

PART II

POLICIES AND PROCEDURES

FOR

PERINATAL CASE MANAGEMENT

PROGRAM



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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PART II - POLICIES AND PROCEDURES FOR THE PERINATAL CASE MANAGEMENT PROGRAM

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PART II - CHAPTER 600
SPECIAL CONDITIONS OF PARTICIPATION

601. Definition of Services

Rev. 07/14

Perinatal Case Management (PCM) services are available to assist the eligible pregnant woman in gaining access to needed medical, nutritional, social, psychosocial, educational and other services in order to: improve maternal and infant health outcomes; encourage the use of cost-effective medical care through referrals to appropriate providers; and discourage over-utilization of costly services. Perinatal Case Management services are available to Medicaid eligible women during the prenatal and postpartum periods. These services may begin at the time of the presumptive eligibility determination for the pregnant woman, at the time of enrollment into one of Georgia's Medicaid care management organizations (CMOs), or following the referral by the woman's licensed obstetric or primary care provider who has identified her as being at risk for an adverse birth outcome. Women eligible for PCM services have free choice of any qualified Medicaid-enrolled PCM provider and free choice of other Medicaid-enrolled medical care providers within the State.

Rev. 04/14
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Rev. 10/15

602. Enrollment

Current enrollment is open to an individual or group qualified to provide perinatal case management services and eligible to enroll as a Medicaid provider under this program. An inpatient healthcare facility is not eligible to enroll as a perinatal case management provider. A signed copy of the applicable license (s) must be submitted with the provider's application for enrollment. Please see Chapter 100, Section 105 of the Part I Policies And Procedures for Medicaid/ PeachCare For Kids manual for detailed information about provider enrollment.

Independent licensed registered nurses are not eligible to enroll as Perinatal Case Management providers under this program. Only Perinatal Case Management program enrolled providers are allowed to bill for case management services under this program.

Rev. 04/14
Rev. 07/14
Rev. 04/15

603. Special Conditions of Participation

The Perinatal Case Management provider must be a Medicaid enrolled:

- GA licensed physician
- Physician's Assistant working under the direction of a licensed physician
- Nurse Practitioner

- Certified Nurse-Midwife
- Entity that employs or arranges for registered nurses to furnish the perinatal case management services such as a local public health agency. Inpatient healthcare facilities may not serve as Perinatal Case Management providers.

Every perinatal case management provider must be or utilize a Perinatal Case Manager to deliver the perinatal case management services.

The Perinatal Case Manager must:

- Have the capacity to provide the full range of perinatal case management services;
- Have demonstrated, direct experience in the delivery of health services to women such as providing primary care, prenatal care, family planning, or case management services; and
- Have demonstrated the ability to provide or coordinate pregnancy-related health and human services.

The Perinatal Case Manager may be a:

- GA licensed physician
- Physician's Assistant working under the direction of a licensed physician
- Nurse Practitioner
- Certified Nurse-Midwife
- GA licensed registered nurse who is employed or contracted with a Perinatal Case Management provider

The Perinatal Case Manager must:

- Have an unrestricted license to practice in the state of Georgia.
- Have a minimum of one-year direct experience in the delivery of perinatal services and coordination of care. This experience must have been acquired within the previous five years. **Appendix B is required**
- Have documented evidence of program orientation, training, and competency evaluation.
- Have the capacity to provide the full range of Perinatal Case Management Services as described in Chapter 900, Sections 903, 904, 905, and 906.
- Maintain documentation of all services provided to perinatal case management participants.

Rev. 07/18

- Coordinate all appropriate referrals (e.g. WIC) with local health departments, primary and rural health clinics, private physicians, federally qualified health centers, community agencies, etc.

Rev. 04/13

Paraprofessional staff may be utilized to support case management services when performed under the supervision of the qualified case manager. This staff must:

- have one year of human service delivery experience or documented college level course work in health or human services acquired within the previous five years.
- have a demonstrated ability to provide or coordinate pregnancy-related health and human services
- have documented evidence of program orientation and training

Rev. 04/13

All providers must maintain current documentation of qualifications for each person providing case management/support services; these records should include orientation program and materials, training, and satisfactory evaluation of skills needed to carry out the program. Keep these records in a central location as well as documentation of successful training in an individual's record. Train-the-trainer is appropriate from previously trained PCMs to new staff.

Services must be provided by the enrolled Perinatal Case Management provider's perinatal case manager.

604 Collaboration Between Providers Must Take Place In Order To Avoid Duplication Of Services

Rev. 07/14

Certain members may be eligible for other types of case management services. Providers should establish whether the member is receiving case management services from any other provider. Once it has been established that a member is receiving other types of case management, the Perinatal Case Management provider MUST determine who is best suited to meet the individual member's needs. Duplication of targeted case management services is strongly discouraged. In order to ensure that a coordinated approach to service delivery occurs and that duplication does not occur, case management providers must collaborate with each other.

PART II - CHAPTER 700
SPECIAL ELIGIBILITY CONDITIONS

All pregnant Medicaid members are eligible to participate in the Perinatal Case Management Program. The target groups are women at risk for adverse outcomes and women who are under the age of 21.

PART II - CHAPTER 800
PRIOR APPROVAL

Rev. 04/14 Perinatal Case Management (PCM) services for Fee For Service (FFS) women do not require prior approval. If a Medicaid pregnant member is enrolled in a Georgia Families care management organization (CMO), the CMO should be contacted regarding any policies and procedures pertaining to prior approvals for its perinatal case management program.

PART II - CHAPTER 900 SCOPE OF SERVICES

901. General

Rev. 07/14

Perinatal Case Management (PCM) is an ongoing process that responds to care needs as they evolve throughout the pregnancy and post-partum period. PCM includes: contact with non-eligible individuals that are directly related to identifying the eligible woman's needs and care for the purposes of helping the eligible woman access services; identifying needs and supports to assist the eligible woman in obtaining services; providing case managers with useful feedback; and alerting case managers to changes in the eligible woman's needs.

NOTE: PCM services will not be used to restrict a woman's access to other services under the Medicaid State Plan. Women will not be compelled to receive PCM services, condition receipt of PCM services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on the receipt of PCM services.

902. Covered Services

Rev. 07/14
Rev. 04/15

Perinatal Case Management includes the following:

- One initial prenatal comprehensive face-to-face assessment, per pregnancy, of the woman's needs to determine her need for any medical, educational, social or other services. Section 903 describes the minimum required components of the initial comprehensive assessment conducted during the initial prenatal comprehensive visit. The assessment activities include:
 - Taking a client history;
 - Identifying the woman's needs and completing related documentation;
 - Assessing the woman's reproductive life plan
 - 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;
- Periodic reassessment for women identified as at risk for an adverse birth outcome. Periodic reassessment of needs will take place monthly as a component of their case management follow up. Additional or different needs identified will be added to their plan of care. Reassessments may be face-to-face (for women with complex needs or at the woman's request) or telephonic.
- Development (and periodic revision) of a plan of care that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the woman;
 - Includes activities such as ensuring the active participation of the eligible woman, and working with the woman (or the woman's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible woman.
- Monitoring and follow up activities:

- Activities and contacts with the woman (either face-to-face or telephonic) occur at least monthly during the pregnancy. They are necessary to ensure the plan of care is implemented and adequately addresses the eligible woman's needs. These activities and contacts may also be with family members, service providers, or other entities or individuals and conducted as frequently as necessary. The purpose of this monitoring is to determine whether the following conditions are met:
 - The services are being furnished in accordance with the woman's plan of care;
 - The services in the plan of care are adequate; and
 - Any changes in the needs or status of the woman are reflected in the plan of care.

In order to provide basic information about the program, the Medicaid member should be given a copy of the **PCM Questions and Answers** sheet located in Appendix C. The member is free to choose any perinatal case manager who is enrolled or contracted with a PCM Program enrolled provider. The Medicaid member should have only one targeted case management provider providing case management services at any one time during the perinatal period. Before providing service, it must be determined if the Medicaid member already has a case manager for the current pregnancy. If she does not, the PCM program should be explained to her.

The PCM Information form (in Appendix D) must be completed by the member before any billable program services are provided. A copy should be given to the member.

903. Initial Prenatal Comprehensive Visit and Assessment (New Patient)

Rev. 04/14
Rev. 07/14
Rev. 10/14
Rev. 10/15
Rev. 04/17

The initial prenatal comprehensive visit is a face-to-face visit conducted at an appointment date and time **agreed to by the member**. The initial prenatal comprehensive visit is for newly pregnant Medicaid enrolled (presumptive eligible or full Medicaid enrollment) women whose case management and administrative records need to be established. During this visit, the perinatal case manager conducts an in-depth assessment of the woman as described below. Priorities must be set based on this comprehensive assessment. Initial linkages must be made with required services for no less than the top three priorities. Appendix E contains the Initial Comprehensive Assessment Form.

- A) The initial prenatal comprehensive face-to-face assessment occurs once per pregnancy and includes: a medical and reproductive health assessment; a review of the nutrition, psychosocial, and health education needs of the woman; gathering information from other sources such as family members, medical providers, social workers, and educators to form a complete assessment of the member; and a reproductive life plan discussion. The reproductive life plan discussion will include information about the availability of immediate postpartum long acting reversible contraceptive (LARCs).

- 1) The nutrition assessment evaluates (at a minimum) the woman's resources for obtaining and preparing food, nutritional status, dietary habits, and dietary risk factors; identifying the woman's needs and completing documentation;
- 2) The psychosocial and socioeconomic assessments evaluate:
 - Economic/environmental factors to include employment, insurance, housing conditions, transportation needs, and substance, alcohol or drug use;
 - Education status;
 - Attitudes toward pregnancy;
 - Parenting experience;
 - Support systems; and
 - Emotional resources and needs.
- 3) The health education assessment will evaluate the health education needs and risk reduction factors.
- 4) Following completion of the various components of the initial prenatal comprehensive assessment, a written, reproductive life plan and an individualized plan of care to meet the identified needs and goals of the woman must be developed. The individualized plan of care must include a list of the identified problems, an intervention or resolution for each, and be implemented following development.

Rev. 04/15
Rev. 04/17

The perinatal case manager will assist the woman in locating Medicaid and community providers and making the necessary connections to the service needs identified in the plan. The case manager must send the initial prenatal comprehensive assessment, reproductive life plan and plan of care to the woman's OB or primary care provider (only after confirmation with the practitioner's office that the practitioner is providing care for the woman) or to the woman's selected care management organization (CMO) only after confirming the woman's assignment to this CMO in the woman's file within the Georgia Medicaid Management Information System (MMIS). When the PCM initial prenatal assessment is conducted during a woman's third trimester of pregnancy, the perinatal case manager's first priority is to send a copy of the completed assessment, reproductive life plan and plan of care to the woman's confirmed OB provider. The completed PCM initial prenatal assessment, reproductive life plan and plan of care **MUST ONLY** be submitted and shared with the woman's selected CMO or OB/primary care provider - otherwise it will constitute a HIPAA violation. Ongoing contact and collaboration with the clinician and other service providers must be

maintained and documented. Appropriate authorization should be obtained from the woman for this ongoing collaboration.

- B) One initial prenatal comprehensive visit and assessment will be paid per pregnancy.

904. Periodic Re-assessments/Follow-Up Visits

- Follow-up visits, either face-to-face or telephonic, will be paid throughout the pregnancy. Follow-up visits may not be provided after delivery.
 - A brief follow-up visit/contact with the woman is required at least monthly during the pregnancy. These visits/contacts are necessary to ensure the plan of care is implemented and that it adequately addresses the woman's needs. Activities and contacts may also include contacts with family members, service providers, or other entities or individuals and should be conducted as frequently described in the plan of care. The purpose of this monitoring is to determine whether the following conditions are met:
 - The services are being furnished in accordance with the woman's plan of care;
 - The services in the plan of care are adequate; and
 - Any changes in the needs or status of the woman are reflected in the plan of care.
 - An extended prenatal follow-up visit may be required to reassess the medical, nutrition, psychosocial and health education needs. The plan of care should be reviewed and evaluated for continued appropriateness and updated if necessary during the extended prenatal follow-up visit.

Rev. 07/14

905. Postpartum Visit

Postpartum services are provided only to established women who received prenatal PCM services. The postpartum visit should occur at least thirty (30) days post-delivery. This face-to-face or telephonic visit must be completed within sixty (60) days after delivery and cannot be later than the last day of Medicaid eligibility.

At this visit, a reassessment will be made. Needs will be identified and the service plan will be updated. Linkages will be made based on the mother's needs for postpartum, family planning and other services. Assistance will be provided with Medicaid eligibility determination, WIC, EPSDT, and other services needed by her infant. The reproductive life plan discussion should be repeated. The postpartum visit will be paid once per pregnancy.

Rev. 04/17

906. Documentation of Services

- A) An individual record must be maintained for each woman receiving perinatal case management services. All services must be documented.
- B) The properly executed PCM Information Form (in the Appendix D) must be kept in the patient's record.
- C) Appendices E, F, G, and H represent required information. Providers must ensure collection and documentation of all data. The information must be kept current. Providers must use the Initial Prenatal Comprehensive Assessment form and may use the progress notes forms shown or may use their own. Progress notes should be narrative in nature (not a check list), and must be signed and dated by the person documenting the information.
- D) There should be documentation related to all appointments that addresses the outcome of each appointment, pertinent findings, and any actions or interventions taken by the case manager when necessary.
- E) There should be documentation that the plan of care is reviewed and evaluated by the case manager for continued appropriateness. Adjustments, additions, and updates to the plan should be noted.
- F) When paraprofessional staff members are utilized, there should be evidence that the case manager has reviewed and evaluated their documentation at least monthly.
- G) PCM records and documentation related to services for which claims are submitted must be readily available for on-site audits and reviews by the Division or its agents. These records must be available within the time frame of the on-site visit, whether announced or unannounced. Records less than two years old should be kept on-site.
- H) The Program Integrity Section is responsible for appropriate follow-up on all information regarding fraudulent or abusive provider and member activities.
- I) The following information must be included and maintained in each case record for all eligible women:
 - 1. The name of the woman
 - 2. The dates of the perinatal case management services
 - 3. The name of the perinatal case management provider and the perinatal case manager
 - 4. The nature, content, units of perinatal case management service received and whether goals specified in the plan of care have been achieved
 - 5. The need for, and occurrence of, coordination with other case managers
 - 6. A timeline for obtaining needed services
 - 7. A timeline for re-evaluation of the plan

Rev. 07/15

Rev. 04/13
Rev. 07/14

PART II - CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001. Reimbursement Methodology

Rev. 04/13
Rev. 07/14

PCM Services will be reimbursed on a fee-for-service basis billed using the CMS-1500 claim form. The fee schedule rates are the same for both governmental and private providers of perinatal case management services. See Appendix A of this manual for a list of covered codes with their reimbursement rates.

Rev. 04/14
Rev. 07/18

The CMS 1500 claim form must be used on or after April 1, 2014.

1002. Billing for Services For FFS Members

Rev. 04/14
Rev. 07/14
Rev. 10/14
Rev. 01/15
Rev. 10/15

When filing for reimbursement, it is necessary to use a diagnosis code. The provider may use any appropriate ICD-10 diagnosis code with an appropriate HCPCS code.

Effective since October 1, 2015, ICD-10 – CM Diagnosis Codes must be used with the HCPCS codes. The diagnosis codes should be placed in field 21, and referenced in field 24 E of the CMS 1500 Claim Form.

Public Health providers must confirm the woman's choice of her OB or primary care practitioner (if she will remain a FFS member) or the woman's choice of her CMO (if she will be enrolled in Medicaid managed care) prior to sending the PCM initial prenatal comprehensive assessment and plan of care to either entity and prior to submitting a claim for the PCM services. Confirmation must be obtained from the practitioner's office or the Georgia MMIS where assignment to a CMO is documented. The initial prenatal comprehensive assessment may only be billed once during the pregnancy.

The initial prenatal comprehensive visit (H1000) must be paid before other visits (H1003, H1002 or T2022U1) can be paid. See Appendix A for detailed information.

NOTE: The H- codes mentioned above provide greater specificity regarding the delivery of perinatal case management services.

If a second comprehensive evaluation is performed in less than 180 days for a different pregnancy, the provider should submit a paper claim and the completed CLAIM ATTACHMENT located in Appendix H. It is not necessary to first receive a denial.

The CLAIM ATTACHMENT should be completed only when the provider has documented proof of the previous pregnancy. This must be kept in the member's PCM record and should include the name of the previous relevant provider.

This claim attachment should **NOT** be submitted if required documentation is not in the record. Submit the claim along with the attachment to:

Georgia Health Partnership/Member and Provider Correspondence
P.O. Box 105200
Tucker, GA 30085-5200

The post postpartum follow-up visit may be billed only once per pregnancy. Postpartum case management services must be completed between thirty (30) and sixty (60) days after delivery and cannot be later than the last day of Medicaid eligibility.

APPENDIX A

Providers should bill HCPCS codes with modifiers as appropriate.

HCPCS Code	Description	Rate	Required Modifier
H1000	Initial Comprehensive Visit	\$72.60	None
H1003	Brief Follow-up Visit	\$12.10	None
H1002	Extended Follow-up Visit	\$36.31	None
T2022	Postpartum Follow-up Visit	\$48.40	U1



APPENDIX B

Provider Enrollment Questionnaire
PERINATAL CASE MANAGEMENT PROGRAM

Perinatal Case Management Provider Name: _____

Provider Contact Person: _____ Telephone Number: _____

**COMPLETE THE FOLLOWING QUESTIONS AND ATTACH DOCUMENTATION WHERE
INDICATED.**

1. Please identify your staff members that will serve as case managers for the Perinatal Case Management Program? (*Please list names.*)

GA licensed physicians: _____

Physician's Assistants (working under the direction of a licensed physician): _____

Nurse Practitioners: _____

Certified Nurse-Midwives: _____

GA licensed Registered Nurses: _____

2. Do the licensed staff members, including the registered nurses, have at least one year of direct experience in the delivery of perinatal care?

Yes _____ No _____

Please attach a complete job history with dates, name of employer, location, and description of responsibilities.

Printed Name: _____ Date: _____

Authorized Perinatal Case Management Provider Representative

Signature: _____ Title: _____



Questions & Answers

Rev. 07/14
Rev. 01/15

PERINATAL CASE MANAGEMENT PROGRAM

- **WHAT IS IT?**

A Medicaid program that pays for a case manager to assist a pregnant woman in identifying her special needs and helps her find ways to meet those needs.

- **WHAT IS THE PURPOSE?**

In the state of Georgia, approximately 9 out of 100 babies weigh less than 5½ pounds and do not get off to the best start. If women are able to find the help they need while they are pregnant, they can take better care of themselves. This has a positive effect on the weight and health of the unborn baby.

- **WHY SHOULD I HAVE A CASE MANAGER?**

It can be very confusing to know where to look for different kinds of help. Would you know how to find childbirth education classes, a nutritionist, or a nurse to come to your home to check you and your baby? A Perinatal case manager knows how to get assistance quicker than if you had to do it on your own.

- **WHO CAN PARTICIPATE IN THE PROGRAM?**

Any Medicaid eligible pregnant woman at risk for a poor birth outcome.

- **WILL MY MEDICAID BE REDUCED IF I DON'T PARTICIPATE?**

No. Your participation is completely voluntary.

- **HOW DO I GET A CASE MANAGER?**

If enrolled in a CMO, contact the CMO that you are enrolled with to seek assistance and additional information about their case management services.

- **WILL I HAVE TO PAY ANYTHING FOR THE CASE MANAGER?**

No. Although this service is not free, it is fully covered by your Medicaid benefits.

- **WHAT IF I WANT MORE THAN ONE CASE MANAGER?**

Medicaid will only pay for one case manager at a time. It is best if you stay with the case manager you select for your whole pregnancy if possible.



APPENDIX D

PERINATAL CASE MANAGEMENT INFORMATION

Approximately 9 out of 100 babies born in Georgia are “low birth weight” which means they weigh less than 5½ pounds and do not get as good a start as they should. The Perinatal Case Management program is a voluntary program available to pregnant women who are members of Georgia Medicaid. The goal of the program is to improve pregnancy outcomes by providing a case manager to help the expectant mother get services specific to her needs. Medicaid pays the perinatal case manager for this service so there is no charge to the Medicaid member.

Medicaid approved perinatal case managers are located in several locations including: health departments; doctors’ offices; and private agencies. These case managers have experience in mother and baby health. If you choose to participate in this program, a case manager will help you find the care and services you need.

What should you expect from your perinatal case manager?

At your first visit, a case manager will ask you many questions in order to make a complete assessment. Then the two of you will identify and discuss your needs and agree on a detailed plan of care to meet those needs. You will be linked with the appropriate services and later, if you enroll in a CMO, a new case manager will be assigned and will check back with you to be sure you received what you needed as outlined in your plan. Your case manager will contact you at least once each month to be sure you are following the plan that was developed. You should feel free to contact your case manager anytime during your pregnancy. If your needs should change, the case manager will work with you to update and modify your plan to meet these new needs right up to delivery. You will also be reassessed by your case manager after you deliver in order to link you with services based on your updated needs, for example, family planning services for you and Health Check for your baby.

What are your responsibilities?

The first step is to complete the initial comprehensive assessment and the reproductive life plan. The selection of your case management provider should be completely **YOUR CHOICE**. It is important that you feel comfortable working with your case manager throughout your pregnancy. We ask that you sign below indicating that you do not already have a Perinatal Case Manager at this time. (*You will be given a copy.*) Medicaid will pay for only one case manager at a time.

Keep your perinatal case manager informed of your current address, telephone number, and other ways to reach you. If you move, let them know. Notify them of any change in your condition and keep them up to date on all your needs.

I have read and understand the information above. It is my statement that I do not have a Perinatal Case Manager at this time and have not previously signed this document for my current pregnancy.

Print or Type Name: _____

Medicaid ID Number: _____

Signature: _____ Date: _____

APPENDIX E

Perinatal Case Management Initial Assessment

To be completed by patient.

Name: _____ **Maiden:** _____ **Medicaid ID:** _____
Nombre Last First M

Address: _____
Direccion

Date of Birth: _____ **Age:** _____ **SSN:** _____ **Email:** _____
Fecha de Nacimiento Numero de Seguro Direccion Electronica

Phone #: Home: _____ **Cell:** _____ **Alternate #:** _____
Casa # de Telefono de Celular

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Race:** _____ **Ethnicity:** _____

How well do you speak English? ☐ Excellent ☐ Good ☐ Need help Do you need someone to translate for you? ☐ Yes ☐ No

What language do you read and speak mostly in your household? _____

In what language do you write best? _____

Education: Years completed? ☐ < 9th grade ☐ GED ☐ High school ☐ Tech ☐ College

Do you have a job? ☐ Yes ☐ No What is the best day and time to call you? _____

Do you receive Food Stamps / WIC or other Government assistance? ☐ Yes ☐ No

Do you have any other insurance in addition to Medicaid? ☐ Yes ☐ No Other Insurer? _____

Do you have family and/or friends who are helpful to you? ☐ Yes ☐ No

Will you have transportation to get to your appointments for this pregnancy? ☐ Yes ☐ No

What is your current living situation? ☐ Live alone ☐ Live with someone Who is that person? ☐ Husband ☐ Boyfriend
☐ Mother ☐ Father ☐ Others _____ ☐ Live in shelter ☐ Homeless

Is public or other assistance needed for household? ☐ Yes ☐ No Please describe: _____

Personal Health History

Have you been pregnant before? ☐ Yes ☐ No How many children do you have? _____

Date of last pregnancy: ____/____/____ If you are under age 16, was this pregnancy the result of a forced act or trick of any kind? ☐ Yes ☐ No **If yes, please notify the person assisting you.**

Please write the names and ages of your children living with you: _____

How many of your children are on Medicaid? _____

Have you experienced any of the following?

Abortions: How many? _____	Stillbirth: How many? _____	Pre-Eclampsia / Eclampsia ☐ Yes ☐ No
Miscarriages: How many? _____	Baby in ICU: How many? _____	Child(ren) that died: How many? _____
Lupus ☐ Yes ☐ No	Stroke ☐ Yes ☐ No	Early labor / delivery ☐ Yes ☐ No
Sickle Cell ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No	Diabetes with pregnancy ☐ Yes ☐ No
Herpes ☐ Yes ☐ No	Syphilis ☐ Yes ☐ No	Chlamydia / Gonorrhea ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No	Vaginal bleeding ☐ Yes ☐ No	Abnormal baby at birth ☐ Yes ☐ No
Repeated Miscarriage ☐ Yes ☐ No	after 20 Weeks ☐ Yes ☐ No	Alcohol or Recreational drugs: ☐ Yes ☐ No
Thyroid Problems ☐ Yes ☐ No	Blood Clot ☐ Yes ☐ No	Drugs _____
Diabetes: Type I or II ☐ Yes ☐ No	Smoking ☐ Yes ☐ No	Cancer: ☐ Yes ☐ No
Multiple Births/Twins ☐ Yes ☐ No	HIV/AIDS ☐ Yes ☐ No	Type _____
Genital Warts ☐ Yes ☐ No	Seizures ☐ Yes ☐ No	Social Problems: _____
Anemia ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Housing, Utilities, WIC ☐ Yes ☐ No

APPENDIX E

Perinatal Case Management Initial Assessment

To be completed by the nurse performing the assessment

Pregnancy-related History

Current weight: _____ lbs. Height: _____ ft. _____ in. Date of last menstrual period: _____

Member is _____ weeks gestation Was pregnancy planned? ☐ Yes ☐ No

Is the pregnancy wanted?: ☐ Yes ☐ No If unwanted, what is the plan? _____ Were options discussed? ☐ Yes ☐ No

Is the father of the baby involved? ☐ Yes ☐ No Does the father accept the pregnancy? ☐ Yes ☐ No ☐ Not sure

If yes, provide father's name, address and phone number: _____

Does the father of this baby plan to be supportive, even if it is just emotional support? ☐ Yes ☐ No

If no, provide the patient with community resource information.

Does the father/partner have a history of alcohol or drug use, violence, abuse or neglect of the patient or their children?

☐ Yes ☐ No If yes, describe: _____

Any other domestic violence or feelings of being unsafe in the home? ☐ Yes ☐ No

Any religious objections to medical treatment (e.g. refusal of blood transfusion)? ☐ Yes ☐ No

Please describe: _____

Assistance needed to locate an OB provider? ☐ Yes ☐ No WIC referral? ☐ Yes ☐ No Plan to breastfeed? ☐ Yes ☐ No

Problems with current pregnancy such as bleeding or cramping or other pregnancy problems? ☐ Yes ☐ No

If yes, what problems? : _____ Doctor notified: ☐ Yes ☐ No

Currently experiencing morning sickness? ☐ Yes ☐ No Able to keep meals down on most day? ☐ Yes ☐ No

Any urinary tract problems (UTI/Pyelo/Bacteriuria) during current pregnancy? ☐ Yes ☐ No

Symptoms of depression at present? ☐ Yes ☐ No Depression with past pregnancies or following past pregnancies? ☐ Yes ☐ No

Other current mental health concerns? Yes No If yes, list them: _____

Any additional stress not related to current pregnancy? ☐ Yes ☐ No Describe: _____

Any prescription medications other than prenatal vitamins? ☐ Yes ☐ No Dosages and frequency: _____

Premature delivery less than 37 weeks gestation? ☐ Yes ☐ No How many? _____

If yes, was it associated with an underlying maternal health condition? ☐ Yes ☐ No

History of low birth weight births <2500 grams? ☐ Yes ☐ No How many? _____

History of very low birth weight births < 1500 grams? ☐ Yes ☐ No How many? _____

Date of last Flu shot: _____

Prior treatments for pregnancy-induced hypertension: ☐ Yes ☐ No If yes, describe treatment: _____

Any problems with the cervix during previous pregnancies? ☐ Yes ☐ No Describe: _____

Other medical problems during previous pregnancy (ies) or current pregnancy that have not been discussed? ☐ Yes ☐ No

Describe: _____

Nurse name (print): _____ Health Department: _____

Phone Number: _____

OB Provider Name: _____ OB contact info: _____

Signature : _____ Date: _____

APPENDIX E

Reproductive Life Plan

Name: _____ Medicaid ID: _____ Date: _____

It is important to let your health care provider know what your plans are for having, or not having, children and for protecting yourself from sexually transmitted infections. Your health care provider can then better help you with your family planning or contraceptive needs, and better advise you about ways to protect your own health and the health of any children you desire to have.

Please tell us about your plans for having, or not having, children and for protecting yourself from sexually transmitted infections by checking the box which is closest to your answer.

1. How would you describe your desire to have a child?

- ☐ I DO NOT want to have a child ever (or ever again)
- ☐ I DO want to have a child:
 - ☐ Now or in the next year
 - ☐ In 1 to 2 years
 - ☐ In 3 to 4 years
 - ☐ In 5 or more years
 - ☐ I am unsure about when
- ☐ I am unsure about whether I want to have a child now or in the future

2. Do you (or your partner) do anything to prevent pregnancy or sexually transmitted infections?

- ☐ I don't have a partner or I'm not sexually active right now
- ☐ I am sexually active with a partner of my same sex
- ☐ No, I (and my partner) do not do anything to prevent pregnancy or sexually transmitted infections
- ☐ Sometimes when we have sex, I (or my partner) do something to prevent pregnancy or sexually transmitted infections
- ☐ Every time we have sex, I (or my partner) do something to prevent pregnancy or sexually transmitted infections

If you (or your partner) do something to prevent pregnancy or sexually transmitted infections 'Sometimes' or 'Every time' you have sex, what method do you use:

- | | |
|--|---|
| ☐ Condoms | ☐ Diaphragm |
| ☐ Birth control pills | ☐ Intrauterine device (IUD) or implant |
| ☐ Patch | ☐ My tubes are tied (tubal ligation) |
| ☐ Depo-Provera | ☐ My partner had a vasectomy |
| ☐ Vaginal ring | ☐ Other _____ |

3. Is there a method of birth control that you or your partner have thought about using or about which you would like to learn more? _____

4. Are you having (or have you had) problems with a birth control method that you would like to talk about with your provider today? _____

5. Are you concerned about any sexually transmitted infections?

- ☐ No ☐ Maybe ☐ Yes

Nurse: Print name: _____

Signature: _____ Date: _____

CARE PLAN

(MEDICAL - BEHAVIORAL-SOCIAL – HEALTH/WELLNESS – EDUCATION)

DPH Referral - Health Department:

Member Name:

DOB:

Medicaid Identification Number:

Priority	Assessed Problems / Barriers or Needs	Planned Goals	Interventions/ Referral*	Start Date	Progress Notes/Updates
1			Interventions		Follow-up
			Referral		Staff signature & Date
2			Interventions		Follow-up
			Referral		Staff signature & Date
3			Interventions		Follow-up
			Referral		Staff signature & Date
4			Interventions		Follow-up
			Referral		Staff signature & Date
5			Interventions		Follow-up
			Referral		Staff signature & Date

The member/patient has participated in the development and prioritization of this individualized care plan. Patient initial _____

Reviewer's Name: _____

Reviewer's Contact Number: _____

Reviewer's Signature/Date: _____

Definitions:

Priority: Issue or concern requiring engagement in the order of importance or urgency
 Assessed Problems/Barriers: Concerns that impact care, services, or outcomes
 Planned Goals: Expected result once problems or barriers are resolved
 Interventions: Activities, Education or Coordination efforts used to reach goals
 Outcomes: Final result of goals – Goals met, Goals Unmet, In Progress
 Start Date: Date the intervention/referral was initiated
 *Referral: Please input Name, Email address, and Phone number for the referral

APPENDIX F

PERINATAL CASE MANAGEMENT RECORD AND TRACKING FORM

CLIENT IDENTIFICATION

FOR LOCAL USE ONLY

Last Name		First Name		M.I.	Maiden				
Medicaid Number:				Infant's Name			Chart #		
Address:		City		Zip Code		Phone Number			
Directions to Home:									
Comments:									
PERINATAL SERVICES TRACKING RECORD									
APPOINTMENT RECORD				PCM FOLLOW-UP					
Appointment Date	Provider	Service	K/DNKA	Contact Date	Face to Face	Other (Specify)	Contact Site HV or Other (Specify)	Code	Initials
			☐ ☐		☐ _____		☐ _____		
			☐ ☐		☐ _____		☐ _____		
			☐ ☐		☐ _____		☐ _____		
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			☐ ☐		☐ _____		☐ _____		
Prenatal Care				Total Contacts Face to Face		TOTAL Home Visits		TOTAL PCM Contacts	
Total # Visits									

APPENDIX G

Perinatal Case Management

PROGRESS NOTES

Member Name:_____ **Medicaid ID:**_____

[illegible]

Form 3703 (Rev. 07-15)



CLAIM ATTACHMENT

PERINATAL CASE MANAGEMENT

Perinatal Case Management Provider Name: _____

Provider's Medicaid ID Number: _____

Address: _____
(Street/PO Box)

(City) (State) (Zip)

Member's Name: _____

Member's Medicaid ID Number: _____ Telephone Number: _____
(Include area code)

SECOND COMPREHENSIVE PERINATAL ASSESSMENT WAS PROVIDED IN LESS THAN 180 DAYS BECAUSE:

1. The previous pregnancy, with an EDC of _____, terminated on _____.
2. The current pregnancy, with an EDC of _____, was diagnosed on _____.

Additional information: _____

Signature: _____ Date: _____
(Authorized Provider Representative)

Print or type Name: _____

Telephone Number: _____
(Include area code)

APPENDIX I DXC TECHNOLOGY

Member and Provider Correspondence

P.O. Box 105200
Tucker, GA 30085-5200

Electronic Data Interchange (EDI)

877-261-8785

*Asynchronous

*Web portal

*Physical media

*Network Data Mover (NDM)

*Systems Network Architecture (SNA)

*Transmission Control Protocol/Internet Protocol (TCP/IP)

Provider Inquiry Numbers:

~ 800-766-4456 (toll free)

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

[Rev. 10/15](#)

[Rev. 01/16](#)

APPENDIX J

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

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

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

For the current 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 K

Georgia Families

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

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

The four licensed CMOs:

 Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	 CareSource 1-855-202-1058 www.caresource.com
 Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	 WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe

Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

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

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

- Amerigroup Community Care
- CareSource
- Peach State Health Plan
- WellCare of Georgia

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

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

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

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only

182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB <= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged

211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged

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

916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

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

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

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/ GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com	866-231-1821 www.wellcare.com

Registering immunizations with GRITS:

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

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

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

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

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

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

Participating in a Georgia Families' health plan:

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

Billing the health plans for services provided:

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

If a claim is submitted to DXC in error:

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

Credentialing

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

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

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

The CVO's one-source application process:

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

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

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

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

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

Billing the health plans for services provided:

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

If a claim is submitted to DXC in error:

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

Receiving payment:

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

Health plans payment of clean claims:

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

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for clean claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. Dental: Checks are mailed weekly on Thursday for clean claims. Vision: Checks are mailed weekly on Wednesday for clean	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for <u>clean</u> claims that have been adjudicated. <u>Pharmacy:</u> Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for clean claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.	WellCare runs claims payment cycles up to six (6) times each week for clean claims. For further information, please refer to the WellCare website, the WellCare provider manual, or contact Customer Service at 866-231-1821

claims (beginning June 7th) Pharmacy: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)			
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How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.	Members can change PCPs for any reason within the first 90 days of their enrollment. After the first 90 days, members may change PCPs once every six months.

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24 th day of the month and are effective for the current month. PCP changes made after the 24 th day of the month are effective for the first of the following month.	PCP changes made between the 1st and 10th of the month will go into effect right away. Changes made after the 10th of the month will take effect at the beginning of the next month

PHARMACY

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

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

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpg.eorgia.com	866-300-1141 ProspectiveProviderGA@WellCare.com or https://www.wellcare.com/en/Georgia/Become-a-Provider

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

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

Health Plan	PBM	BIN #	PCN
Amerigroup Community Care	ESI	003858	MA
CareSource	CVS Caremark	004336	MCAIDADV Group: RX0835
Peach State Health Plan	Envolve Pharmacy Solutions (PBM) Caremark (Claims Processor)	004336	MCAIDADV
WellCare of Georgia	Caremark	004336	MCAIDADV

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through DXC by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. DXC will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

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

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
----------------------------------	-------------------	--------------------------------	----------------------------

No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes	Yes, you may also use the WellCare subscriber ID
--	--	-----	--

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

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

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

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

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
1 (800) 454-3730	1 (855) 202-1058 1(866) 930-0019 (fax)	1 (866) 399-0929	1 (866) 231-1821 1 (866) 455-6558 (fax)

APPENDIX L



Information for Providers Serving Medicaid Members in the Georgia Families 360SM Program

Georgia Families 360SM the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

DCH, Amerigroup, and partner agencies -- the Department of Human Services (DHS) and DHS' Division of Family and Children Services (DFCS), the Department of Juvenile Justice (DJJ) and the Department of Behavioral Health and Developmental Disabilities (DBHDD), as well as the Children's and Families Task Force continue their collaborative efforts to successfully rollout this new program.

Amerigroup is responsible through its provider network for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

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

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

APPENDIX L

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

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

APPENDIX M

Rev. 04/12

Rev. 07/12

Non-Emergency Transportation

People enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid recipients to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?

If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, **you must contact the NET Broker serving the county you live in** to ask for non-emergency transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NET broker?

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, **call the Member CIC at 866-211-0950.**

Region	Broker / Phone number	Counties served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb and Gwinnett

Central	LogistiCare Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	LogistiCare Toll free 1-888-224-7988	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	LogistiCare Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

APPENDIX N

Rev. 10/15

ICD-10 Overview

Please refer to Appendix J of the Part I Policies And Procedures For Medicaid/PeachCare For Kids manual for detailed information pertaining to ICD-10.