

PART II

POLICIES AND PROCEDURES
for
MEDICAID SECONDARY CLAIMS USER GUIDE



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

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**Policy Revision Record
from 2024 to Current¹**

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added D=Deleted M=Modified	(Revision required by Regulation, Legislation, etc.)
7/1/2025	602.4	Required under Section 202 of the Consolidated Appropriations Act (CAA) of 2022 enacted March 15, 2022 and amends Code Section §49-4-148 of the Official Code of Georgia Annotated, relating to recovery of medical assistance from third party liable for sickness, injury, disease, or disability, so as to revise certain provisions to comply with federal law; to bar liable third-party payers from refusing payment solely because of a healthcare item or service did not receive prior authorization; to require a third party to respond to an inquiry from the Department of Community Health regarding a healthcare claim within 60 days.	A	Section §49-4-148 of the Official Code of Georgia Annotated Section 202 of the Consolidated Appropriations Act (CAA) of 2022, section 1902(a)(25)(I) of the Act
7/1/2025	603.3.1	Required under Section 202 of the Consolidated Appropriations Act (CAA) of 2022 enacted March 15, 2022 and amends Code Section §49-4-148 of the Official Code of Georgia Annotated, relating to recovery of medical assistance from third party liable for sickness, injury, disease, or disability, so as to revise certain provisions to comply with federal law; to bar liable third-party payers from refusing payment solely because of a healthcare item or service did not receive prior authorization; to require a third party to respond to an inquiry from the Department of Community Health regarding a healthcare claim within 60 days.	A	Section §49-4-148 of the Official Code of Georgia Annotated Section 202 of the Consolidated Appropriations Act (CAA) of 2022, section 1902(a)(25)(I) of the Act
4/12/2025	608.2.8	Part I manual was referenced, replace with to Refer to the Part I Policies and Procedures Manual for Medicaid and PeachCare for Kids	M	
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4/1/2025	Overview	Part I manual was referenced, replace with to Refer to the Part I Policies and Procedures Manual for Medicaid and PeachCare for Kids	M	
1/1/2025	N/A	No changes were made this quarter	N/A	
10/1/2024	Appendix A	Added link for Georgia Families and Georgia 360	A	
10/1/2024	Appendix A & B	Deleted Georgia Families and Georgia Families 360	D	

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

Medicaid Secondary Claims User Guide Overview

The purpose of this guide is to assist Georgia Medicaid Fee-For-Service providers with submitting Medicaid secondary claims. A Medicaid secondary claim is a claim where there is potentially another payer with primary responsibility for payment. Refer to the Part I Policies and Procedures Manual for Medicaid and PeachCare for Kids.

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

Provider Access to Georgia Medicaid Forms

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

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

Complete an Adjustment Request Form (DMA-501) for Crossovers and COB

Complete a COB Notification Form (DMA-410)

Complete a Medicare Notification Form (DMA-460)

Complete a Coordination of Benefits/Third Party Liability Accident Information Form (DMA-312) via the web portal.

Correctly submitted claim attachments

Medicaid Secondary Claims User Guide

Chapter 600: Introduction

601. What is Coordination of Benefits (COB)?

By federal law, Medicaid is the “payer of last resort” in most circumstances. Medicaid considers payment on a claim after a third-party resource is billed. A third-party resource is any individual, entity or program that is or may be liable for payment of part or all of the expenses for medical care furnished to a Medicaid member. It is the obligation of any legally liable third party other than Medicaid or the member to pay the primary cost of the member’s medical care. COB is the process of determining the primary payer. Cost avoidance procedures will be applied to all services and claims, including claims for prenatal services, labor and delivery, and postpartum care services. Providers are not required to initially file claims with the primary insurance carrier if the services are for preventive and pediatric care services under the Health Check program (also known as EPSDT) and claims covered by absent parent-maintained insurance. (Rev.01/2024)

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

Third party resources for members generally come from two sources:

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

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

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

602. When should I submit a COB Claim?

Filing a Medicaid/PeachCare for Kids Claim

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

602.1. Cost avoid – Requires providers to bill the primary payer before billing Medicaid. If a COB claim is required to cost avoid, Medicaid will deny the claim until the primary payer processing information is included on the claim. Effective October 1, 2021, cost avoidance procedures will be applied to all services and claims, including claims for pre-natal services, labor and delivery, and postpartum care services. (Rev. 01/2024)

602.2. Pay-and-chase – This method of claims processing is limited to certain claims. Claims

that pay-and-chase are claims for preventive and pediatric services under Health Check (formerly EPSDT). And claims covered by absent parent-maintained insurance. For these claims, Medicaid processes the member's medical claim and then attempts to recover from the liable third party. Thus, providers are allowed to bill Medicaid first and then Medicaid, not the provider, will seek reimbursement from the primary payer. If a provider chooses to bill Medicaid for these services instead of the primary payer, the provider must not bill the third-party resource/primary payer if Medicaid pays the claim. NOTE: Even though Medicaid will pay these claims initially, Medicaid is not the primary payer on these charges. Medicaid will pay the maximum allowable amount and then Medicaid will bill the primary payer for reimbursement of the payments for the services. (Rev. 01/2024)

602.3. Identification of Other Insurance

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

Questioning the member to identify any other insurance so that a claim to the primary payer can be filed.

Checking www.mmis.georgia.gov (GHP) Web site for insurance coverage on the member so that a claim to the primary payer can be filed.

Questioning the member regarding any updates to the coverage(s) shown on www.mmis.georgia.gov Website.

Filing a claim with the known primary insurance(s) prior to filing with Medicaid.

The discount amount reported on the EOB from the primary payer.

602.4. Inquiries

Third-party payers are required to respond to a Department 's inquiry regarding the status of a claim for payment for any healthcare item or service within 60 days of receiving the inquiry.

603. How are COB Claims Reimbursed?

603.1. Medicaid Reimbursement

DCH takes into account many factors when determining the amount of payment on a Medicaid COB claim. Factors include, but are not limited to: (Rev.04/2010)

the payment amount from a primary payer,

the Medicaid maximum allowable amount for a specific covered service.

the discount amount reported on the EOB from the primary payer.

603.2. When another Insurer's Payment is involved

- 603.2.1. Any items or services for which another insurance carrier's reimbursement amount is equal to or greater than the Medicaid maximum allowable amount will be paid at zero by Medicaid. Claims that "pay" at zero are considered to be paid claims, not denied claims.
- 603.2.2. When the payment from another insurance carrier is less than the Medicaid maximum allowable amount, Medicaid can pay up to the Medicaid maximum allowable amount. The sum of the Medicaid payment and the other insurance payment(s) will not exceed the Medicaid maximum allowable amount.
- 603.2.3. Medicaid will consider making full payment for a covered service(s) when the primary insurance carrier denies payment for any reason or when there is no payment by the primary carrier because of the member's coinsurance and/or deductible. Full payment means an amount up to the Medicaid maximum allowable amount. The reason for the primary insurance carrier denial or non-payment is part of the consideration of payment by Medicaid.
- 603.3. Department Payment and Third-Party Payer's Authorization
 - 603.3.1. Third-party payers must accept the Department's payment for a healthcare item or service on behalf of a recipient of medical assistance as the third-party payer's authorization for the provision of those services and shall not refuse to pay for a healthcare item or service solely on the basis that the third-party payer did not previously authorize such item or service.
- 603.4. When a Managed Care Plan is the Primary Insurer
 - 603.4.1. It is a member's responsibility to remain abreast of the physicians, pharmacies, hospitals, and other providers who participate in his or her managed care plan. When a member's claim is denied by the managed care plan for failure to comply with the rules, policies, and procedures of the plan, the member, not DCH, is responsible for payment to the provider. Providers should inform members if they are not a network provider in the member's managed care plan
 - 603.4.2. Some services denied by a primary managed care plan may be paid by Medicaid up to the Medicaid maximum allowable amount. Whether or not Medicaid will pay depends on the reason for the denial by the primary plan. Examples of services denied by the primary payer that Medicaid may pay include, but are not limited to, the following situations: (Rev. 04/2010)
 - 603.4.2.1. Have provisions that allow Medicaid to cover the service when the primary plan will not pay. Claims denied by the primary plan because of a recommendation unique to Medicaid may be covered by Medicaid; however, the service must be a Medicaid covered service in order for Medicaid to pay.

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

604. Tort/Casualty (Personal Injury) Liability

- 604.1. In certain situations, the cause of a member's medical condition may invoke a third party's legal liability. These situations might include but is not limited to injuries resulting from an automobile accident, injuries suffered on-the-job, medical malpractice, or "slip and fall" injuries. In such situations and pursuant to O.C.G.A §49-4-148, DCH is subrogated or substituted for the member or his/her representative's right to recovery against the person or entity legally liable for the injury and subsequent treatment of the member (i.e., the Department has the right to recover any Medicaid payments from settlement awards).
- 604.2. When a provider learns that a third party might be responsible for reimbursement associated with Medicaid/PeachCare for Kids member's medical costs, the provider must choose between billing Medicaid and billing the third party or third-party carrier. Providers are prohibited from
 - 604.2.1. Filing claims with Medicaid and subsequently billing the third-party carrier (or the member) for the same service, even if the provider refunds Medicaid; and
 - 604.2.2. Billing Medicaid, the third-party carrier, or member for the difference between the amounts Medicaid has paid and the amount the provider charged.
- 604.3. In the event that a provider is aware that a member's condition was the result of an accident at the time of submission of the associated claims, a Coordination of Benefits/Third Party Liability Accident Information Form (DMA-312) should be submitted online via the web portal. To access the online DMA-312 form, you must log into the Georgia Medicaid Management Information System (GAMMIS) web portal at www.mmis.georgia.gov using your username and password. The online DMA-312 form is located under the TPL tab/ link (Rev. 04/2016, 07/2018)
- 604.4. If a provider chooses not to initially bill Medicaid, the provider may submit a DMA-312 "Coordination of Benefits/Third Party Liability Accident Information online form," within six (6) months of the date of service to request an extension within the timely filing limits, if necessary, in order to pursue the liable third party. By completing and submitting the online DMA-312 form, an extension of 12 months may be granted if the

submitted form is approved.

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

- 604.4.1. Complete the form and submit it to the Department. (On the DMA- 312 form, check the box or field “Request Claim Filing Extension and attach a copy of claim)
- 604.4.2. Submit the DMA-312 form and a copy of the claim to the address listed on the form.
- 604.5. The DMA-312 form will be reviewed and either stamped APPROVED, DENIED, or returned to the provider for additional information if form is incomplete.
- 604.6. If the DMA-312 form is approved, the provider must print and maintain an approved copy and submit it with the Medicaid claim(s) when or if the provider decides to cancel the lien and bill for Medicaid’s payment.

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

- 604.7. If the DMA-312 form is returned to a provider for additional information, the provider must complete the unanswered questions on the form and resubmit to DCH online via the web portal.
- 604.8. Approval of the DMA-312 form grants the requesting provider an additional twelve (12) months in which to file their Medicaid claim. This extension will not exceed twenty-four (24) months from the month of service for tort related claims.
- 604.9. The provider may also use the DMA-312 form to inform the Department of the potential tort related claim. (On the DMA-312 form – check the box or field “For information only”).
 - 604.9.1. Checking the “For information only” box indicates that a provider is not requesting an extension but is notifying the Department that there is a potential casualty recovery case. The provider may later submit the tort related claim to Medicaid in accordance with all billing guidelines.
 - 604.9.2. Once the hospital claim is billed to the Department, the provider must release their hospital lien since the Department, and not the provider, has the right to seek reimbursement from the liable third parties.
 - 604.9.3. If a provider elects not to bill Medicaid initially and subsequently receives a liability payment less than the Medicaid allowable amount for the claims, the provider may bill Medicaid for the balance between the liability payment amount and Medicaid allowable amount.
 - 604.9.3.1. Providers may not keep any liability payment in excess of Medicaid’s payment. Should the Department discover that a provider has attempted to receive payment from a

third party, or third-party carrier after having received reimbursement from Medicaid/PeachCare for Kids, the Department will recoup their reimbursement, regardless of whether the provider ultimately received any payment from that liable third party.

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

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

605. Medicare:

605.1. What is Medicare?

Medicare is a federal health insurance program for:

People age 65 or older.

People under age 65 with certain disabilities, and

People of all ages with End-Stage Renal Disease (ESRD).

605.2. Original Medicare has two parts:

605.2.1. Part A and Part B Part A (Hospital Insurance) – Included services are Hospital Inpatient care, Hospice, Skilled Nursing Facility, and blood pints.

605.2.2. Part B (Medical Insurance) - Included services are Outpatient Services provided in a doctors' office, outpatient facility or inpatient facility.

605.3. Medicare Advantage plans / Medicare Part C

This combines parts Part A and Part B and sometimes the Medicare prescription program (Medicare Part D).

605.3.1. These plans cover the same benefit as the Original Medicare plans; however, they are administered by private health insurance payers.

605.3.2. Some of these plans offer additional services beyond what the Original Medicare plans offer.

605.3.3. These claims do not automatically cross-over to Medicaid; the provider must submit the claim to Medicaid.

605.4. Medicare Part A, B and C Plans

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

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

605.5. Medicare Part D Plan

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

605.6. What is a Crossover

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

605.6.1. The claim must be approved by Medicare in order to be considered a crossover claim. "Approved" means that the charges are covered by the Medicare program, are provided by an appropriately enrolled Medicare provider, and are provided to a Medicare entitled beneficiary. "Approved" does not necessarily mean paid; sometimes all of the charges approved by Medicare are applied to the deductible. In these situations, the claim is approved, but no payment is made by Medicare. It is important to remember that claims that are not approved by Medicare, in other words, denied claims, are not crossover claims. If a member is Qualified Medicare Beneficiary (QMB) (aid categories 460 or 660) and Medicare denies the claim, do not bill Medicaid. QMB members are only eligible for crossover claims.

605.6.2. The claim must be sent to Medicaid. There are two ways this can occur: Medicare's Coordination of Benefits Contractor (COBC) can automatically send the claim to Medicaid (called an auto-crossover claim), or the provider can file a crossover claim through the GAMMIS web portal at www.mmis.georgia.gov or electronic that includes the Medicare payment information. (Rev.04/2016)

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

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

605.7. Medicare Crossover Claims - Helpful Information

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

605.7.2. Providers identified in the Department's external audits, who repeatedly change their crossover claims to match Medicaid billing requirements may be subject to adverse action by the Department (i.e., changes made, or additions made to a detail line billing or changed value codes, changed provider ID numbers, or changed procedure codes or any changes made on a COBRA/COBA claim). (Rev.04/2016)

EXCEPTIONS: Medicaid does require National Drug Codes (NDC's) for outpatient injectable drugs. Medicare does not require NDC codes for outpatient services (Rev. 04/2016)

605.8. Medicare Covered Services

605.8.1. Part A Medicare covered services that Medicaid also covers:

- 605.8.1.1. semiprivate room
- 605.8.1.2. meals
- 605.8.1.3. regular nursing services
- 605.8.1.4. rehabilitation services
- 605.8.1.5. drugs
- 605.8.1.6. medical supplies
- 605.8.1.7. lab tests
- 605.8.1.8. x-rays
- 605.8.1.9. operating room
- 605.8.1.10. recovery room
- 605.8.1.11. intensive care
- 605.8.1.12. coronary care

- 605.8.1.13. blood pints
- 605.8.1.14. medically necessary services and supplies
- 605.8.2. Part A Medicare covered services that Medicaid does not cover:
 - 605.8.2.1. telephone
 - 605.8.2.2. television
 - 605.8.2.3. private duty nurses
 - 605.8.2.4. amount between a semiprivate and private room rate unless it is medically necessary
- 605.9. Part B Medicare covered services:
 - 605.9.1. doctor services (including surgery) provided at a hospital, a doctor's office, or home
 - 605.9.2. mammograms, pelvic exams, bone density tests, and PAP smears for women
 - 605.9.3. an annual flu shot
 - 605.9.4. a one-time physical exam (called a "wellness exam") done within six months of the patient's enrollment date for Medicare Part B
 - 605.9.5. medical services provided by nurses, surgical assistants, or laboratory or X-ray technicians
 - 605.9.6. outpatient hospital treatment, such as emergency room or clinic charges, X-rays, injections, and lab work an ambulance, if required for a trip to or from a hospital or skilled nursing facility
 - 605.9.7. drugs or other medicine administered at a hospital or doctor's office medical equipment and supplies, such as splints, casts, prosthetic devices, body braces, heart pacemakers, corrective lenses after a cataract operation, glucose monitoring equipment, therapeutic shoes for diabetics, and equipment (such as ventilators, wheelchairs, and hospital beds)
 - 605.9.8. some types of oral surgery
 - 605.9.9. some costs for outpatient physical and speech therapy
 - 605.9.10. a limited number of services by podiatrists and optometrists
 - 605.9.11. some care and counseling by psychologists, social workers, and daycare personnel
 - 605.9.12. some preventative screening exams if the doctor says the patient is at risk

- 605.9.13. manipulation of out-of-place vertebrae by a chiropractor
- 605.9.14. Alzheimer's-related treatments
- 605.9.15. scientifically proven obesity therapies and treatments, and
- 605.9.16. Part-time skilled nursing care, physical therapy, and speech therapy provided in your home.
- 605.9.17. Ancillary services for inpatient hospital care

606. Medicare Payment Guidelines

- 606.1. The original Fee-for-Service Medicare Part A:
 - 606.1.1. For Skilled Nursing Care, Medicare pays for the first 20 days if the patient goes directly from the hospital to the skilled nursing care facility. Medicare will pay a portion of the care for the 21st through the 100th day. Medicare will not pay any benefit after the 100th day.
 - 606.1.2. For Inpatient Hospital Care during the first 60 days, Medicare will pay all covered costs except the deductible. For days 61 – 150, Medicare pays a set dollar amount.
 - 606.1.3. After the 50th day, Medicare will not pay any of the costs. Bill Medicaid for any costs that Medicare does not pay.
 - 606.1.4. For Dually eligible members utilizing their Medicare benefits in a nursing home, Medicare should be the primary payer until the Member no longer meets the requirements of skilled services under the Medicare guideline.
- 606.2. The original Medicare Part B:
 - 606.2.1. Pays only 80% of approved charges; Medicaid will pay the remaining 20% (coinsurance) up to Medicaid's maximum allowable amount for the service. Medicare pays 50% of outpatient psychiatric care.
- 606.3. Medicare Advantage Plans (MAP), Part C:
 - 606.3.1. Previously known as Part C or Medicare Health Maintenance Organizations (HMO's), these Medicare replacement plans now include several different types of plans including HMO's, Preferred Provider Organizations (PPO's) or private fee-for-service (FFS) plans with a variety of co-payments and benefit packages. Plans vary so the allowed services and payments for each plan will not always be the same. Medicaid will pay eligible cost share amounts up to the Medicaid maximum allowable amount for the service.
- 606.4. Negative Paid Medicare Crossover Claims:
 - 606.4.1. Medicare crossover claims with a negative Medicare paid amount will

not be reimbursed by GA Medicaid. (Rev. 07/2016)

607. Crossover Billing Considerations:

- 607.1. Crossover claims must be received by the Department within 12 months of the month of service.
- 607.2. Medicaid providers must accept Medicare assignment in order to submit claims to Medicaid for consideration of payment.
- 607.3. Medicare denied claims: File a Medicare claim that was denied by Medicare via the web portal (www.gammis.com) or EDI as a Medicaid claim and attach the Medicare denial or the DMA 460. The claim is not a crossover since Medicare denied the charges, which changes the timely filing limitation from 12 months to 6 months from the month of service or 3 months from the of denial whichever is the later. NOTE: Medicare denied claims are straight Medicaid claims, not crossovers. All Medicaid billing requirements must be followed. (Rev. 07/2016)

608. Claims

- 608.1. Claims submitted to Medicare Carriers or Fiscal Intermediaries will be forwarded to the Department's Third-Party Administrator by automatic transfer via the COBC. When claims automatically crossover to Medicaid, providers do not have to submit a Medicaid secondary claim to the Department. Medicare identifies claims selected for automatic crossover from eligibility files that Medicaid forwards to the COBC monthly. The provider's Medicare number must be on file with the Department and associated with only one Medicaid location in order for the automatic crossover of claims to occur. If the Remittance Advice (RA) indicates Remark Code "MA07", the claim has been forwarded to (crossover) Medicaid for adjudication. If the forwarded claims is not processed by the Department within forty-five (45) days from the receipt of Medicare payment, a claim may be submitted directly to the Department's third-party administrator via the GAMMIS web portal at www.mmis.georgia.gov or electronic).

NOTE: There is no 45-day waiting period if the RA does not show the MA07. (Rev. 04/2016)

- 608.2. Claims will not crossover automatically if any of the following situations exist:
 - 608.2.1. The Medicare rendering provider number is not on file with the Department or is not associated with an active Medicaid provider number.
 - 608.2.2. The Medicare provider number is associated with more than one Medicaid location - it can only be associated with one. If you use your Medicare ID# when billing for multiple locations, you must choose one Medicaid location for all your crossover claims.
 - 608.2.3. The member was not listed on the eligibility file sent to Medicare for the month the claims were processed.

- 608.2.4. The provider did not include the beneficiary's Medicaid ID number when billing Medicare.
- 608.2.5. The provider did not correctly show Medicaid as the secondary payer.
- 608.2.6. Medicare denied the claim.
- 608.2.7. The member is enrolled in MAP- The DMA-460 is also an acceptable attachment for these claims, but do not use both on the same claim.
- 608.2.8. When Medicare adjusts a Medicare claim, the adjusted claim does not automatically crossover. Thus, when Medicare adjusts a claim and Medicaid has not yet paid on it, submit a claim to Medicaid using the adjusted EOMB information. If Medicaid has already paid on the claim that Medicare adjusted, submit an Adjustment Request Form, DMA-501, to Medicaid using the new Medicare payment information. Refer to the Part I Policies and Procedures Manual for Medicaid and PeachCare for Kids for additional information on adjustments; and
- 608.2.9. Medicaid is the tertiary payer: Another insurer/third party made a payment on the claim. Medicare is primary, the other insurer/payer is secondary, and Medicaid is tertiary.

609. Medicare Eligibility Discrepancies

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

610. Additional Industry Standards Affecting COB and Crossover Claims

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

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

- 610.1. Web Portal submissions
- 610.2. IVR system inquiries

- 610.3. Telephone inquiries
- 610.4. Prior authorization requests

611. National Drug Code and Injectable Drug for Outpatient Services

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

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

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

- 611.1. 837 P- Electronic Professional Claims Submission
- 611.2. 837 I – Electronic Institutional Claims Submission (Rev.04/2010)
- 611.3. GAMMIS Web Portal

612. Adjustments Involving COB and Crossover Claims

When Should I file an Adjustment on a Claim?

- 612.1. When a primary payer such as a commercial plan or Medicare adjusts a claim and a new EOB or EOMB is received, determine if that adjusted claim has been filed with Medicaid and paid. If yes, review the paid claim for a possible adjustment. To adjust a Medicaid claim, complete an Adjustment Request Form (DMA-501). Remember, only Medicaid paid claims can be adjusted. Submit the Adjustment Request through the GAMMIS web portal at www.mmis.georgia.gov. Attach a copy of the EOB or RA/EOMB showing the primary payer's adjustment. (04/2016)
- 612.2. If the primary payer adjusts a claim that Medicaid denied, no adjustment is needed. If the primary payer's adjustment results in a claim that Medicaid will possibly pay, file a new claim to Medicaid and include the corrected EOB or RA/EOMB as an attachment.
- 612.3. How to complete and Adjustment

Adjustment Request Form (DMA-501)

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

Please Return To:
GHP
P.O. Box 105206
Tucker, GA 30085-5206

ADJUSTMENT REQUEST FORM

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

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

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

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

6. Explanation for Adjustment
7. FOR DCH USE ONLY CCN _____ FS Line Amount \$ _____

Provider Signature _____ Date _____

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

Blocks 1 - 3 must be completed for each claim adjusted.

In Block 4, check Box “B” for a COB adjustment or check Box “D” for a Medicare adjustment.

In Block 5A (Line to be Corrected), enter zero (0) if you are adjusting the total paid or the total patient liability for the claim. If you are only adjusting a line number, enter the line number corresponding to the claim that Medicaid has processed.

In Block 5B (Information to be Changed), show what data field of the paid claim is changing. For example, on a facility claim, if the prior payment is changing, enter “Box 54 A - prior Payments.”

In Block 5C (From (Current) Information), enter the incorrect information that was submitted on the original claim processed by Medicaid. This will be the same information that appears on the RA from Medicaid or Medicare.

In Block 5D (To (Corrected) Information), enter the corrected amount from the adjusted EOB or RA/EOMB.

NOTE: Refer to the Part I Policies and Procedures Manual for Medicaid and PeachCare for additional information regarding the individual provider Adjustment process. (Rev. 04/2016)

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

613. COB and Medicare Notification Forms

Tips for Submitting the DMA-410 and the DMA – 460 Forms

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

The form must be signed and dated. The signature date must be within 12 months of the date of service. Forms with older dates will not be valid attachments for COB or crossover claims. The date must be the month, day, and year.

The member's name and Medicaid ID number must be on the form. If either is missing, the form is an invalid attachment to the claim and the information submitted will not be used in processing the claim. This could result in the claim denying.

Enter the Medicaid provider ID number in the space provided. The ID number is required for all information being reported. If the number is not shown, the form is not a valid attachment and will not be used for claims processing.

Complete separate forms for each insurance card if the member has multiple cards, such as a medical card, a pharmacy card, or a Medigap/Medicare supplemental insurance policy. Changes to coverage's can be reported on the forms also. New coverage and change information is recorded in Part III of the forms.

Do not attach the COB Notification Form and the EOB to the claim – attach only one. If the information on the EOB does not clearly show why the primary claim processed as it did, use the DMA-410 to clarify. If the EOB clearly shows how the claim was processed, attach the EOB. Do not attach the Medicare Notification Form and the RA/EOMB to the claim – attach only the one that most clearly explains the claims processing.

When there is no EOB and the provider is billing for a managed care co-payment, complete Section I on the DMA-410 showing the insurance carrier and the co- payment amount. When there is no EOMB and the provider is billing for a Medicare Advantage Plan co-payment, complete Section I of the DMA-460 showing the plan and the copayment amount.

When the EOB shows the carrier denied the claim due to “Out-of-Network”, but in reality, the service is not covered even with a network provider, check the line on the DMA-410 showing “Service is non-covered” and use the DMA-410 as the attachment rather than the EOB. Document the patient's file to show how it is known that the service is not covered.

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

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

Section III of the DMA-410 COB Notification form must be filed electronically, via the GAMMIS Web Portal at www.mmis.georgia.gov. To provide this information, upload a scanned image of the member's insurance card for COB updates by logging into the GAMMIS Web Portal at www.mmis.georgia.gov, perform an eligibility request for the member in question, select the new "Member Transactions" button and follow the instructions provided on the member transactions page. Please note that Providers will need to continue using the paper format of the DMA 410-Form for sections I: Co-Payment Notification and Section II: COB Non-Coverage Affidavit. (Rev. 10/2018)

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

**DEPARTMENT OF COMMUNITY HEALTH – DIVISION OF MEDICAL ASSISTANCE
COB NOTIFICATION FORM**

Member Name: _____ Medicaid ID#: _____

I. CO-PAYMENT NOTIFICATION**No EOB Available. Coverage is through: _____
Insurance / benefit plan. The co-payment for their service is _____****II. COB NON-COVERAGE AFFIDAVIT**

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

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

Insurance Representative: _____ Telephone #: _____

☐ Insurance was cancelled on _____ (date)☐ Service is non-covered, annual/lifetime service limits exceeded.☐ Member not covered under this policy.☐ Out-of-Network Provider, No In-Network provider available to provide Medicaid covered services (explain below).☐ Other (explain) _____**By signing, I certify that, to the best of my knowledge, the information above is verified and accurate, and that this notification form applies to any associated claim(s) and is made a part thereof.**_____
Signature of Patient Account Representative_____
Date_____
Provider #

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

Attach this form to your claim(s) for paper claim submission, or if claim submitted electronically, indicate the associated ICN above and forward to HPE for processing.**III. COB INFORMATION UPDATE****When completing only this portion of the form, upload member's information and a scanned image of the member's insurance card via the GAMMIS Web Portal at www.mmis.georgia.gov.****THIS FORM MAY BE PHOTOCOPIED**

DMA-460: EB-EOMB

ICN: _____

DEPARTMENT OF COMMUNITY HEALTH – DIVISION OF MEDICAID MEDICARE NOTIFICATION FORM

Member Name: _____ Medicaid ID # _____

I MEDICARE CO-PAYMENT NOTIFICATION

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

II. MEDICARE NON-COVERAGE AFFADIVIT

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

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

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

Signature of Patient Account Representative

Date

Provider #

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

III. MEDIGAP/MEDICARE SUPPLEMENTAL INSURANCE INFORMATION UPDATE

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

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

Policyholder: _____ Patient Relationship to Policyholder: _____

Employer: _____ Group # _____

Subscriber/Member ID #: _____ Effective Date: _____ Coverage

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

Other (Specify): _____

THIS FORM MY BE PHOTOCOPIED

DMA 460 Rev.

614. Submitting COB and Crossover Attachments

Specific Guidelines for Submitting Cob and Crossover Attachments

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

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

Medicare deductible, coinsurance, and Medicare payment

615. Special Billings for Certain COB and Crossover Claims

615.1. Special Billings for Crossover Claims (Rev. 07/2015)

Inpatient Part B only for hospital claims

The purpose of this section is to assist with submitting a claim for inpatient hospital claims when the member has no Medicare Part A coverage or the Medicare Part A coverage is exhausted, but the member still has an effective Medicare Part B coverage. *Inpatient hospital admissions for “Part B Only” members must be pre-certified.* All Medicare Part B ancillary charges must be submitted to Medicare first and crossed over/adjudicated through Medicaid’s system prior to submitting the Inpatient charges to Medicaid. (Rev. 04/2016)

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

615.2.1. Submit the Part B ancillary charges to Medicare.

615.2.2. The Part B ancillary charges are paid by Medicare and then crossover to Medicaid.

615.2.3. If Medicaid approves the claim, a payment of the lesser of the coinsurance and deductible up to the Medicaid maximum allowable amount for the claim will be made on the Part B charges.

615.2.4. Submit the Part A Inpatient Charges with the EOMB from Medicare Part B along with the Medicaid Remittance Advice showing the amount that Medicaid paid for the coinsurance and deductible electronically through the GAMMIS web portal, www.mmis.georgia.gov.

615.2.5. Medicaid will process the Inpatient claim as a COB Hybrid claim by deducting the paid ancillary charges from the Diagnosis Related Group (DRG) amount to be paid.

Example:

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

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

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

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

The Medicaid allowed charges for the inpatient DRG rate is \$20,000. Medicaid pays the inpatient claims for \$15,000 (DRG allowed amount is \$20,000 minus the ancillary amount of \$5000 previously paid).

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

DMA-460

If a Letter of Benefits Exhausted is received from CMS, enter this information on the DMA-460 and retain the letter in the patient's file.

The denial EOMB from Medicare Part A.

- 615.3. Understanding the edits that denied the Part B only claim
 - 615.3.1. Prior-Authorization Required – Edits 3001, 3003, 3047 PA units exceeded – Edit 3052 (The ancillary changes for the Part B claim should not have a PA#. Crossovers do not require pre-certification.)
 - 615.3.2. Patient Status code in Field Locator 17 is not billable to Medicaid. (The Inpatient Claim will process as a primary Medicaid claim. Providers must use the 'Patient Status' code billable under the Hospital Services Program.)
 - 615.3.3. Billing value codes with no amount in Field Locator 40 (1st or 2nd value code amounts missing – an amount wasn't included with the value code.) – Edit 462 or 463
 - 615.3.4. Missing/invalid covered days – Edits 282, 283, 518, or 573
 - 615.3.5. Admit date missing or invalid – Edits 275 or 276
 - 615.3.6. Value Code visits do not correspond to the revenue code units billed – Edit 384
- 615.4. Reasons the claim will be denied:
 - 615.4.1. No Medicaid payment for the Part B services
 - 615.4.2. Total Charges or billed amount must match the amount on EOMB.
 - 615.4.3. EOMB does not contain an outpatient crossover bill type.
 - 615.4.4. Medicare coinsurance, deductible, and payment amounts cannot be identified on provider's EOMB.
 - 615.4.5. No Letter of Benefits Exhausted or Medicare EOMB denial for benefits attached.
 - 615.4.6. The 'From Date' does not begin with the date after the benefits have

exhausted.

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

615.5. Medicare Part B – Retail Drugs

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

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

615.6. Special Billings for COB Claims

615.6.1. Mother and Baby billed as One to the Health Insurance Carrier

Scenario:

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

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

Once the newborn is showing as an eligible Medicaid member, the provider should submit two separate claims, one for the mother and one for the newborn. The payment from the primary insurance must be reflected on both the mother and baby claim. In the event that the primary insurance pays for a partial stay, such as the first 30 days of a continuous hospital stay, the DOS on the claim submitted to Medicaid must be inclusive of the entire hospital stay in which the member is Medicaid eligible, and any prior payment from the primary insurance must be present on the claim. The Coordination of Benefits (COB) payment should be prorated between the mother and the newborn claims. The prorated amount is entered in field 54 on the UB-04 form (i.e., the Prior Payments field). A copy of the EOB must be submitted with each claim. The EOB must show the prorated COB Paid Amount and prorated Patient Liability. Please see the below example: (REV.04/2016)

	Combined EOB	Mother’s EOB	Child’s EOB
Charges	\$6000	\$5000	\$1000
Paid by Primary	\$3000	\$2500	\$ 500
Patient’s Liability	\$ 500	\$ 417	\$ 83

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

615.6.2. Partial Hospital Stay

Scenario 1

The member was admitted into the hospital as a Medicaid member and the member's other insurance effective date occurred after the member was admitted. (rev.10/2019)

The Medicaid eligibility effective date was 2/01/2003. The member's other insurance with XYZ Health was effective 12/03/2003. The member was admitted into the hospital on 12/01/2003 and discharged as of 12/17/2003. (Rev.04/2010)

The claim to Medicaid should have the following:

Precertification for the entire stay

DOS should be from 12/01/2003 to 12/17/2003, the exact dates that the member was eligible for Medicaid

The amount paid by XYZ health insurance should be in the Prior Payments field of the UB-04.

Scenario 2

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

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

The claim to Medicaid should have the following:

Precertification for DOS 12/07/2003 to 12/17/2003.

DOS on claim should be from 12/07/2003 to 12/17/2003, the exact dates the member was eligible for Medicaid.

The amount paid by XYZ health insurance should be prorated and entered in the Prior Payments field of the UB-04.

Prorating DOS for Scenario 2 XYZ Days: 12/01/2003 to 12/17/2003 = 16 days DMA Days: 12/07/02003 to 12/17/2003 = 10 days XYZ Paid: \$50,000 XYZ daily paid rate: $\$50,000/16 = \$3,125.00$ Prior Payment field on UB-04 for DMA is: $\$3125.00 = \$31,250.00$

615.6.3. Co-Pay Only Claims

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

615.6.3.1. The rendered services are covered by Medicaid

615.6.3.2. The rendering provider is an in-network provider for the member's manage care plan.

615.6.3.3. An EOB is received as an attachment to the claim or a DMA-410 is received as an attachment to the claim.

615.7. If an EOB is received:

- 615.7.1. The member's information on the EOB matches the information on the claim. (For example, member name, member ID, etc.).
- 615.7.2. The dates of service and the procedure codes on the EOB match those on the claim.
- 615.7.3. The billed amount on the claim must match the co-payment amount on the EOB.

615.8. If a DMA 410 is received:

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

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

Appendix A
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>

Appendix B

Affordable Care Act

A. Affordable Care Act

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

Appendix C
Pathways Fee for Service

A. Pathways Fee for Service (FFS) COS 200

Pathways HIPP Employer Sponsored Insurance (ESI) COS 201

For additional Pathways to Coverage TM information, please visit our page at:

Georgia Pathways HIPP | Georgia Department of Community Health

See next page for the table with coverage differences between Pathways HIPP COS 200 and Pathways HIPP COS 201

Pathways Health Insurance Premium Payment (HIPP) Program		
Description	Pathways FFS (COS 200)	Pathways Employer Sponsored Insurance (ESI) (COS 201)
Covered Services	Covered services are only those included in the state plan.	Covered services are only those included in the state plan, regardless of whether the service is covered by the ESI plan. Note that EPSDT services that are medically required can be paid without ESI information. Note all other insurance EOB information (OI payment and patient responsibility) will be required by the GA MMIS claims processing for aid category 201.
Prior Authorization (PA)	For Aid Category 200, PA required as defined by the state plan.	For Aid Category 201, PA not required. Note that EPSDT medically required services submitted without ESI may require a PA based on the state plan policy.
Non Emergency Medical Transportation (NEMT)	Members who are 19 or 20 years of age with Aid Category 198, 199, 200, or 201 will be given an NEMT assignment.	Members who are 19 or 20 years of age with Aid Category 198, 199, 200, or 201 will be given an NEMT assignment.
Vision	Vision claims will deny for Individuals 21 years and over.	Vision claims will deny for Individuals 21 years and over.
Dental	Dental claims will deny for Individuals 21 years and over.	Dental claims will deny for Individuals 21 years and over.
Health Check formerly known as Early Periodic Screening Diagnostic Testing (EPSDT)	If the member is 21 years or older, claim is denied.	If the member is 21 years or older, claim is denied.
Co-payment	The member subsystem identifies which members are required to pay co-pay. The claims processing subsystem deducts copay on services based on the state plan.	The member subsystem identifies which members are required to pay co-pay. The claims processing subsystem deducts copay on services based on the state plan. Note all other insurance EOB information (OI payment and patient responsibility) will be required by the GA MMIS claims processing for aid category 201.
Co-insurance	Covered services are only those included in the state plan, regardless of whether the service is covered by the ESI plan	Covered services are only those included in the state plan, regardless of whether the service is covered by the ESI plan Note all other insurance EOB information (OI payment and patient responsibility) will be required by the GA MMIS claims processing for aid category 201.
Deductibles	Covered services are only those included in the state plan, regardless of whether the service is covered by the ESI plan	Covered services are only those included in the state plan, regardless of whether the service is covered by the ESI plan Note all other insurance EOB information (OI payment and patient responsibility) will be required by the GA MMIS claims processing for aid category 201.