

PART II

POLICIES AND PROCEDURES
for
ADULTS WITH AIDS TARGETED CASE
MANAGEMENT



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.)
10/1/2026	N/A	No Changes	N/A	N/A
4/1/2025	N/A	No Changes	N/A	N/A
1/1/2025	Appendices J, K and L	Deleted Georgia Families, Georgia Families 360 and Non-Emergency Medical Transportation (NEMT) Appendices.	D	N/A
1/1/2025	Appendix X	Added comprehensive appendix which includes links to the websites providing information on Georgia Families, Georgia Families 360 and NEMT.	A	N/A

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

Adults with Aids Targeted Case Management
Chapter 600: Special Conditions of Participation

601. Definition of Case Management

Case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, education, and other services.

602. Enrollment

Enrollment is open to all providers who meet the conditions of participation in Part I of this manual and the special conditions listed in Section 603.

Please note that the term "provider" as used throughout this manual, in the context of providing case management services for adults with AIDS or symptomatic HIV disease, refers to the entity that has assumed the responsibility for meeting all conditions of participation. The term "entity" as used throughout this manual, refers to a facility, agency, organization, department, office, corporation, or partnership. (Rev.07/2014)

603. Special Conditions of Participation

To be qualified as a case management provider for Targeted Case Management for Adults with AIDS services in Georgia, certain requirements must be met. All providers must meet applicable state and federal laws governing the participation of providers in the Medicaid program. Additionally, each provider agency must demonstrate a minimum of three (3) years of experience in providing case management or health-related services to AIDS or symptomatic HIV disabled individuals.

- 603.1. Case Management Provider agencies must submit evidence of qualified case management and/or healthcare staff employed directly or through contract and have the capacity to provide the full range of case management services
- 603.2. Case Management provider agencies must provide evidence of dedicated qualified supervision of staff or contractors who meet the eligibility criteria for case managers as outlined in Section 603.2; a. – d.
- 603.3. Eligible case managers must meet the following qualifying criteria:
 - 603.3.1. Case managers must hold a Bachelor's degree or Master's degree in social work (MSW) or an equivalent social service or healthcare degree from an accredited college or university, OR
 - 603.3.2. be a licensed registered nurse (RN), with a Bachelor's or Master's degree from an accredited college or university; AND
 - 603.3.3. have at least one-year experience in a social services delivery system;
 - 603.3.4. have considerable skill in the methods of locating, developing, and coordinating the provision of supportive services in the community for

the AIDS or HIV symptomatic HIV disabled individual.

- 603.4. Qualified providers maintain such records as are necessary to fully disclose the extent of services provided and to furnish the Division with information as it may periodically request. All service records, which must be maintained for 3 years after the delivery of service, must contain written documentation of the following information:
- 603.4.1. all telephone or face-to-face contacts with members and/or their families, significant others, and care providers;
 - 603.4.2. member's name and Medicaid number;
 - 603.4.3. date of service;
 - 603.4.4. time spent providing service;
 - 603.4.5. person providing service;
 - 603.4.6. nature of the service; and
 - 603.4.7. place of service; and
 - 603.4.8. determination of appropriateness for case management services.

NOTE: Actual place of service should be documented and billed in accordance with the place of service descriptions and codes outlined in the CMS 1500 Georgia Medicaid/PeachCare for Kids Provider Billing Manual. Place of service code 99 (Other) should only be used when/if the actual place of service is not included in the list place of service codes and descriptions in the CMS 1500 billing manual.

- 603.5. Qualified providers have a financial management system that provides documentation of services and costs. Qualified providers also:
- 603.6. Ensure that individual Case Managers are able to facilitate services for each member on their case load without jeopardizing the quality of services provided. The member case load assigned to each case manager is at the discretion of the provider.
- 603.7. Ensure the eligible members will have free choice of the providers of Case Management Services and free choice of medical and other care providers.
- 603.8. Ensure that services are rendered by the enrolled provider (i.e., services cannot be sub-contracted).
- 603.9. Maintain regularly scheduled hours of operation and include provisions for members to receive services outside normal business hours.
- 603.10. Refer clients to other Case Management service providers if delay occurs before the initiation of services.
- 603.11. Have the demonstrated ability to collaborate with public and private health care and other service providers

- 603.12. Ensure that payment for case management services does not duplicate payments made to public or private agencies for the same purpose.
- 603.13. Maintain documentation that a case manager has a monthly ancillary contact with each member. For New Client Comprehensive Assessments and Extended Follow-ups, the case manager must provide documentation of a face-to-face contact
- Ancillary contact is defined as a telephone or face-to-face contact with a family member, significant other, or agency from which the client receives or may receive services
- 603.14. Provider applicants must complete, in full, the provider certification enrollment form contained in Appendix G. This form must accompany the enrollment application.

Chapter 700: Special Eligibility Conditions

701. Member Eligibility

Medicaid recipients twenty-one (21) years of age and older who have been diagnosed as having AIDS or symptomatic HIV disease and are at the greatest risk of hospitalization are eligible to participate in the Targeted Case Management Program for Adults with AIDS.

A member qualifies for case management services if he or she:

- 701.1. Is 21 years of age or older at the time of enrollment into the program and is Medicaid eligible; and
- 701.2. Has been diagnosed as having AIDS or symptomatic HIV disease. The individual meets this criterion if he or she:
 - 701.2.1. Is HIV+ as indicated through enzyme-linked immunosorbent assay (ELISA) and confirmed by the Western Blot or another generally accepted diagnostic test for HIV infection.
 - 701.2.2. Is HIV+ and has been diagnosed with symptomatic HIV disease as defined by having a documented history of one or more of the following symptoms;
 - 701.2.2.1. diarrhea;
 - 701.2.2.2. fatigue;
 - 701.2.2.3. fever;
 - 701.2.2.4. night sweats;
 - 701.2.2.5. swollen glands;
 - 701.2.2.6. malaise and/or rash;
 - 701.2.2.7. anemia; or
 - 701.2.2.8. T-cell lymphocyte counts < 200/mm³;
 - 701.2.3. Is HIV+ and/or has been determined to have AIDS as documented by being definitively diagnosed with one of the following indicator diseases:
 - 701.2.3.1. Coccidioidomycosis;
 - 701.2.3.2. Is HIV encephalopathy (also called "HIV dementia", AIDS dementia", or "subacute encephalitis due to HIV"?)
 - 701.2.3.3. Histoplasmosis;
 - 701.2.3.4. Isosporiasis;

- 701.2.3.5. Kaposi's sarcoma;
- 701.2.3.6. Lymphoma;
- 701.2.3.7. Tuberculosis;
- 701.2.3.8. Candidiasis;
- 701.2.3.9. Salmonella;
- 701.2.3.10. HIV wasting syndrome (emaciation, "slim disease")
- 701.2.3.11. Cryptococcosis;
- 701.2.3.12. Cytomegalovirus infection (CMV);
- 701.2.3.13. Herpes Simplex;
- 701.2.3.14. Cryptosporidiosis;
- 701.2.3.15. Mycobacterium avium Intracellular (MAI) complex or M. kansasii disease;
- 701.2.3.16. Pneumocystis carinii pneumonia (PCP)
- 701.2.3.17. Progressive multifocal leukoencephalopathy (PML); or
- 701.2.3.18. Toxoplasmosis;
- 701.3. Needs specific intervention with acute problem solving in one or more of the following situations
 - 701.3.1. acute medical needs such as respite care, dialysis, home health care, and services required during the later stages of illness;
 - 701.3.2. loss of access to care;
 - 701.3.3. substance abuse;
 - 701.3.4. mental illness;
 - 701.3.5. homelessness; or
 - 701.3.6. crisis. A crisis is any event that:
 - 701.3.6.1. is unanticipated
 - 701.3.6.2. occurs abruptly, with little or no warning
 - 701.3.6.3. poses a threat to the stability, health/safety, and/or treatment plan of the member, and

701.3.6.4. for which the member does not have the resources and/or capacity to manage alone.

Examples of a crisis are unplanned pregnancy, loss of employment or social support; changes in the member's medical condition, changes in the member's housing situation, legal problems, and/or other significant life events

701.4. Is not receiving treatment or care in a total care environment.

701.5. Is at the greatest risk of hospitalization

702. Collaboration Between Providers to Avoid Duplication of Services

Certain members may be eligible for other types of case management (e.g., a pregnant Medicaid member may be enrolled in Perinatal Case Management). Providers must establish whether the member is receiving case management services from another provider. If a member is enrolled in more than one Targeted Case Management (TCM) program, the case managers from both TCMs MUST determine which TCM is most appropriate in meeting the needs of the member. Duplication of targeted case management services is not allowed. Only one TCM provider will be reimbursed per member per month for TCM services.

The TCM provider is responsible for maintaining the confidentiality of a member's records. Therefore, the provider may choose to ask members to sign a release form, which allows the case manager to communicate with other Medicaid case management providers to avoid duplication of services. The Case Management Agreement form (DMA-630) found in Appendix A, may be used for this purpose. This form should be duplicated as needed.

703. Transfer of Members between Targeted Case Management Adults with AIDS providers

Eligible members may choose to change TCM Adults with AIDS providers by submitting a written request to their present provider, giving 30 days' notice for such action. The provider may discontinue providing case management services by providing a 30-day notice granting transfer to another case management provider.

Only one Comprehensive Assessment may be billed for each member served. When the member transfers from one Adult with AIDS case management provider to another, a copy of the Comprehensive Assessment must follow the member. The Case Management Agreement Form (DMA-630) found in Appendix A may be transferred with the member's records and need not be completed again by the new provider.

704. Loss of eligibility

Medicaid will not reimburse for case management services provided to an ineligible member. A member is no longer eligible for case management services if, at the time services are rendered, the member:

704.1. no longer qualifies for Medical Assistance;

704.2. has declined case management services;

- 704.3. is being cared for in a total care environment;
- 704.4. is no longer at risk of hospitalization; or
- 704.5. no longer meets the criteria outlined in Section 701

Chapter 800: Prior Approval

801. Prior Approval

The Division of Medical Assistance does not require prior approval for Targeted Case Management Services for Adults with AIDS.

Chapter 900: Scope of Services

901. General

Under the Case Management Program, enrolled providers receive reimbursement for identifying, coordinating, and reviewing the delivery of appropriate services for Medicaid eligible adults with AIDS or symptomatic HIV disease, who need assistance with acute problem solving.

902. Covered Services

Targeted Case Management for Adults with AIDS is performed through a set of interrelated activities incorporated into three billing units which are described below: comprehensive assessment, brief follow-up, and extended follow-up.

902.1. New Client Comprehensive Assessment

Assessment of an individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:

- 902.1.1. taking client history
- 902.1.2. identifying the needs of the individual, and completing related documentation
- 902.1.3. gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

902.2. Assessment also includes service to each new member whose case management records must be established. This service must be initiated within 48 hours of the request for services and must be completed within 30 days of enrollment into case management. This service may be billed only once for each member served.

For each member, providers must provide ALL of the following:

- 902.2.1. Obtain a recent medical assessment (within last two months) from the client's primary physician; or a Physician, Physician's Assistant, or Nurse Practitioner of choice.
- 902.2.2. Gather identifying information concerning the eligible member and his or her family, caregivers, and informal supports. A list of family members, significant others, and children not living with the client should be recorded. Primary caregivers, primary contacts, and legal guardians of children should be identified
- 902.2.3. Conduct a psychosocial assessment to identify and prioritize the member's service needs based on an evaluation of the member's medical history, social support network, emotional status, housing and physical

environment, employment potential, need for financial planning, health education, medical services, etc.

902.3. Care Plan

TCM Adults with AIDS providers develop a specific plan of care/service plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social education, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.

The service plan is written by the case manager in conjunction with the member. Service plan implementation includes:

- 902.3.1. assisting the member and his or her family or significant others in locating providers of the identified needed services;
- 902.3.2. contacting providers to schedule appointments and to make applications for services and entitlements;
- 902.3.3. confirming service delivery dates with providers and social supports;
- 902.3.4. documenting services that cannot be accessed;
- 902.3.5. collaborating with other providers, including other case management providers, to ensure that there is no duplication of service; and
- 902.3.6. updating the individualized service plan and documenting any changes from the original.

902.4. Brief follow-up

Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the care plan is implemented effectively and adequately, may be with the individual, family members, providers or other entities and conducted as frequently as necessary, but no less than once per month, to help determine such matters as:

- 902.4.1. whether services are being furnished in accordance with an individual's care plan
- 902.4.2. whether the services in the care plan are adequate
- 902.4.3. whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

The brief follow-up service is conducted after the comprehensive assessment is completed and the service plan is implemented. This service may be billed once per month for each member. Date(s) of service must occur after the comprehensive

assessment. A brief follow-up and comprehensive assessment may not be billed in the same month.

Providers are responsible for the following activities for each member each month:

- 902.4.4. implementing the individualized service plan as described above in the Section 902 (B) (1-6) Care Plan;
- 902.4.5. monitoring the appropriateness of the member's service delivery by contacting the member, the family, support persons, service providers, etc.;
- 902.4.6. following-up immediately with the member, family, support persons, and providers if any problems are identified during the monitoring phase; and
- 902.4.7. reassessing the member's situation by identifying changes that have occurred since the last contact, measuring progress towards meeting the defined goals and objectives, and updating the service plan as appropriate.

902.5. Extended follow-up

Includes reassessment of the eligible member with AIDS to determine the services needed to resolve a crisis situation . One unit of extended follow-up may be billed monthly, not to exceed three (3) per calendar year. An extended follow- up and a brief follow-up may not be billed in the same month. Date(s) of service must occur after the comprehensive assessment.

Extended follow-up activities include

- 902.5.1. direct contact with the member to provide intensive reassessment of the member's emotional, social, medical, housing, nutritional, and other needs as warranted by a crisis situation
- 902.5.2. updating the service delivery plan after a crisis situation occurs
- 902.5.3. implementing the service delivery plan as described in the New Client Comprehensive Assessment -- Section 902 (A).

902.6. Referral

Referral and related activities help an individual obtain needed services, including activities that help link eligible individuals with medical, social educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual. Referral activities occur as a regular part of TCM services and are not billed separately.

903. Non-covered Services

Case Management does not include the direct delivery of any services related to an underlying medical, educational, social needs or other **service to which an eligible individual has been referred, such as foster care services. Services such as (but not limited to) the following are not allowed as a part of case management services:**

- 903.1. Research gathering and completion of documentation required by the foster care program
- 903.2. Assessing adoption placements
- 903.3. Recruiting or interviewing potential foster care parents
- 903.4. Serving legal papers
- 903.5. Home investigations/inspections
- 903.6. Providing transportation
- 903.7. Administering foster care subsidies
- 903.8. Making placement arrangements

The following are examples of services that will not be reimbursed by Medicaid under the Targeted Case Management Program for Adults with HIV/AIDS:

- 903.9. case finding
- 903.10. legislative advocacy
- 903.11. counseling
- 903.12. training
- 903.13. transportation

904. Documentation of Services

An individual record must be maintained on each member enrolled.

In order to receive reimbursement, all services must be documented in writing. All service records must contain at least the following information:

all telephone or face-to-face contacts with members and/or their families, significant others, and care providers;

- 904.1. member's name and Medicaid number;
- 904.2. date of service;
- 904.3. time spent providing service;

- 904.4. person providing service;
- 904.5. nature of the service;
- 904.6. place of service; and
- 904.7. determination of appropriateness for case management services as related to the current health status of the member.

All records must be maintained for 3 years after service has been provided.

Chapter 1000: Basis for Reimbursement

1001. Reimbursement Methodology

Targeted Case Management for Adults with AIDS will be reimbursed on a fee- for-service basis billed monthly

For private providers, payments are limited to the lesser of the submitted charge or the established fees based on actual cost as determined by time studies conducted pursuant to methodology approved by Centers for Medicare and Medicaid Services.

Public providers of case management services will be reimbursed directly on a negotiated rate basis not to exceed actual cost.

Public providers should submit cost reports to the Division within five months after the fiscal year end.

Reimbursement rates will be evaluated annually and adjusted prospectively to reflect actual cost.

1002. Billing for Services

Only one service procedure code may be billed each calendar month. Since services must be completed prior to billing and services may span several days during the month, the last day of the calendar month must be submitted as the billing date on claims

In the event of multiple types of targeted case management, only one type will be reimbursed during the calendar month for each member. System edits provide that the first claim submitted will be paid, and later claims for a different type of targeted case management during the same month of service will be denied

At least one of the most current and approved International Classification of Diseases (ICD)10 indicative of HIV/AIDS must be included on the claim when billing for Targeted Case Management Adults with AIDS. Please see Appendix K of this manual for information about utilization of ICD 9 and the transition to ICD 10.

1003. Billing Codes

The following procedure codes are to be used for billing and documentation purposes for the Targeted Case Management Program for Adults with AIDS:

Unit of Service	Procedure Code
New Client Comprehensive Assessment	T2023
Extended Follow-up	T2023 TS U1
Brief Follow-up	T2023 TS

1004. General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social

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

Effective 4/1/2014, DCH will edit claims 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 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.

The following resources are available for more information:

Access the department's DCH-i newsletter and FAQs at <http://dch.georgia.gov/publications>

Search to see if a provider is enrolled at <https://www.mmis.georgia.gov/portal/default.aspx>

Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider's last **name**.

Access a provider listing at <https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Notices/tabId/53/Default.aspx>

Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

Appendix A
Targeted Case Management Program Case Management Agreement Form

NAME:

MEDICAID #:

ADDRESS:

With the signing of this agreement, I voluntarily agree to participate in the Targeted Case Management Program. I understand that I have the right to choose any enrolled case manager to be the provider of my case management services, and I have chosen the person indicated below. Further, I agree to:

- A. work with my case manager to develop a plan of service,
- B. uses the services as outlined in my care plan to achieve the goals set for me,
- C. communicates with my case manager, at least monthly and as needed, to review my plan of services, to make any changes to the stated activities and follow through on those changes.

I also realize the enrollment in the Case Management Program does not limit my freedom to choose providers of other medical services I might need.

I give my case manager the right to act on my behalf to arrange for the activities stated in my plan of services. In addition, I (check one)

_____agree _____do not agree.

to the release of information about my medical condition or plan of services by my case manager when the information is necessary to coordinate needed services.

My case manager explained to me that if, at any time, I am not satisfied with him/her, I have the right to apply for a change of case manager or discontinue case management services by submitting a written request to the Division giving 30 days' notice for such action. My case manager may discontinue providing case management services to me by giving me a 30-day notice to request a transfer to another case manager.

I hereby certify that this agreement has been explained to me by my case manager.

Client's Signature

Date

Case Manager's Signature

Date

Appendix B
Medicaid Assistance Eligibility Certification Medicaid and Peachcare for Kids' Member Identification Card Sample

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.nnmis.georgia.gov		
300 OERSTED		
If member is enrolled in a managed care plan, contact that plan for specific claim filing and prior authorization information.		
Payor: For Non-Managed Care Members Customer Service: 1-800-766-4456 (Toll Free)		
HP Enterprise Services Member: Box 105200 Provider: Box 105201 Tucker, GA 30085 Prior Authorization: GMCF 1455 Lincoln Parkway, Suite 800 Atlanta, GA 30346	SXC, Inc. Rx BIN-001553 Rx PCN-GAM SXC Rx Prior Auth 1-866-525-5827	Mail RX Drug Claims to: SXC Health Solutions, Inc. P.O. Box 3214 Lisle, IL 60532-8214 Rx Provider Help Line 1-866-525-5826
This card is for identification purposes only, and does not automatically guarantee eligibility for benefits and is non-transferable.		

Appendix C
CMS 1500 Claim Form

Effective May 1, 2015, the Department will only accept electronic claims. Any paper claims submitted to the fiscal agent for payment will be returned to the provider. Please refer to the Medicaid and Peachcare for Kids Part I Policies and Procedures manual, Section 112, for more information.

Appendix D
Gainwell Technologies Contact Information

The most current and accurate contact information for Gainwell Technologies can be found at the following link:
<https://www.mmis.georgia.gov/portal/PubAccess.Contact%20Information/Links/tabId/45/Default.aspx>

Appendix E
Reimbursement Rates

Procedure Code	Description of Service	Reimbursement Rate
T2023	New Client Comprehensive Assessment	\$126.00
T2023 TS U1	Extended Follow-up	84.00
T2023 TS	Brief Follow-up	42.00

Appendix F
Adults with Aids TCM National Code Table

National Code	Description	Modifier	Rate
T2023	Targeted Case Management Monthly		126.00
T2023	Targeted Case Management Monthly	TS(Follow-up Service) U1(Extended Follow-up)	84.00
T2023	Targeted Case Management Monthly	TS(Follow-up Service)	42.00

Instructions for National Codes:

T2023 is the monthly targeted case management code taken from the National Code Table. The code is Health Insurance Portability and Accountability Act (HIPAA) compliant and replaces the Georgia Local Codes, Y5100, Y5101 and Y5102. Effective with the dates of service beginning March 1, 2004, submit the appropriate code when billing the monthly targeted case management claim (CMS 1500) for Adult with AIDS Services.

When submitting a claim for a New Client Comprehensive Assessment use the T2023 code. The T2023 code should be used, with the TS, U1 modifiers, when billing for an Extended Follow-up visit and the T2023 code should be used, with the TS modifier, when billing the Brief Follow-up.

Appendix G
Targeted Case Management for Adults with Aids Provider Agency Certification

To be qualified as a case management provider for Targeted Case Management for Adults with AIDS services in Georgia, certain requirements must be met. All providers must meet applicable state and federal laws governing the participation of providers in the Medicaid program. Additionally, each provider must have one (1) or more documented years of experience in providing case management services to AIDS or symptomatic HIV disabled individuals, including the supervision of individuals who meet the eligible criteria for case managers outlined below.

A. Eligible case managers must meet the following qualifying criteria:

- i. Case managers must hold a bachelor's degree or master's degree in social work (MSW)
- ii. or an equivalent graduate degree from an accredited college or university.

OR

- iii. be a licensed registered nurse (RN), with a bachelor's or master's degree from a
- iv. accredited college or university.

AND

- v. have at least one-year experience in a social services delivery system,

AND

- vi. have considerable skill in the method of locating, developing, and coordinating the
- vii. provision of supportive services in the community for the AIDS or HIV disable
- viii. individual

B. Have qualified case manager(s) and the capacity to provide the full range of case management services.

C. Maintain such records as are necessary to fully disclose the extent of services provided and to furnish the Division with information as it may periodically request.

D. Have a financial management system that provides documentation of services and costs.

E. Ensure that eligible recipients will have free choice of the providers of case management services and free choice of medical and other care providers.

F. Maintain regularly scheduled hours of operation and include provisions for clients to receive services outside normal business hours.

G. Have the demonstrated ability to collaborate with public and private health care and other service

providers.

H. Ensure that services are rendered by the enrolled provider (i.e., services cannot be sub-contracted).

The undersigned does hereby attest that _____
(Provider Agency)

understands and is in compliance with the requirements listed above. I further acknowledge receipt of the Policies and Procedures for Targeted Case Management for Adults with AIDS manual and understand all the conditions contained therein.

Provider's Address

By: _____
Signature of Authorized Representative

Please print name and title

Date

Appendix H Department of Community Health Case Management Hierarchy

A. Duplication of Case Management Services

- i. Federal policy and the Department of Community Health (DCH) prohibit the reimbursement for case management services to more than one agency or Medicaid provider that renders case management services to an individual. This policy is set forth according to the federal Requirements and Limits Applicable to Specific Services defined in the State Medicaid Manual, section 4302.
- ii. It is the responsibility of the case manager to ensure that the member is not receiving case management services from any other agency. The case manager must obtain from the member information regarding any and all other services that he/she may be receiving prior to enrolling the member in a case management program. If the case manager should learn that the member is enrolled in another case management program, the case manager is advised not to render any case management services until it is verified that his/her case management services are primary. This may require termination of the member from another case management provider before case management from the new provider can be billed. It is the case manager's responsibility to advise the member of the various case management choices available to the member and to allow the member to make an affirmative choice among them.
- iii. DCH will reimburse only one provider agency for case management services. The Department has established the case management hierarchy below to define which case management is primary and will be reimbursed the case management provider highest on the hierarchy will be reimbursed if 2 case management providers should submit claims for the same month of service.
 1. COS 830 - (Case Management Organization - CMO) and
 2. COS 851 - (SOURCE Case Management)
 3. COS 100 - (MR Case Management Support) Only participants enrolled in COS 680 or 681
 4. COS 764 - (Child Protective Services Targeted Case Management) COS 800 - (Early Intervention Case Management)
 5. COS 765 - (Adult Protective Services Targeted Case Management) COS 762 - (Adults with AIDS Targeted Case Management)
 6. COS 763 - (At Risk of Incarceration Targeted Case Management)
 7. COS 100 - (Case Management Support) Only MRDD participants on the Short-term planning list.
 8. COS 960 - (Children Intervention School Service)
 9. COS 790 - (Rehab Services/DSPS)

Members enrolled in the DMO may opt out to enroll in another case management program. However, the member (not the case **management agency**) **must contact the DMO to initiate the opt out process.**

NOTES: Persons enrolled in hospice have case managers who manage all of their care and may not receive case management from any other program while enrolled in hospice. The Department's hospice lock-in system will automatically cause any other claims for case management to be denied.

Appendix I
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>