office Box 10946 Chicago, Illinois 60610	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

- 902.1.1. 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.
- 902.1.2. 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.
- 902.1.3. It is the responsibility of the laboratory to obtain the member's diagnosis from the prescribing practitioner at the time the referral is made.

903. 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:

- 903.1. Codes deleted from previous editions of the CPT are not reimbursable.

- 903.2. Most of the codes for "Unlisted Procedures", which end in "99", are not accepted by the Division.
- 903.3. The 26 and TC modifiers should be used only when necessary; other modifiers used for clarifying circumstances are not accepted by the Division.
- 903.4. The appropriate "Place of Service" codes located on the back of the CMS-1500 claim form must be used.
- 903.5. 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.

904. Service Limitations

- 904.1. 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.
- 904.2. 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.
- 904.3. When any of the twenty-three automated tests are performed:
 - 904.3.1. Bill the CPT for each individual test, or
 - 904.3.2. Bill the CPT for the Organ Disease Panel (OD) plus the individual CPT code for any automated tests not included in the panel.
- 904.4. 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.
- 904.5. 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.
- 904.6. 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.

905. Public Health Laboratory Services

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

- 905.1. Fee for Service (FFS) Medicaid will begin reimbursing providers the \$10 lab handling fee assessed by the GPL. The \$10.00 reimbursement is limited to CPT lab codes:

CPT 83655—Assay of lead

CPT 86803—Hepatitis C AB test

- 905.2. Providers are also required to continue to submit all other specified lab tests to the GPLH, as outlined in the Part II Policy and Procedure for Independent Laboratory Services, Section 905. Only CPT codes 83655, 86403, 86689 and 86803 are subject to reimbursement.
- 905.3. 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.
- 905.4. 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.
- 905.5. 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.
- 905.6. 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.
- 905.7. Reference Laboratory- is a laboratory that referring specimen from another, referring laboratory for testing and that actually performs the test. (Rev 10/2021)

906. Newborn Screens

- 906.1. 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.
- 906.1.1. Procedure Codes 82017 82127 82131 82261 84150 82775
82776 83020 83498 84030 84436 84437 84442 84443
- 906.1.2. 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.

907. Hemoglobin Testing

- 907.1. 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.
- 907.1.1. CPT 83020 include SS, SC, SE, S Beta Thalassemia, SO, and SD.

- 907.1.2. All blood specimens with a sickle cell indicator must be forwarded in an appropriate sickle cell outfit to the Waycross Regional Public Health Laboratory.
- 907.1.3. The Division will provide reimbursement for hemoglobin tests for possible diagnosis other than sickle cells.

908. Gonorrhea and Syphilis Testing

- 908.1. The Department will not provide reimbursement for diagnosis ICD 10 CM A54 through A64 with the following procedure codes:
 - 908.1.1. Procedure codes 87070, 87081, and 87205
 - 908.1.2. Patients requiring dark field exams must be referred to their local Health Department.

909. Tuberculosis Testing

- 909.1. The following procedures are for tuberculosis diagnosis ICD 10 CM A15.0 through A15.9 & A18.4 testing:
 - 909.1.1. CPT 87116 and 87118
 - 909.1.2. All sputum with a tuberculosis indicator must be forwarded in the sputum outfit provided by the State laboratory in Atlanta only. Under no condition will the Division reimburse for tuberculosis testing.

910. Salmonella and Shigella Testing

- 910.1. Diagnoses included are ICD 10 CM A02.0 – A03.9.
 - 910.1.1. The procedures are: 87045 and 87081.
 - 910.1.2. 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.
 - 910.1.3. Drug Testing
- 910.2. We are implementing the following changes for drug testing for Calendar Year (CY) 2017:
 - 910.2.1. For presumptive testing, create three codes, 80305, 80306 and 80307. Only one of the three presumptive codes may be billed per day.
 - 910.2.2. 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.

- 910.2.3. For definitive testing, the unit used to determine the appropriate definitive code to bill is “drug class.”
- 910.2.4. Each drug class may only be used once per day in determining the appropriate definitive code to bill.
- 910.2.5. 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;

911. Presumptive Drug Class Screening (PDSC):

- 911.1. 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.
- 911.2. 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.
- 911.3. 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.

912. Definitive Drug Testing:

- 912.1. **Code: G0480** Drug test(s) definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomer's), 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.
- 912.2. **Code: G0481:** Drug test(s) definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomer's), 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.
- 912.3. **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.

912.4. **Code: G0483:** Drug test(s) definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomer's), 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.

912.5. **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.

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

912.5.2. 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

913. HIV Screening Testing

- 913.1. 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

914. HIV Resistance Testing

- 914.1. 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.
- 914.2. 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.
- 914.3. Reimbursement will be made when resistance testing is recommended in the following situations:
- 914.3.1. When a patient presents with virologic failure during Highly Active Antiretroviral Therapy; and
 - 914.3.2. When the patient has suboptimal suppression of viral load after initiation of antiretroviral therapy.
- 914.4. Reimbursement will not be considered:
- 914.4.1. When the patient's plasma viral load is <1000 HIV copies/ML.
 - 914.4.2. After the discontinuation of drugs; and
 - 914.4.3. With chronic HIV infection prior to initiation of therapy.
- 914.5. The following procedures are for HIV resistance testing:
- 914.5.1. 87901 – Genotype analysis

- 914.5.2. 87903 – Phenotype analysis up to 10 drugs
- 914.5.3. 87904 – Each additional drug, up to 5 drugs; use this code in conjunction with 87903
- 914.5.4. 87900-Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics
- 914.6. The following procedure is for HIV detection testing:
 - 914.6.1. 87536 – Detection test for HIV-1 virus

915. Molecular Diagnostic Testing

- 915.1. 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.

916. 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:

- 916.1. Procedures completed in laboratories operated as a part of a physician's private office (described in the Policies and Procedures for Physician Services).
- 916.2. 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).
- 916.3. Experimental services or procedures or those not recognized by the United States Public Health Service as universally accepted procedures.
- 916.4. Procedures deleted from previous and current editions of the CPT and those shown as "Unlisted Procedure" which end in "99".
- 916.5. Professional interpretation for procedures normally interpreted by an attending practitioner.
- 916.6. Services and/or procedures performed without regard to the policies contained in this manual:
- 916.7. Services provided free-of-charge to Medicaid members by state or public laboratories.
- 916.8. The collection and handling of specimens sent to an independent laboratory for further distribution to another testing facility.
- 916.9. Laboratory test procedures included in the dialysis facility's composite rate.
- 916.10. Specimen collection and or handling fee (Venipuncture or Catharized Urine).

- 916.11. Services for which the performing provider does not have appropriate CLIA certification.
- 916.12. Reimbursement for more than twenty-five multiple drug screens per member per fiscal

Chapter 1000: Basis for Reimbursement

1001. Reimbursement Methodology

- 1001.1. 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.
- 1001.2. 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. Rev. 07/2016
- 1001.3. Multiple laboratory procedures billed for the same member should be submitted on one claim for that date of service.

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). (Rev 04/2022)

1002. Co-payment

- 1002.1. Members receiving services are not subject to co-payment requirements. Independent Laboratory Services are exempt.

1003. CLIA Requirements

- 1003.1. 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.
- 1003.2. 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.
- 1003.3. It is not necessary to send procedure codes and certification areas to the Department anymore.

- 1003.4. If a procedure code is excluded from CLIA requirements, the provider will not be required to have any type CLIA certification.

1004. National Correct Coding Initiative (NCCI)

- 1004.1. 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.
- 1004.2. 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

- 1005.1. 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.
- 1005.2. 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. 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.

- 1005.2.1. For the NEW CMS-1500 claim form:

- 1005.2.2. 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).
- 1005.2.3. For claims entered via the web:
- 1005.2.4. 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.
- 1005.2.5. For claims transmitted via EDI:
- 1005.2.6. 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

- 1006.1. When it is necessary to obtain multiple results during 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 during 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.).
- 1006.2. 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) <table style="width: 100%;"><tr><td style="width: 33%;">HP Enterprise Services</td><td style="width: 33%;">SXC, Inc.</td><td style="width: 33%;">Mail RX Drug Claims to:</td></tr><tr><td>Member: Box 105200</td><td>Rx BIN-001553</td><td>SXC Health Solutions, Inc.</td></tr><tr><td>Provider: Box 105201</td><td>Rx PCN-GAM</td><td>P.O. Box 3214</td></tr><tr><td>Tucker, GA 30085</td><td>SXC Rx Prior Auth</td><td>Lisle, IL 60532-8214</td></tr><tr><td>Prior Authorization: GMCF</td><td>1-866-525-5827</td><td>Rx Provider Help Line</td></tr><tr><td>1455 Lincoln Parkway, Suite 800</td><td></td><td>1-866-525-5826</td></tr><tr><td>Atlanta, GA 30346</td><td></td><td></td></tr></table> This card is for identification purposes only, and does not automatically guarantee eligibility for benefits and is non-transferable.		HP Enterprise Services	SXC, Inc.	Mail RX Drug Claims to:	Member: Box 105200	Rx BIN-001553	SXC Health Solutions, Inc.	Provider: Box 105201	Rx PCN-GAM	P.O. Box 3214	Tucker, GA 30085	SXC Rx Prior Auth	Lisle, IL 60532-8214	Prior Authorization: GMCF	1-866-525-5827	Rx Provider Help Line	1455 Lincoln Parkway, Suite 800		1-866-525-5826	Atlanta, GA 30346		
HP Enterprise Services	SXC, Inc.	Mail RX Drug Claims to:																				
Member: Box 105200	Rx BIN-001553	SXC Health Solutions, Inc.																				
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Tucker, GA 30085	SXC Rx Prior Auth	Lisle, IL 60532-8214																				
Prior Authorization: GMCF	1-866-525-5827	Rx Provider Help Line																				
1455 Lincoln Parkway, Suite 800		1-866-525-5826																				
Atlanta, GA 30346																						

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

A. 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:

i. 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.

ii. 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.

New CMS 1500 Clam Form (version 02/12) & FLD Locator Instructions



HEALTH INSURANCE CLAIM FORM

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

☐ ☐ PICA										PICA ☐ ☐									
1. MEDICARE (Medicare#) ☐ MEDICAID (Medicaid#) ☐ TRICARE (ID#/DoD#) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (ID#) ☐ FECA BLK LUNG (ID#) ☐ OTHER (ID#) ☐										1a. INSURED'S 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 ☐									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐									
CITY STATE										7. INSURED'S ADDRESS (No., Street)									
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:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES ☐ NO ☐									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
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.										11. INSURED'S POLICY GROUP OR FECA NUMBER									
SIGNED DATE										a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										b. OTHER CLAIM ID (Designated by NUCC)									
15. OTHER DATE MM DD YY QUAL										c. INSURANCE PLAN NAME OR PROGRAM NAME									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, complete items 9, 9a, and 9d.									
19. ADDITIONAL CLAIM INFORMATION (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.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate to service line below (24E) ICD 10d.										SIGNED									
A. B. C. D.										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
E. F. G. H.										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
I. J. K. L.										20. OUTSIDE LAB? YES ☐ NO ☐ \$ CHARGES									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										22. RESUBMISSION CODE ORIGINAL REF. NO.									
F. \$ CHARGES G. DAYS OR UNITS H. EPDIT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER									
1 2 3 4 5 6										25. FEDERAL TAX ID. NUMBER SSN EIN									
26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐									
28. TOTAL CHARGE \$										29. AMOUNT PAID \$									
30. Rsvd for NUCC Use										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)									
32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()									
SIGNED DATE										a. NPI b.									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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)

Appendix E
Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

A. Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

For information on the Georgia Families, Georgia Families 360, or Non-Emergency Medical Transportation program, please access the overview document at the following link:

- i. **Georgia Families Overview:**
<https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx>
- ii. **Georgia Families 360 Overview:**
<https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx>
- iii. **Non-Emergency Medical Transportation Overview:**
<https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx>

Appendix F

Reconsideration Requests

A. 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' messages 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 are 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.

B. 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.

C. Reconsideration Submission Instructions

- i. Open the Provider Workspace and select [Submit Reconsideration Request](#).
- ii. On the search page, enter the PA number in the Request ID box.
- iii. Click [Search](#).
- iv. 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.

- v. Click Enter a [Reconsideration Request](#) at the bottom of the page.
- vi. The Reconsideration Request Information form opens.
- vii. At the top of the form, the contact information for the requesting provider is inserted by the system.
- viii. 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.
- ix. In the first text box, indicate why the reconsideration is being requested and how you would like the PA to be changed because of the reconsideration.

- x. 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.

The screenshot shows a web form for submitting a reconsideration request. At the top, there is a 'Request ID' field with a blacked-out value. Below this, a message states: '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.' A red message follows: '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.' Below the message is a contact information section with fields for 'Contact Name', 'Phone', 'Ext', 'Fax' (with the number 444-444-4444), and 'Email'. The 'Phone' and 'Email' fields are blacked out. Below the contact section are two large text areas. The first is titled 'Describe what you want changed.' and contains the text 'Describe what is being requested'. The second is titled 'Provide your rationale for changing the Prior Authorization Request.' and contains the text 'Provide rationale or attach to the reconsideration.' At the bottom of the form are two buttons: 'Submit' and 'Close Window'.

- xi. Click [Submit](#).
- xii. If the submission is successful, a page displays confirming that the reconsideration has been entered successfully; and the attachment panel is available.

The screenshot shows a confirmation page titled 'Reconsideration Request Information'. A blue message states: 'Your Reconsideration Request has been successfully entered into the system. Should a review staff member have any questions, you will be contacted.' Below this, a message says: 'To attach documents, use Create an Attachment below. You may attach files that are no more than approximately 20 pages.' A section titled 'Create an Attachment' contains the instruction: 'If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".' Below the instruction is a text input field, a 'Browse...' button, and an 'Attach File' button.

- xiii. 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 brown. 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.