PART II

POLICIES AND PROCEDURES
for
THE EARLY INTERVENTION CASE MANAGEMENT PROGRAM
(SERVICE COORDINATION SERVICES)



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

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Policy Revision Record
[from 2024 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
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[1] The revisions outlined in this Table are from 2024 to current. For revisions prior to 2024, please see prior versions of the policy.

Part II: The Early Intervention Case Management Program (Service Coordination Services)
Chapter 600: Special Conditions of Participation

601. Definition of Services

Service coordination is an active, on-going process of specific case management activities which are aimed at: assisting parents in gaining access to the early intervention services designed to meet the developmental needs of each eligible child; the needs of the family related to enhancing the child's development; and informing parents and families of the rights and procedural safe guards that are authorized under the state's Part C of IDEA Early Intervention Program (EIP). Service coordination consists of the activities defined below.

601.1. Case Management Services

The Federal definition of Case Management Services means services which will assist Medicaid eligible individuals to gain access to needed medical, social, educational and other services. Such services include but are not limited to, the following:

601.1.1. Assessment of eligible individuals to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social or other services.

601.1.2. Development of a specific care plan based on the information collected through assessment that specifies the goals and actions to address the medical, social, educational and other services needed by eligible individuals.

601.1.3. Referral and related activities to help an individual obtain needed services.

601.1.4. Monitoring and follow-up activities including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the individual.

601.2. Intake/assessment is the process of identifying the recipient's medical, social, educational and other needs. A face-to-face interview with the recipient and the recipient's family is required.

601.2.1. Individualized Family Service Plan (IFSP) is the process of determining, with the member's parent(s) or legal guardian, service coordinator, and other providers, what services and resources are necessary to meet the identified needs and how they might be appropriately delivered. The IFSP is designed to maintain current service delivery and to resolve gaps in services so that comprehensive care is attained.

601.2.2. Service coordination is a process of facilitating the member's access to the services and resources identified in the IFSP. In the coordination function, the service coordinator will avoid the duplication of services for the member.

601.2.3. Implementation requires putting into action the services that are required for the recipient's progress toward meeting the goals and objectives outlined in the IFSP.

601.2.4. Monitoring is the process of evaluating the recipient's IFSP to determine if the IFSP's goals were met. Direct, personal contact with the recipient and periodic contact with the recipient's family (if appropriate) are essential to the monitoring process.

601.2.5. Evaluation/Review is the process of determining whether the IFSP is appropriate, whether a new plan is necessary, or whether services should be terminated. Evaluation is accomplished through periodic in-person reassessment of the member, and also consultation with providers, and consultation with the member's family.

601.2.6. Advocacy is where the service coordinator may advocate on behalf of the member for appropriate community resources, and coordinate with the multiple providers of services defined in the IFSP.

Note: The IFSP must be signed by the parent and at a minimum, the service coordinator. The six-month review of the IFSP must be signed by the parent and the service coordinator. This does not negate the need for the Plan of Care (POC) or Letter of Medical Necessity (LMN) which must be signed by the child's primary care practitioner (PCP) or other prescribing practitioner at the request of the PCP.

602. Enrollment

All providers who meet the Conditions of Participation in Medicaid's Part I Policies and Procedures for Medicaid and PeachCare for Kids (Part I Manual) and the special conditions listed in Section 603 below are eligible for enrollment. See Appendix A for provider enrollment contact information.

Early Intervention service coordinators must possess knowledge and understanding about infants and toddlers who are eligible under Part C of the Individuals with Disabilities Education Act, Early Intervention Programs, the EIP regulations, the nature and scope of services available under Early Intervention, as well as the system of payment for services and other pertinent information.

603. Special Conditions of Participation

603.1. Provider Qualifications

603.1.1. Have qualified service coordinators and the capacity to provide the full range of management services to children with developmental disabilities.

603.1.2. Meet applicable state and federal laws governing the participation of providers in the Medicaid programs.

603.1.3. Ensure that all service coordinators employed or contracted by the Lead Agency submit their credentials to the Local Lead Agency prior to service provision. An evaluation is done if the service coordinators meet appropriate professional standards consistent with State approved or recognized certification, licensing, registration or other requirements.

603.1.4. Ensure that all service coordinators complete and pass the online BCW Service Coordinator Orientation.

603.2. Service Coordinators Staff Qualifications

603.2.1. Meet the qualifications of service coordinators under Part C of the Individuals with Disabilities Education Act as amended; and

603.2.2. Have a Bachelor's or Master's degree in either education, early childhood education,

elementary education, child development, social work, sociology, psychology, school psychology, clinical psychology, developmental psychology, child psychology, nursing, audiology, speech language pathology, physical therapy, occupational therapy, family/community counseling, nutrition, special education, dietetics, human services or a related field or be a licensed Registered Nurse (RN).

NOTE: Other related degrees might be considered based on examination of the transcript by the Department of Public Health (Babies Can't Wait Program staff). At least 20% of the credit hours of the transcript must address child development, disabilities, or family systems.

603.2.3. All providers desiring to enroll in the Medicaid Early Intervention Case Management Program must first have their credentials evaluated through the local lead agency to determine if they meet appropriate professional standards consistent with State approved or recognized certification, licensing, registration or other requirements. This includes an assessment to determine if the Service Coordinator is adequately prepared and trained to provide Early Intervention Case Management Services.

603.2.4. Prior to enrolling in the Medicaid Early Intervention Case Management Program, Service Coordinators must complete and pass the online BCW Service Coordinator Orientation and receive a certificate of completion. A copy of this certificate must be sent to Medicaid attached to the enrollment application in order to receive a Medicaid Provider number.

603.2.5. Early Intervention Service Coordinators must complete Project SCEIs (Skilled, Credentialed Early Interventionists) training modules within six months of enrollment in the Early Intervention Case Management program. An original copy of the certificate of completion must be on file in the provider's office.

603.2.6. Personnel who are required to take the Level II SCEIs modules may elect to take the PRAXIS II test in early childhood special education. If a passing score is received, the individual is exempted from taking the SCEIs modules, i.e., they effectively meet the requirement of completing all SCEIs modules. Either passing the PRAXIS II, a standardized test offered by the Education Testing Service (the test may be taken more than once), or completion of the SCEIs modules must be accomplished within six months from the initial date of employment by or contract with the Babies Can't Wait Program.

603.2.7. Early Intervention Service Coordinators must complete 20 contact hours of continuing education every 2 years upon completion of Project SCEIs training modules or successful completion of PRAXIS II test in ECSE. Ten (10) hours must be specific to young children with disabilities and their families. Continuing education hours will only be granted for activities that clearly focus on (1) young children, birth to eight; (2) families of young children birth to eight; and/or (3) a particular disability covered under BCW.

603.2.8. Documentation of completion of hours must be submitted to Project SCEIs within 45 days of completion of activity. The 2-year cycle begins on July 1 following completion of SCEIs modules or PRAXIS.

Chapter 700: Special Eligibility Conditions

701. Definition

In the Early Intervention Case Management program, the Division of Medical Assistance Plans utilizes the Department of Public Health's definition of developmental delay, which specifies that children may be determined to be eligible with significant delay in one or more of the following five areas: cognitive development; physical development, including vision and hearing; communication development; social or emotional development; or adaptive development; or have an established risk of developmental delay due to a diagnosed physical or mental condition of known etiology and significant developmental consequences, which is recognized by BCW regardless of whether a delay is manifested at the time of identification.

702. The Department of Public Health is the lead agency for Part C Early Intervention

Children who are eligible for Part C services under the Early Intervention Case Management Program must be under the age of three, must have a determination of eligibility made by the Multidisciplinary Team (MDT) and must have an IFSP and a plan for transition for preschool or other community services by their third birthday.

Exception: For children whose third birthday occurs during the months of June, July or August, Service Coordination services may be billed to the Division for transition to preschool or other community services during the months of June, July and August. The focus of this transition Service Coordination is to assist the family to obtain medically necessary services under a PCP's treatment plan. This does not apply to children under an active Individualized Education Program.

703. Criteria to Determine Eligibility for Services

The Multidisciplinary Team (MDT) is comprised of at least two professionals from different disciplines, the parents(s), and the Service coordinator. The MDT utilizes the following criteria to determine a child's eligibility as a result of developmental delay:

703.1. Category 1: Infants and Toddlers with Established Risk for Developmental Delay

Children who have an established risk of developmental delay due to a diagnosed physical or mental condition of known etiology and significant developmental consequences, regardless of whether a delay is manifested at the time of identification. Such conditions/disorders include, but are not limited to:

703.1.1. Major chromosomal abnormalities (e.g., Down syndrome, Fragile X);

703.1.2. Anomalies or syndromes of unknown etiologies (e.g., Spina Bifida, hydrocephaly, microcephaly, Prader-Willi);

703.1.3. Severe sensory impairment;

703.1.4. Fetal Alcohol Syndrome;

703.1.5. Inborn errors of metabolism;

703.1.6. Severe orthopedic or persistent muscle tone abnormalities (e.g., cerebral palsy, muscular dystrophy);

703.1.7. Seizure disorders;

703.1.8. Autism;

703.1.9. Pervasive developmental disorders

Note: Other physical or mental conditions which have a high probability of resulting in a developmental delay may be diagnosed by a physician and qualify a child for eligibility consideration under this category.

703.1.9.1. Eligibility Procedures for Category 1 Established Risk

703.1.9.1.1. The eligibility of children who have been referred with a physical or mental diagnosis must be confirmed by the following information:

703.1.9.1.2. Reason for referral/statement of concern and the source of the referral;

703.1.9.1.3. Statement from family about referral;

703.1.9.1.4. Parent/legal guardian information which may include parent/legal guardian interview, parent/legal questionnaire or developmental checklist, and other information collected during intake; and

703.1.9.1.5. Review of pertinent records related to the child's current health status and medical history, including vision and hearing.

Note: The above collected information must be documented in the child's EI record at the time of the IFSP and before the initiation of services. A statement from a physician or appropriate referring agent confirming the physical or mental health diagnosis must be included in the child's EI record.

703.1.9.2. Implementation

Placement in this category establishes eligibility of children who are evaluated by qualified professionals as having physical or mental conditions of known etiology and developmental consequences, regardless of whether a delay is manifested at the time of identification. Children are eligible by virtue of the diagnosis and need not meet any further criteria. The MDT confirms the eligibility of these children based upon the established risk for developmental delay.

All information above is considered in making a decision and must substantiate eligibility. The parent(s) is/are always considered equal

members of the MDT. Eligibility decisions require the MDT to review information and arrive at consensus. All methods and measures should ensure that family-centered, diversity sensitive principles are carefully maintained.

The above information must be in the child's EI record and in the Reasons for Eligibility section of the IFSP.

The MDT does not need to complete additional specific child evaluation procedures to determine eligibility beyond what is required for Category 1 listed in a-i above. Rather, the team's major responsibility is for assessment of the child's current strengths and needs for the development of an appropriate intervention program. Appropriate MDT members should employ methods and measures useful for program planning for the individual child. All methods and measures should ensure that family-centered, diversity sensitive principles are carefully maintained.

703.2. Category 2: Infants and Toddlers with a Significant Developmental Delay

Children are considered to have a significant developmental delay and eligible for EI Services through the BCW Program, as determined by the Multi-Disciplinary Team (MDT), when the delay interferes with the child's ability to interact within his/her natural environment relative to expected developmental sequences of cognitive, communication, adaptive, physical, and social-emotional development to such a degree that ongoing development is comprised. The following are procedures for determining the eligibility of children in this category.

The Multi-Disciplinary Team (MDT) is composed of at least two professionals from two different disciplines, the Service Coordinator and the family.

703.2.1. Eligibility Determination

703.2.1.1. Children are determined eligible for the BCW Program through evaluation by a MDT Evaluation as defined in 34 CFR 303.322(b) (1) which refers to the procedures used by the EI MDT to assist in the determination of a child's initial and continued eligibility.

703.2.1.2. Appropriate evaluation methods and procedures must be nondiscriminatory in nature and include appropriate use of team approaches, including use of multiple methods and multiple sources of information leading to an informed clinical team opinion which can be clearly described and documented.

703.2.1.3. No one measure or single procedure is used as the sole criterion for determining a child's eligibility.

703.2.1.4. The choice of MDT members' evaluation procedures for any child should be based on the presenting needs of the individual child and the family.

703.2.1.5. Prior to proceeding with the determination of eligibility, Procedural Safeguards must be presented and explained to the family as outlined in the Babies Can't Wait Standards and Implementation Manual.

703.2.1.6. It should be noted that eligibility does not determine types of services or level of service. Once eligibility is established, assessment of the child must occur to identify the child's unique strengths and areas of need, and the nature and extent of EI services that are needed by the child and the family.

703.2.1.7. All service coordinators, public or private, must have electronic access to the IFSP prior to beginning service coordination. The IFSP must be reviewed by the Early Intervention Coordinator.

703.2.1.8. It is the responsibility of the EI Coordinator to ensure that all necessary procedures have been followed and that the informed clinical opinion of the MDT regarding the eligibility decision includes consideration of all of the information collected and presented. If consensus of eligibility is not initially reached, additional evaluation information must be gathered in the appropriate developmental areas. It should be noted that eligibility does not determine types of services or level of service. Once eligibility is established, assessment of the child must occur to identify the child's unique strengths and areas of need, and the nature and extent of EI services that are needed by the child and family.

703.2.2. Eligibility Procedures for Category 2 - Developmental Delay

The eligibility of children who have been referred because of a suspected developmental delay must be determined by the following information:

703.2.2.1. Reason for referral/statement of concern and the source of the referral;

703.2.2.2. Statement from family about the referral;

703.2.2.3. Parent /legal guardian information which may include parent/legal guardian interview, parent/legal guardian questionnaire or developmental checklist, and other information collected during intake;

703.2.2.4. Review or pertinent records related to the child's current health status and medical history, including vision and hearing. AND

703.2.2.5. Additional information from a state approved standardized diagnostic instrument comprehensive across all developmental domains and either a standardized behavior checklist or curriculum-based measure or systematic observation of functional abilities in the child’s daily routine or natural setting. The standardized diagnostic instrument must yield a score of 2 standard deviations below the norm in one developmental area or 1.5 standard deviations in two or more developmental areas. The above collected information must be documented in the child's early intervention record.

703.2.2.6. An eligibility decision is then confirmed through consensus of the MDT involved in the above evaluation procedures.

703.2.2.7. If consensus of eligibility is not initially reached, additional evaluation / assessment information is gathered in the appropriate developmental areas.

703.2.3. Implementation

All information above is considered in making a decision and it must substantiate eligibility. The parent(s) is/are always considered equal members of the MDT. Eligibility decisions require the MDT to review information and arrive at consensus. All methods and measures should ensure that family-centered, diversity sensitive principles are carefully maintained.

A review of pertinent medical records (item 'D' above) must be completed by a nurse or other trained medical professional to ensure that all information is considered within the context of potential implications for the child's disability and subsequent programming.

The above information must be in the child's EI record and in the IFSP. A statement of eligibility must be confirmed in the review. All service coordinators, public or private, must have a copy of this form in their records for each child on their caseload prior to beginning service coordination. This IFSP must be reviewed by the Early Intervention Coordinator or designee.

It is the responsibility of the EI Coordinator to ensure that all necessary procedures have been followed and that the informed clinical opinion of the MDT regarding the eligibility decision includes consideration of all of the information collected and presented. If consensus of eligibility is not initially reached, additional evaluation information must be gathered in the appropriate developmental areas. It should be noted that eligibility does not determine types of services or level of service. Once eligibility is established, assessment of the child must occur to identify the child's unique strengths and areas of need, and the nature and extent of EI services that are needed by the child and the family.

703.2.3.1. The provision of case management services will not restrict an individual's free choice of providers which would be in violation of section 1902(a)(23) of the Act.

703.2.3.1.1. Eligible recipients will have free choice of the providers of case management services.

703.2.3.1.2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Chapter 800: Prior Approval

801. Prior Approval is not required

Chapter 900: Scope Of Services

901. General

Early Intervention Case Management for infants and toddlers is an integral and necessary part of services designed to meet the developmental needs of each eligible child to enhance the child's development. Case management is an active, on-going process consisting of specific activities which are aimed at assisting parents on behalf of their child in gaining access to the early intervention services and to receive the rights and procedural safeguards that are authorized under the Early Intervention program.

Service coordination services will be provided by service coordinators assigned by the Early Intervention Coordinator or Service Coordinator supervisor.

An active (reimbursable) member is one who has an appropriately developed Individualized Family Service Plan (IFSP) within 45 days of initial referral to the Early Intervention Program. The service coordinator will be identified by name on the IFSP.

902. Responsibilities

The integral and necessary Early Intervention Case Management services and specific activities include:

902.1. Coordinating the referral and scheduling of evaluations and assessments;

902.2. Facilitating and participating in the development, review and evaluation of the IFSP;

902.3. Assisting parents or guardians in gaining access to early intervention services and other services identified in the IFSP for the benefit of the eligible child;

902.4. Assisting families on behalf of their child to identify and utilize available service providers and financial resources to obtain services and goods;

902.5. Coordinating and scheduling the child's appointments for early intervention services and other services, such as medical services for diagnostic and treatment purposes;

902.6. Facilitating the timely delivery of available services;

902.7. Informing families of the availability of advocacy services and support groups which will benefit the child;

902.8. For the benefit of the child, assist families in gaining access to the appropriate educational setting, day care or pre-school program or to other resources;

902.9. Arrange transportation services to all appointments made for the benefit of the eligible child; and,

902.10. Facilitating the development of a transition plan to pre-school services when appropriate.

902.10.1. The Early Intervention Service Coordinator is responsible for: Coordinating the performance of evaluations and assessments.

Evaluations refer to those procedures used by appropriately qualified personnel to determine a child's initial eligibility under Part C, consistent with the definition for

eligibility as established by Georgia, including determining the status of the child in each of the developmental areas.

902.10.1.1. Evaluations

All eligible infants and toddlers must be evaluated and assessed utilizing a multidisciplinary approach or reviewing diagnostic information from the child's attending physician's medical record. Children who require an evaluation must have the evaluation performed by the Multidisciplinary Team (MDT).

The Primary Service Provider team should facilitate formation of the team based on the child's presenting needs, obtain pertinent records and facilitate the meeting.

902.10.1.1.1. Assessment means the ongoing procedures used by appropriately qualified personnel throughout the period of a child's eligibility under Part C to identify:

902.10.1.1.2. The child's unique strengths and needs and the services appropriate to meet those needs; and

902.10.1.1.3. The resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability.

902.10.1.2. Assessment for Program Planning

This assessment must be performed by a multidisciplinary team. In all cases, the assessment must be conducted by personnel trained to utilize appropriate methods and procedures which must include informed clinical opinion as defined in the Babies Can't Wait Programs policies and procedures. The assessment must include an assessment of the following developmental areas: cognitive; physical; including vision and hearing; communication development; social or emotional development; and adaptive development. There also may be an assessment of the concerns and priorities of the family relating to enhancing the development of their child.

Family Assessment may be utilized only with informed written parental consent as part of this process. When used, it must be performed by personnel trained in appropriate methods and procedures. The family assessment must be based on a personal interview with the family and the family's description of its strengths, resources and needs.

902.10.2. The Early Intervention Service Coordinator is responsible for: Facilitating, coordinating and participating in the development, review and evaluation of the IFSP.

The IFSP must specify the name of the Service Coordinator responsible for the implementation of the plan and coordination with other agencies and

persons. The plan must:

902.10.2.1. Be in writing and contain these descriptive statements:

902.10.2.1.1. the infant's or toddler's present levels of physical development, cognitive development, communication development, social or emotional development, and adaptive development, based on objective criteria;

902.10.2.1.2. the family's resources, priorities, and concerns relating to enhancing the development of the family's infant or toddler with a disability;

902.10.2.1.3. the major outcomes expected to be achieved for the infant or toddler and the family, and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes or services are necessary;

902.10.2.1.4. specific early intervention services necessary to meet the unique needs of the infant or toddler and the family, including the frequency, intensity, and method of delivering services;

902.10.2.1.5. a statement of the natural environments in which early intervention services shall appropriately be provided, including a justification of the extent, if any, to which the services will not be provided in a natural environment. (Natural environment includes the home and other community settings in which children without disabilities participate).

902.10.2.1.6. the projected dates for initiation of services and the anticipated duration of the services;

902.10.2.1.7. the identification of the service coordinator with Georgia's Medicaid program and who will be responsible for the implementation of the plan and coordination with other agencies and persons;

902.10.2.1.8. the steps to be taken to support the transition of the toddler with a disability to preschool or other appropriate services; and

902.10.2.1.9. parental consent - the contents of the Individualized Family Service Plan shall be fully explained to the parents and informed written consent from the parents shall be obtained prior to the provision of early intervention services described in such plan. If the parents do not provide consent with respect to a

particular early intervention service, then the early intervention services to which consent is obtained shall be provided.

902.10.2.2. Be developed jointly by the family and appropriate qualified personnel involved in the provision of early intervention services;

902.10.2.3. Be based on the multidisciplinary evaluation and assessment of the child and of the child's family; and

902.10.2.4. Include services necessary to enhance the development of the child and the capacity of the family to meet the developmental needs of the child.

902.10.2.5. Be reviewed once a year resulting in the development of a new IFSP. The family shall be provided a review of the plan at 6 months intervals or more often where appropriate based on infant or toddler and family needs. This periodic review shall document progress toward outcomes and any need for modification or revision of outcomes of services.

902.10.2.6. In the event of exceptional circumstances (such as illness or hospitalization of an eligible child), which make it impossible to complete a multidisciplinary assessment and IFSP within the 45-day time limit, the service coordinator will document the circumstances and assure that an interim IFSP is developed and implemented.

902.10.2.7. If a child's annual IFSP is due within 45 days of the child's third birthday and transition from BCW, the IFSP team may review the current IFSP, and with team consensus, determine that services are appropriately outlined on the IFSP and should continue as written until transition. In that situation, re-evaluation and development of a new IFSP should not occur. Extension of an IFSP shall not exceed 45 days and the IFSP must terminate on the day prior to the child's 3rd birthday.

903. Performance of Service

903.1. The service coordinator must have a minimum of one face-to-face member/child and family (family may be parent, primary caretaker, legal guardian, or foster parent) contact per month that is to be billed to Medicaid. This contact must be documented in the member's active clinical record. The case manager must also have a minimum of three indirect contacts per month on behalf of the member. Examples of indirect contacts are:

903.1.1. Telephone calls that result in a progress note:

903.1.1.1. To family = 1 indirect contact

903.1.1.2. To medical staff = 1 indirect contact

903.1.1.3. To other agencies = 1 indirect contact

903.1.1.4. To schedule a meeting = 1 indirect contact per meeting regardless of the number of persons called

903.1.1.5. To coordinate meetings resulting in scheduling = 1 indirect contact per meeting

903.1.1.6. To transition or arrange to transition child = 1 indirect contact

903.1.1.7. To therapist = 1 indirect contact

903.1.1.8. All contacts must be related to the child's IFSP, and the documentation must reflect efforts related to the child's IFSP in every direct and indirect contact.

903.1.2. Visits

903.1.2.1. To family after 1 minimum face-to-face contact = 1 indirect contact

903.1.2.2. To daycare or other community agency = 1 indirect contact

903.1.2.3. To therapist = 1 indirect contact

903.1.2.4. Meeting to transition child = 1 indirect contact

903.1.2.5. Attendance at other meetings on behalf of child = 1 indirect contact

903.1.2.6. Non-covered contacts include emails, letters, & faxes.

903.2. Service Coordination Ancillary/ Indirect Contacts

903.2.1. In order to bill for service coordination services for an individual child, the BCW service coordinator must have a minimum of one face-to-face child and family contact per month when billing Medicaid. This contact must be documented in the child's active clinical record. In addition, the service coordinator must also have a minimum of three indirect contacts per month on behalf of the child when billing Medicaid.

903.2.2. All contacts must be related to the child's IFSP and the documentation must reflect efforts related to the child's IFSP in every direct and indirect contact.

903.2.3. On June 25, 2003 Public Law 108-36, Keeping Children and Families Safe Act of 2003 was signed into law. This Act reauthorized and amended the Children Abuse Prevention and Treatment Act (CAPTA) and required "provisions and procedures for referral of a child under the age of 3 who is involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C of the Individuals with Disabilities Education Act" (Sec. 114). Per the Individuals with Disabilities Education Act, service coordinators are responsible for coordinating the provision of the identified early intervention services and other services identified on the IFSP. With written consent, informed coordinators must ensure that at least one ancillary or indirect contact per month occurs with the appropriate Division of Family and Children Services (DFCS) or Child Protective Services (CPS) caseworker for each child who: (1) has a substantiated case of abuse or neglect, (2) is in foster care or DFCS custody, or (3) is a ward of the state of Georgia. This will promote ongoing communication and collaboration between all professionals working to support children and families.

903.2.4. A minimum of three attempts to contact must be documented prior to completing an ancillary contact with an alternate relevant team member or professional in any month due to inability to contact caseworker. These contacts may be phone calls/phone messages, email contacts, letters, and/or face-to-face visits. It is recommended that at least two different forms of communication, such as visit and phone call, letter and email, be used if multiple attempts are necessary, in order to provide varied opportunities and times during which the caseworker may receive communication and respond.

903.2.5. Minimum contacts must be attempted and adequate response time (at least 2 working days for telephone calls/phone messages and 5 working days for letters) allowed following each contact attempt. All attempts to contact the caseworker must be documented in the BCW service coordinator's documentation. Contacts in excess of three may occur as appropriate.

903.2.6. These contacts must be documented in the member's active clinical record. There is no maximum number of contacts or tasks per month. The contact date and site (in-home, school. etc.), purpose of the contact, relevant circumstances, results of the contact, and the signature of the Service Coordinator must be documented for each contact.

903.2.7. Documentation must be maintained for six years after service is rendered. The local lead agency must maintain the official early intervention record, including the original IFSP. The local lead agency must maintain original service coordination documentations for all service coordinators who are employees. Service coordinators who are employees of other agencies who contract with the Department of Public Health or who contract directly with the Department of Public Health must maintain original service coordination documentation because they are the enrolled provider subject to audits.

903.3. The Service Coordinator must maintain a copy of the most current IFSP in the member's active clinical record. The Service Coordinator must include in a plan of action methods to monitor delivery and effectiveness of services identified in the IFSP and the continued need for services using some regular, on-going contact with service providers, the child and parents, or other resources used by the child and family.

903.4. The Service Coordinator must assist and enable the child and family to receive their rights and procedural safeguards under the law in the native language of the family.

903.5. The Service Coordinator must obtain informed written parental consent to conduct the initial evaluation and assessment (of the child and family); emphasize their right to refuse and if parental consent is not given, inform the parent of all procedural safeguards under the Early Intervention program.

903.6. The Service Coordinator must explain the contents of the IFSP to the parents or guardian and informed written consent must be obtained prior to the implementation of the IFSP.

903.7. The Service Coordinator must inform families of the availability of advocacy services and support groups;

903.8. The Service Coordinator must develop and advocate for the development of services and resources needed by the child and family but not available including pre-school resources if

indicated; and

903.9. The Service Coordinator must facilitate the development of a transition plan to appropriate pre-school services which may include, but are not limited to Part B preschool services, childcare, Early Head Start and Head Start, and/or other community programs & services as early as nine months prior to the member's third birthday, and no later than three (3) months prior to the member's third birthday. Documentation of the transition plan must be written into the active clinical record.

903.10. The Service Coordinator must develop a transition plan to community services for children who are not eligible for Part B pre-school services.

903.11. The Service Coordinator must review the IFSP once a year and document that review. This review must result in the development of a new IFSP for children who continue to meet BCW eligibility requirements. The family shall be provided a review of the plan at 6-month intervals or more often where appropriate based on infant or toddler and family needs. This periodic review must document progress toward outcomes and any need for modification or revision of outcomes of services.

903.12. The Service Coordinator must document evidence of provider participation in the IFSP process including any changes or modifications.

903.13. The Service Coordinator must ensure that procedural safeguards, release forms and cost participation forms are documented and, in the member's, clinical record.

903.14. The Service Coordinator must document service coordination efforts to plan, seek and negotiate a mix of services and supports that support the goals listed in the IFSP and lead toward progress of listed outcomes for that individual member.

903.15. The Service Coordinator must assist families of eligible children in gaining access to the early intervention services and other services identified in the IFSP.

903.16. The Service Coordinator must assist families in identifying and utilizing available service providers and financial resources to obtain service and goods.

903.17. The Service Coordinator must coordinate and monitor the provision of early intervention services and other services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is receiving. This involves ensuring that the therapist and other BCW providers receive access to an electronic copy of the completed and active IFSP within 10 calendar days of the development of and any revisions or changes to the IFSP. Parent(s) signature on the IFSP document shall serve as consent for implementation of the services and activities listed in the IFSP. No additional documentation is required. Any changes in the IFSP must be communicated to the therapist or other health professional whose services will be affected by the change. This should be done and documented in the record within 10 calendar days of the IFSP development or of any changes to the IFSP.

903.18. Facilitate the timely delivery of available services.

903.19. Prior written notice must be given to the parent(s) of a child eligible for early intervention services at least 5 calendar days before a local lead agency or a BCW service provider proposes or refuses to initiate or change. The notice must be in sufficient detail to inform the parents about:

903.19.1. The action that is being proposed or refused;

903.19.2. The reasons for taking the action;

903.19.3. All procedural safeguards that are available under BCW; and

903.19.4. The state complaint procedures, including a description of how to file a

903.19.5. complaint and timeliness under those procedures.

903.19.6. In the event the parent waives the 5-day notice, which is documented on the Prior Written Notice form, adequate notice must still be given to other team members to facilitate their participation. In the event the parent requests an IFSP meeting, no notice is required.

904. Non-Covered Services

The services and procedures listed below are non-covered by the Division under the Early Intervention Case Management Program. This list is representative of non-covered services and procedures and is not meant to be exhaustive.

904.1. Coverage under more than one Medicaid case management program per member per month (e.g., Perinatal Case Management).

904.2. Months that one face to face encounter and three ancillary encounters are not performed.

904.3. Record reviews for the purpose of eligibility determination obtained from other licensed medical practitioners and sources.

904.4. Unsuccessful attempts to provide the minimum of one (1) face-to-face recipient and family contact per month and 3 indirect contacts per month on behalf of the recipient.

904.5. Services normally provided free-of-charge to indigent patients.

904.6. Services not provided in compliance with the provisions of this manual.

904.7. Services provided to a child who has been admitted to a hospital or other institutional setting as an inpatient.

904.8. Services provided after the age of three to children whose third birthday does not fall in the months of June, July or August.

904.9. Changes or modification made to the IFSP or regarding services without the participation of the family and relevant BCW provider(s).

904.10. Services not included on the IFSP.

Chapter 1000: Basis For Reimbursement

1001. Reimbursement Methodology

1001.1. Early Intervention Case Management services will be reimbursed directly to the providers of case management services on a negotiated rate basis not to exceed actual costs, which meets all requirements of the OMB Circular a-87 dated January 15, 1981.

1001.2. A start-up billing rate not to exceed six months will be allowable (See Procedure Code Reimbursement Rates).

1002. Billing for Services

1002.1. The maximum billing for any one calendar month is one unit of service, which will consist of, at a minimum, one face-to-face contact with the eligible member and family and a minimum of three indirect contacts per any one calendar month on behalf of the member. These contacts must be documented in the member's active clinical record and specifically related to the child's IFSP. Since services must be completed prior to billing and services may span the entire month, the last day of the calendar month should be used as the billing date on claims.

1002.2. Providers must bill with an appropriate diagnosis code (ICD-9) to receive reimbursement for services. Select the diagnosis code that best describes the member's condition or circumstances. Effective October 1, 2015, use the Tenth Edition (ICD-10) code sets. ICD10-CM replaces the ICD-9-CM (diagnosis) codes (Volumes 1-2) and ICD10-PCS replaces the ICD-9-CM (procedure) codes (Volume 3).

1002.3. Third Party Liability is not required to bill for early intervention case management services.

1002.4. Any change to the IFSP requires 5 calendar days prior written notice to the parent(s) and BCW service providers. The service coordinator must document this change on the IFSP and the relevant BCW service provider must receive access to an electronic copy of the modified IFSP within 10 days of the change. This service must be completed, if applicable, prior to billing the Division of Medical Assistance Plans for service coordination services for the month.

1002.5. The service coordinator, family, and other appropriate, relevant service providers constitute an IFSP team for the purposes of revising or modifying the IFSP.

1002.6. Meeting arrangements must be made with, and written notice provided to, the parent(s) and other IFSP team members at least 5 calendar days prior to the IFSP meeting. These services must be completed prior to billing.

1002.7. Collaboration between case management providers must take place in order to avoid duplication of services. Duplication of services is strongly discouraged. Only one provider will be reimbursed per member per month for case management services. It is the responsibility of the case manager to ensure that the member is not receiving services from another case manager prior to rendering services.

1002.8. Effective July 1, 2017, service coordinators may receive reimbursement for conducting an Autism Developmental Screening to aid in earlier identification and referral to diagnostic and treatment services. Service coordinators should use a scientifically validated checklist such as the Modified Checklist for Autism in Toddlers-Revised (M-CHAT-R™). Service coordinators should

administer the screening when it has not been performed by the child's primary care physician according to the suggested schedule at 18 and 24 months of age or when autism is suspected. The procedure code / modifier combination for this service is 96110 UA.

1003. Billable Procedure Codes

PROCEDURE CODES REIMBURSEMENT RATES

HIPAA Compliant Procedure Code	HIPAA Modifier 1	Current Price
T2022- Case management per month		$145.00
T2022- Case management per month	TS-Follow-up service	$135.00
96110 - 1 unit	UA	$11.77

1003.1. Providers are required to bill the appropriate modifier (s) with the new HIPAA codes.

1003.2. T2022 Refers to the first 6 months of case management services provided by a new provider; this does not refer to the first 6 months of case management services for each member/child. (See Chapter 1000, Basis for Reimbursement, Section 1001.2)

1003.3. Effective 4/1/20, the Department of Community Health (DCH) will allow medically necessary services to be rendered via telehealth. Each billed procedure code must be submitted with the usual program modifier(s). Place of service code 02 must be added to the allowed procedure codes to indicate the services are related to telehealth services.

Appendix A
Georgia Health Partnership (GHP)

A. Provider Correspondence
P.O. Box 105200
Tucker, Georgia 30085-5200

B. Electronic Data Interchange (EDI)
1-877-261-8785 or 770-325-9590

i. Asynchronous

ii. Web Portal

iii. Physical Media

iv. Network Data Mover (NDM)

v. Systems Network Architecture (SNA)

vi. Transmission Control Protocol (TCP/IP)

C. Provider Contact Center

800-766-4456 (Toll free) or 770-325-9590

The web contact address is **http://www.mmis.georgia.gov**

Appendix B
Office Of Child Health District Coordinators

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
1-1 ROME Northwest Health District	Bartow Gordon Catoosa Haralson Chattooga Paulding Dade Polk Floyd Walker	**Tamela.Baker** 1309 Redmond Road, NW Rome, GA 30165 (706) 802-5076 FAX: (706) 802-5071 Tamela.Baker@dph.ga.gov	**Stacy Henderson** 1309 Redmond Road, NW Rome, GA 30165 (706) 802-5626 FAX: (706) 802-5309 Stacy.Henderson@dph.ga.gov	**Brittany Hatcher** 1309 Redmond Road, NW Rome, GA 30165 (706) 802-5312 FAX: (706) 802-5309 Brittany.Hatcher@dph.ga.gov
1-2 Dalton North Georgia Health District	Cherokee Murray Fannin Pickens Gilmer Whitfield	**Lois Blockley** 1710 Whitehouse Ct. Dalton, Georgia 30720 706-529-5763 Ext.1431 FAX (706) 529-5794 Lois.Blockley@dph.ga.gov	**Holli Collier** 1710 Whitehouse Ct. Dalton, GA 30720 Phone: (706) 529-5763 Ext. 1409 FAX: (706) 529-5767 Holli.Collier@dph.ga.gov	**Susan Sims** 1710 Whitehouse Ct. Dalton, GA 30720 706-529-5763 Ext.1420 FAX: (706) 529-5798 susan.sims@dph.ga.gov
2 Gainesville North Health District	Banks Lumpkin Dawson Rabun Forsyth Stephens Franklin Towns Habersham Union Hall White Hart	**Shari Whiting** 440 Prior Street SE Gainesville, GA 30501-1119 (770) 535-5963 FAX: (770) 538-2784 Shari.Whiting@dph.ga.gov	**Angela Gilstrap** 440 Prior Street, SE Gainesville, GA 30501-1119 Phone : (770) 538-2788 FAX : (770) 531-6494 Angie.Gilstrap@dph.ga.gov	**Tonya Newsom, MBA, MA, LPC, CPCS** 440 Prior Street SE Gainesville, GA 30501 (770) 538-2778 Direct Line FAX: (770) 538-2784 Tonya.Newsom@dph.ga.gov
3-1 Cobb Public Health District	Cobb Douglas	**Yvette Garrett** Cobb County Board of Health 1738 County Services Parkway, Bldg. B Marietta, GA 30008 (770) 319-4717 FAX : (770) 514-2803 Yvette.Garrett@dph.ga.gov	**Sherri Gary** Cobb County Board of Health 1738 County Services Parkway, Bldg. B Marietta, GA 30008 (770) 319-4719 ext. 2121 FAX: (770) 514-2803 Sherri.Gary@dph.ga.gov	**Amanda Holley, MPH, BSN, RN** Cobb County Board of Health 1738 County Services Parkway, Bldg. B Marietta, GA 30008 (770) 514-2404 FAX: (678)-354-0751 Amanda.Holley@dph.ga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
3-2 Fulton Public Health District	Fulton	**Fanthnecia "Nisey" Dunbar** 2805 Metropolitan Parkway Atlanta, Georgia 30315 (770) 520-7289 or 404-612-8770 FAX : (770) 264-7554 Fanthnecia.Dunbar@fultoncountyga.gov	**Wendolyn Miller** 2805 Metropolitan Pkwy. Atlanta, GA 30315 (404) 612-1496 FAX: (770) 264-7554 Wendolyn.Miller@fultoncountyga.gov	**Cynthia Corsino, MPH** 2805 Metropolitan Pkwy, SW Atlanta, GA 30315 (770) 520-7285 FAX: (770)264-7554 cynthia.corsino@fultoncountyga.gov
3-3 Clayton County Health District	Clayton	**Sandra Pye, RN (Interim)** 1117 Battlecreek Rd Jonesboro, Georgia 30236 (678) 610-7259 FAX: (678) 610-7781 Sandra.Pye@dph.ga.gov	**Yolanda Willis** 1117 Battlecreek Rd Jonesboro Georgia 30236 (678) 610-7417 FAX : (678) 610-7781 Yolanda.Willis@dph.ga.gov	**Andrew Gaines** 1117 Battlecreek Rd Jonesboro, GA 30236 (678) 610-7299 FAX: (678)472-2244 Andrew.Gaines@dph.ga.gov
3-4 Gwinnett East Metro Health District	Gwinnett Rockdale Newton	**Laura Moncada** **Easter Seals N. Georgia** 4335 Steve Reynolds Blvd Norcross, GA 30093 (770) 822-9115 ext. 105 FAX: (770) 822-9457 lmoncada@esng.org	**VACANT** 2570 Riverside Pkwy P.O. Box 897 Lawrenceville, GA 30046 (770) 339-9078 FAX: (770) 237-5309	**Kelly Griffith, M. ED** 2570 Riverside Pkwy P.O. Box 897 Lawrenceville, GA 30046 (678) 339-4264 FAX: (886) 680-1530 kelly.griffith@gnrhealth.com
3-5 DeKalb Health District	DeKalb	**(Ellie) Beronica Gonsalves** 440 Winn Way Decatur, Georgia 30031-0987 (404) 294-3722 Referral: (404) 508-7981 FAX: (404) 294-6316 Ellie.Gonsalves@dph.ga.gov	**Patrice Cannon** 440 Winn Way Decatur, GA 30031-0987 (404) 508-7762 FAX: (404) 294-6316 Patrice.Cannon@dph.ga.gov	**Aletha Dixon** 440 Winn Way Atlanta, GA 30317 (404) 294-3814 Referral: (404) 508-7981 FAX: (404) 294-6316 Aletha.Dixon@dph.ga.gov
4 LaGrange Health District	Butts Lamar Carroll Meriwether Coweta Pike Fayette Spalding Heard Troup Henry Upson	**Tracy Bain** 301 Main Street LaGrange, GA 30240 (706) 298-7750 FAX: (706) 845-4351 Tracy.Bain@dph.ga.gov	**Wendy Wilson** 301 Main Street LaGrange, GA 30240 Wendy.Wilson@dph.ga.gov mailto: (706) 298-7753	**Tracy Bain** 301 Main Street LaGrange, GA 30240 (706) 298-7750 FAX (706) 845-4351 tracy.bain@dph.ga.gov
5-1 Dublin	Bleckley Pulaski	**Debra Pileggi** 1110 Hillcrest Pkwy, Suite B Dublin, GA 31021	**Hannah Hicks** 1110 Hillcrest Parkway, Suite B	**Tamiko Coley** 1110 Hillcrest Pkwy, Suite B

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
South Central Health District	Dodge Telfair Johnson Treutlen Laurens Wheeler Montgomery Wilcox	Direct Line (478)275-6841 FAX: (478) 274-78935-6764 Debra.Pileggi@dph.ga.gov	Dublin, GA 31021 (478)275-5119 FAX: (478) 275-5117 Hannah.Hicks@dph.ga.gov	Dublin, GA 31021 (478) 274-7717 FAX: (478) 274-7893 Tamiko.Coley@dph.ga.gov
5-2 Macon North Central Health District	Baldwin Monroe Bibb Peach Crawford Putnam Hancock Twiggs Houston Washington Jasper Wilkinson Jones	**Lisa Wiles** 201 Second St., Suite 1100 Macon, Georgia 31201 (478) 745-9200 FAX: (478) 745-9040 Lisa.Wiles@dph.ga.gov	**Tekeisha Jenkins, RN** 201 Second St. Ste. 1100 Macon, GA 31201 (478) 538-0802 FAX: (478) 751-6429 Tekeisha.Jenkins@dph.ga.gov	**Belinda Hunt, LPN** 201 Second St. Ste. 1100 Macon, GA 31201 (478) 751-6359 FAX: (478) 751-6429 Belinda.Hunt@dph.ga.gov
6 Augusta East Central Health District	Burke Columbia McDuffie Emanuel Richmond Glascock Screven Jefferson Taliaferro Jenkins Warren Lincoln Wilkes	**Javonna Williams** 1916 North Leg Road Augusta, GA 30909-4437 (706) 667-4273 FAX: (706) 667-4278 Javonna.Williams@dph.ga.gov	**Jan Walker, RN** 1916 North Leg Road Augusta, GA 30909-4402 (706) 667-4606 FAX: (706) 667-4555 Jan.Walker@dph.ga.gov	**Jan Walker, RN** 1916 North Leg Road Augusta, GA 30909-4402 (706) 667-4606 FAX: (706) 667-4555 Jan.Walker@dph.ga.gov
7 Columbus West Central Health District	Chattahoochee Quitman Clay Randolph Crisp Schely Dooly Stewart Harris Sumter Macon Talbot Marion Taylor	**Kiara Loud** 5601 Veterans Pkwy Columbus, GA 31904 (706) 321-6362 FAX: (706) 327-1355 Kiara.Loud@dph.ga.gov	**LaShondria Jones** 5601 Veterans Pkwy Columbus, GA 31904 706-321-6324 FAX: (706) 327-1355 Lashondria.Jones@dph.ga.gov	**Shikethia Simmons, RN** 5601 Veterans Pkwy Columbus, GA 31904 (706) 307-6365 FAX: (706)327-1355 Shikethia.Simmons@dph.ga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
	Muscogee Webster			
8-1 Valdosta South Health District	Ben Hill Irwin Berrien Lanier Brooks Lowndes Cook Tift Echols Turner	**Jessie Judkins** 206 South Patterson Street 3rd Floor P. O. Box 1027 Valdosta, GA 31603-1027 (229) 259-5138 FAX: (229) 245-6561 Jessie.Judkins@dph.ga.gov	**Kirbi Spires BSN, RNC-OB, C-EFM** 206 South Patterson Street P. O. Box 1027 Valdosta, Georgia 31603-1027 (229) 245-4310 FAX : (229) 245-4317 Kirbi.Spires@dph.ga.gov	**Reomona Thomas, MSN, RN** 206 S. Patterson Street 3rd Floor PO Box 1027 Valdosta, GA 31602-1027 (229) 293-6286 FAX: (229) 293-6292 Reomona.Thomas@dph.ga.gov
8-2 Albany Southwest Health District	Baker Lee Calhoun Miller Colquitt Mitchell Decatur Seminole Dougherty Terrell Early Thomas Grady Worth	**Sharonda Davis** 1306 South Slappy Boulevard Suite A – Colony Square South Albany, GA 31701 (229) 299-4447 FAX: (229) 420-1156 Sharonda.Barlow@dph.ga.gov	**Quinteria Murray** 1306 South Slappy Blvd. Suite A – Colony Square South Albany, GA 31701 (229) 229-4447 Ext. 6703 FAX: (229) 353-3201 Quinteria.Murray@dph.ga.gov	**Mattie Woodson, BSN, RN** 1306 South Slappy Blvd. Suite A – Colony Square South Albany, GA 31701 (229) 299-4447 or (866) 987-0204 Mattie.Woodson@dph.ga.gov
9-1 Coastal Health District	Bryan Glynn Camden Liberty Chatham Long Effingham McIntosh	**Stefanie Clardy** 420 Mall Blvd. Savannah, GA 31406 (912) 644-5806 FAX : (912) 349-2326 Stefanie.Clardy@dph.ga.gov	**Christina Sanchez, ASN, RN** 420 Mall Blvd Savannah, GA 31406 (912) 644-5812 FAX: (912) 349-2326 Christna.Sanchez@dph.ga.gov	**Christina Sanchez, ASN, RN** 420 Mall Blvd. Savannah, GA 31406 (912) 644-.5208 FAX: (912) 349-2326 Christina.Sanchez.@dph.ga.gov
9-2 Waycross Southeast Health District	Appling Coffee Atkinson Evans Bacon Jeff Davis Brantley Pierce Bulloch Tattnall Candler Toombs Charlton Ware	**Sherrian Dorsey (Interim)** 1123 Church Street, Annex B Waycross, GA 31501 Toll Free; (800) 429-6307 FAX: (912) 287-6689 Sherrian.Dorsey@dph.ga.gov	**Jill Aldridge** 1123 Church Street, Annex B Waycross, GA 31501 ((912) 285-6304 FAX: (912) 287-6644 Jill.Aldridge@dph.ga.gov	**Julie Prestenbach, RN** 1123 Church Street, Annex B Waycross, GA 31501 (912) 284-2920 FAX: (912)338-5914 Julie.Prestenbach@dph.ga.gov

District	Counties Served	Babies Can't Wait Coordinator	Children's Medical Services Coordinator	Children 1st Coordinator
	Clinch Wayne			
10 Athens Northeast Health District	Barrow Madison Clarke Morgan Elbert Oconee Greene Oglethorpe Jackson Walton	**Robin O'Donnell, LMSW, CLC** 740 Prince Ave., Building 15 Athens, GA 30606 (706) 227-7191 FAX: (706) 227-7184 Robin.O'Donnell@dph.ga.gov	**Caylie Mahaffey** 740 Prince Ave., Building 15 Athens, GA 30606 (706) 389-6923 ext. 2706 FAX: (706) 552-4536 Caylie.Mahaffey@dph.ga.gov	**Robin O'Donnell, LMSW, CLC** 740 Prince Ave., Building 15 Athens, GA 30606 (706) 227-7191 FAX: (706) 227-7183 Robin.O'Donnell@dph.ga.gov

Appendix C
State Staff Contacts

MCH Child Health Services				
Last Name	**First Name**	**Telephone Number**	**Email Address**	**Title**
Welborn	Kathy	404-651-7442	Kathy.welborn@dph.ga.gov	Coordinator, Children 1st
Clark	Pamela	404-657-3153	Pamela.Clark@dph.ga.gov	Clinical Coordinator, NBS
Culpepper	Brandt	404-651-5482	Brandt.Culpepper@dph.ga.gov	Team Lead, EDHI
Harris	Jaquay	404-657-3173	Jaquay.Harris@dph.ga.gov	Data Entry Specialist, NBS
Souza	Keilana	470-388-4902	Keilana.Souza@dph.ga.gov	Program Coordinator, Children 1st
Turner	Tina	470-462-7434	Tina.Turner1@dph.ga.gov	Deputy Director, Child Health Services
VACANT				Team Lead, NBS
Williams	Raven		Raven.Williams@dph.ga.gov	Program Coordinator, NBS
Abeyta	Karin		Karin.Abeyta@dph.ga.gov	Program Coordinator, EDHI
MCH Children & Youth With Special Healthcare Needs				
Peart	Sharifa	404-657-2861	Sharifa.Peart@dph.ga.gov	Program Director, CYSHCN/CMS
Rainey	Quondalynn	404-657-2874	Quondalynn.Rainey@dph.ga.gov	Program Coordinator, CMS
Givens	Kira		Kira.Givens@dph.ga.gov	Youth Engagement Program Coordinator, CDC PHAP Associate CMS
Conner	Jackie	404-463-0812	Jackie.Conner@dph.ga.gov	Child Health EPI I
Snarey	Elizabeth	404-651-5995	Elizabeth.Snarey@dph.ga.gov	Family Support Coordinator, BCW/CMS
VACANT				Clinical Coordinator, CMS
Griswell	Synita	404-232-1630	Synita.Griswell@dph.ga.gov	Program Coordinator, Autism & Developmental
VACANT				
MCH Early Intervention				
Spencer	Kimberlee	678-347-5318	Kimberlee.spencer@dph.ga.gov	Deputy Director/Part C Coordinator, Early Intervention
Byrd	Kevin	404-673-0703	Kevin.Byrd@dph.ga.gov	Deputy Director/Part C Coordinator, Early Intervention
Glecia	Carter		Glecia.Carter@dph.ga.gov	(Metro) Regional Coordinator Team Lead, BCW
Jenni	Nowicki	404-651-5494	Jenni.Nowicki@dph.ga.gov	(North) Regional Coordinator Team Lead,

				BCW	
Artis	Krystal	678-708-5838	Krystal.Artis@dph.ga.gov	(South) Regional Coordinator Team Lead, BCW	
Dian	Facey	404-985-2281	Dian.Facey@dph.ga.gov	Provider Relations Specialist, Early Intervention	
Mesha	Robinson		Mesha.Robinson@dph.ga.gov	Training and Support Coordinator, Early Intervention	
VACANT				Part C Data Manager/Evaluator	
Reynolds	LaToya	404-657-5622	Latoya.Reynolds@dph.ga.gov	Administrative Coordinator/SICC Coordinator, BCW	

Appendix D
Children's Intervention Services, COS 840

A. Refer to COS 840 Manual for children receiving therapy services under the Medicaid Children's Intervention Services Program.

Appendix E
Georgia Families

A. Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs. It is important to note that GF is a full-risk program; this means that the three CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The three licensed CMOs:

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

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°.

i. Eligibility Categories for Georgia Families:

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

	Alternatives for Youths (CBAY)
Resource Mothers Outreach	

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

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

1. Amerigroup Community Care
2. CareSource
3. Peach State Health Plan

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

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

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

4. Included Categories of Eligibility (COE):

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	

5. 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
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
308	SSI Work Continuance – Blind
309	SSI Work Continuance – Disabled
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
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

iii. Health Care Providers

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

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

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

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

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

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

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

Participating in a Georgia Families' health plan:
Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:
For members who are in Georgia Families, you should file claims with the member's health plan.

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

1. 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.

2. The CVO's one-source application process:
   a. Saves time
   b. Increases efficiency
   c. Eliminates duplication of data needed for multiple CMOs
   d. Shortens the time period for providers to receive credentialing and recredentialing decisions

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

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

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

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

Billing the health plans for services provided:

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

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

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

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

Health plans payment of clean claims:

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

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision:** Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy:** Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. **Pharmacy:** 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.

iv. How often can a patient change his/her PCP?

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • 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.

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

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

B. Pharmacy

i. 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.

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

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

1. 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.

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

Health Plan	**PBM**	**BIN #**	**PCN #**	**GROUP #**	**Helpdesk**
Amerigroup Community Care	IngenioRx	020107	HL	WKJA	1-833-235-2031
CareSource	Express Scripts (ESI)	003858	MA	RXINN01	1-800-416-3630
Peach State Health Plan	CVS	004336	MCAIDADV	RX5439	1-844-297-0513

iv. If a patient does not have an identification card:

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

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

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

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

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

vii. 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.

viii. Who to call to request a PA:

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

Appendix F
Non-Emergency Medical Transportation

A. Definition

Non-Emergency Medical Transportation (NEMT) services are defined as medically necessary transportation for any eligible Medicaid member and companion, if required, who have no other means of transportation available to any Medicaid-reimbursable service for the purposes of receiving treatment, medical evaluation, obtaining prescription drugs or medical equipment.

i. How do I get NEMT services?

1. If you are a qualifying Medicaid recipient and have no other means of transportation for your medical care or services covered by Medicaid, you may contact a transportation broker for transport to and from your appointment. The member must contact the Broker to request NEMT services at least three (3) business days prior to a non-urgent, scheduled appointment. The three (3) day advance scheduling includes the day of the call but not the day of the appointment. Advance scheduling will be mandatory for all NEMT services except urgent care and follow-up appointments when the timeframe does not allow advance scheduling. Urgent care or same day reservations may require verification from your direct provider of service confirming you must be seen that day. Each broker has a toll-free telephone number to schedule transportation services, and available weekdays (Monday-Friday) from 7 a.m. to 6p.m.

2. All counties in Georgia are grouped into five regions for NEMT services. A NEMT Broker covers each region. If you need NEMT services, you must contact the NEMT Broker serving the county you live in to ask for Non-Emergency Medical Transportation. Contact Southeastern for Atlanta and North Regions and ModivCare, formerly LogistiCare, for Central, East and Southwest See the chart below to determine which broker serves your county and call the broker's telephone number for that region.

ii. What if I have problems with a NEMT provider or broker?

1. The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. If you have a question, comment, or complaint about a NEMT provider or broker that has not been resolved with the broker, you may contact the Georgia Department of Community Health, NEMT unit.

NEMT REGIONS & COUNTIES SERVED

Region	NEMT Broker & Phone Number	Counties Served
North	**Verida *(formerly 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** ***(formerly Southeastrans***) 404-209-4000 *Note: For Georgia Families 360°* 1-866-991-6701	Fulton, DeKalb, and Gwinnett
Central	**ModivCare** ***(formerly 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	**ModivCare** ***(formerly LogistiCare)*** Toll free 1-888-224-7988 *Note: For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities* 1-800-486-7642 Ext. 461 or 436	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler, and Wilkes
Southwest	**ModivCare** ***(formerly 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 G
Department Of Community Health Case Management Hierarchy

A. Duplication of Case Management Services

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.

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.

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 fee. The provider highest on the hierarchy will be reimbursed if 2 case management providers should submit claims for the same month of service.

i. COS 830 - Care Management Organization - CMO

ii. COS 851 - SOURCE Case Management

iii. COS 100 - MR Case Management Support Only participants enrolled in COS 680 or 681

iv. COS 764 - Child Protective Services Targeted Case Management

v. COS 800 - Early Intervention Case Management

vi. COS 765 - Adult Protective Services Targeted Case Management

vii. COS 760 - Children at Risk Targeted Case Management

viii. COS 762 - Adults with AIDS Targeted Case Management

ix. COS 763 - At Risk of Incarceration Targeted Case Management

x. COS 100 - Case Management Support - Only MRDD participants on the Short-term planning list.

xi. COS 960 - Children Intervention School Services

xii. COS 790 - Rehab Services/DSPS

NOTE: 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 H
Georgia Families 360º



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

Georgia Families 360º SM, 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.

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 360$^{0}_{SM}$ 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 360º SM Every member in Georgia Families 360^{0} is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

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

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

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

Appendix I
Ordering, Prescribing, and Referring (OPR) Update

A. Ordering, Prescribing, and Referring (OPR)

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.

i. For the NEW CMS-1500 claim form:

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

ii. 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.

iii. 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.