peach state health plan™

Provider Manual

1-866-874-0633

pshp.com

Table of Contents

Description of Georgia Families

Georgia Families® is a statewide, full-risk management system that serves certain Medicaid members, PeachCare for Kids® members, and Planning for Healthy Babies® enrollees.

The GF program is designed to:

- Improve the Health Care status of the member population
- Establish a "Provider Home" for members through its use of assigned Primary Care Providers (PCP's)
- Slow the rate of expenditure in the Medicaid Program

The Georgia Medicaid Management Information System (GAMMIS) serves as the primary web portal for Medicaid, PeachCare for Kids® and all related waiver programs administered by the Department of Community Health's Medical Assistance Plans Division. The GAMMIS portal provides timely communications, data exchange and self-service tools for members and providers with both secure and public access areas and can be accessed at www.mmis.ga.gov.

GAMMIS is maintained by Hewlett Packard (HP), the Department of Community Health's fiscal agent currently contracted to process Medicaid and Peachcare for Kids claims and other non-claim specific payments.

Helpful Links

Georgia Department of Community Health
dch.georgia.gov

National Committee for Quality Assurance
www.NCQA.org

The Joint Commission
www.jointcommision.org

GAMMIS
www.mmis.ga.gov

Peach State Health Plan

Peach State Health Plan, Inc. is a care management organization (CMO) contracted with the Georgia Department of Community Health (DCH) to serve Medicaid and other government services program members. Peach State Health Plan has developed the expertise to work with Medicaid members to improve their health status and quality of life. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Peach State Health Plan works to accomplish this goal by partnering with the primary care providers (PCP) who oversee the healthcare of Peach State Health Plan members.

Effective June 1, 2006, Centene Corporation® (Centene) began providing Medicaid managed care services to members in the designated regions of Georgia as Peach State Health Plan. Centene and its wholly owned health plans have a long and successful track record offering Medicaid managed care services. For more than 20 years, Centene has provided comprehensive managed care services to the Medicaid population and currently operates health plans in Arizona, Arkansas, California, Florida, Georgia, Florida, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Mississippi, Missouri, New Hampshire, Ohio, South Carolina, Texas, Washington, and Wisconsin. Peach State Health Plan serves our Georgia members in a manner consistent with our core philosophy that quality healthcare is best delivered locally. Peach State Health Plan is a physician-driven organization that is committed to building interactive partnerships with providers.

Peach State Health Plan has been designed to achieve the following goals:

- Ensure access to primary and preventive care services
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

We at Peach State Health Plan strive to provide members with an improved health status. Peach State Health Plan continually seeks to improve member and provider satisfaction. All of our programs, policies and procedures are designed with these goals in mind. We hope that you will assist Peach State Health Plan in reaching these goals.

Peach State Health Plan Guiding Principles

- High quality, accessible, cost-effective healthcare for our members
- Integrity and the highest ethical standards
- Mutual respect and trust in our working relationships
- Communication that is open, consistent and two-way
- Diversity of people, cultures and ideas
- Innovation and encouragement to challenge the status quo
- Teamwork and meeting our commitments to one another

Peach State Health Plan allows open practitioner/member communication regarding appropriate treatment alternatives, including medication treatment options, regardless of benefit coverage limitations. Peach State Health Plan does not penalize practitioners for discussing medically necessary or appropriate care with the member.

Peach State Health Plan Approach

Recognizing that a strong health plan is predicated on building mutually satisfactory associations with providers, Peach State Health Plan is committed to:

- Working as partners with participating providers
- Demonstrating that healthcare is a local issue
- Performing its administrative responsibilities in a superior fashion

All of Peach State Health Plan's programs, policies and procedures are designed to minimize the administrative responsibilities in the management of care, enabling you to focus on the healthcare needs of your patients, our members.

Peach State Health Plan Summary

Peach State Health Plan's philosophy, for our Georgia Medicaid members, is to provide access to high quality, culturally sensitive healthcare services by combining the talents of PCPs and specialty providers with a highly successful, experienced managed care administrator. Peach State Health Plan believes that successful managed care is the delivery of appropriate, medically necessary services - not the elimination of such services.

It is the policy of Peach State Health Plan to conduct its business affairs in accordance with the standards and rules of ethical business conduct and to abide by all applicable federal and state laws.

At Peach State Health Plan, we take the privacy and confidentiality of our members' health information seriously. We have processes, policies and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state privacy law requirements. If you have any questions about Peach State Health Plan's privacy practices, please contact our Privacy Official at 1-800-704-1484. In addition to this manual, the Peach State Health Plan Provider Tool Kit (for providers and their staff) includes helpful and valuable information on serving members, and matters specified in the Provider Training Manual are incorporated herein for all purposes.

Peach State Health Plan At-A-Glance

For your ease, we have included this Reference Guide to assist you in the day-to-day operations of your office.

How to Reach Us:

PEACH STATE HEALTH PLAN
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA. 30339
1-800-704-1463

MEMBER SERVICES
1-800-704-1484
Fax 1-800-659-7518
TDD/TTY 1-800-659-7487
Or Georgia Relay services
1-800-255-0056 (TDD only) or 1-800-255-0135 (Voice)

PROVIDER SERVICES
1-866-874-0633
Fax 1-800-659-7492

MEDICAL MANAGEMENT/CASE MANAGEMENT
1-800-704-1483

NURSEWISE
24-hour Nurse Line - 1-800-704-1484 Option #7

PHARMACY - US SCRIPT
Help Desk 1-800-460-8988
Prior Authorizations
1-866-399-0928 (Phone)
1-866-399-0929 (Fax)

PHARMACY CLAIM SUBMISSION
US Script PBM
2425 W. Shaw Ave.
Fresno, CA 93711

CHEMOTHERAPY/RADIATION THERAPY - EVITI
1-888-678-0990

DENTAL
Envolve Dental
1-844-464-5632
https://dental.envolvehealth.com/

VISION
Envolve Vision
1-866-458-2139
https://visionbenefits.envolvehealth.com/

TELEMEDICINE CONSULT
Georgia Partnership for TeleHealth - 1-866-754-4325

PAPER CLAIMS SUBMISSION
Peach State Health Plan
PO Box 3030
Farmington, MO 63640-3812
Attn: Claims Department

FOR CLAIM APPEALS
Peach State Health Plan
PO Box 3000
Farmington, MO 63640-3812

RECONSIDERATION RELATED TO CLAIMS
PO Box 3030
Farmington, MO 63640-3812

FOR APPEALS RELATED TO PLAN MEDICAL DECISIONS (ADMINISTRATIVE REVIEW)*
Peach State Health Plan
Grievance and Appeals Coordinator
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA. 30339
Fax: 866-532-8855
***Member's Consent is required**

CENPATICO PAPER CLAIM SUBMISSION
Peach State Health Plan
PO Box 6700
Farmington, MO 63640-3805
1-800-947-0633

ELECTRONIC CLAIM SUBMISSION
Peach State Health Plan
C/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at: EDIBA@centene.com

DENTAL CLAIM SUBMISSION
Envolve Dental – GA Claims
PO Box 22085
Tampa, FL 33622-2085

VISION PAPER CLAIM SUBMISSION
Envolve Vision
P.O. Box 7548
Rocky Mount, NC 27804
Vision Provider Services - 1- 866-458-2139

Provider Responsibilities

All Peach State Providers are required to participate in initial and ongoing education and training in accordance with Peach State guidelines and applicable federal and state regulations.

Primary Care Provider (PCP)

The primary care provider (PCP) is the cornerstone of Peach State Health Plan. The PCP serves as the "medical home" for the member. The "medical home" concept assists in establishing a member-provider relationship and ultimately better health outcomes. The PCP is required to adhere to the responsibilities outlined below.

Covered PCP Services

The PCP is responsible for supervising, coordinating, and providing all primary care to each assigned member. In addition, the PCP is responsible for coordinating and/or initiating referrals for specialty care (both in and out-of-network), maintaining continuity of each member's healthcare and maintaining the member's Medical Record, which includes documentation of all services provided by the PCP as well as any specialty services, including behavioral health. The PCP is also responsible for sending status reports to member's behavioral health provider. The PCP shall arrange for other participating physicians to provide members with covered physician services as stipulated in their contract. Each participating PCP shall provide all covered physician services in accordance with generally accepted clinical, legal, and ethical standards in a manner consistent with practitioner licensure, qualifications, training and experience. These standards of practice for quality care are generally recognized within the medical community in which the PCP practices.

Covered services include:

- Professional medical services, both inpatient and outpatient, provided by the PCP, nurses, and other personnel employed by the PCP. These services include the administration of immunizations, but not the cost of the immunization.
- Periodic health assessments and routine physical examinations (performed at the discretion of the PCP, and consistent with DCH and nationally recognized standards recommended for the age and sex of the covered person).
- Vision and hearing screenings.
- All supplies and medications found on the GA DCH Physician Injectable Drug List Provider Manual when used or provided during a covered member's office visit. Some Injectable drugs require a prior authorization, which can be obtained by calling 1-800-704-1483 to obtain the correct forms or process. Providers should review the Biopharmaceutical Pharmacy Program List published on the Peach State Health Plan website to determine if the medication requires authorization. Some oncology drugs are excluded from prior authorization requirements.
- All tests routinely performed in the PCP's office during an office visit.
- The collection of laboratory specimens (Note: See the Provider Stat List for information on labs that can be performed and reimbursed in an office setting. All other office based labs must be submitted through our contracted laboratory providers.)
- Voluntary family planning services such as examinations, counseling, and pregnancy testing.
- Well-child care and periodic health appraisal examinations, including all routine tests performed as customarily provided in a PCP's office.
- Referral to specialty care physicians and other health providers with coordination of care and follow-up after referral.
- PCP's supervision of home care regimens involving ancillary health professionals provided by licensed nursing agencies. Please note that these services are subject to prior authorization by Peach State Health Plan.
- Any other outpatient services and routine office supplies normally within the scope of the PCP's practice.
- EPSDT Preventive visits performed according to the Bright Futures periodicity schedule, and immunizations according to the Advisory Committee on Immunization Practices (ACIP) guidelines, and in keeping with procedures outlined in the Peach State Health Plan Provider Manual.
- A treatment plan developed with member and applicable specialist participation for members who need a course of treatment or regular care monitoring.

Planning for Healthy Babies Waiver Program

The Planning for Healthy Babies Program (P4HB) is an 1115 Medicaid Demonstration Waiver that expands the provision of family planning services to uninsured women, ages 18 through 44, who have family income at or below 200 percent of the Federal poverty level (FPL) and who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP). In addition, the Planning for Healthy Babies program provides Inter-pregnancy Care (IPC) services to women who meet the same eligibility requirements above and who deliver a very low birth-weight (VLBW) infant (less than 3 pounds and 5 ounces).

Eligibility for P4HB Program

The following eligibility criteria must be met for participation in the P4HB Program:

- Be a US citizen or person with qualified proof of citizenship.
- Be a woman between the ages of 18 and 44.
- Be a Georgia resident.
- Not be eligible for any other Medicaid program or managed care program.
- Meet family gross income requirements of no more than 200% of the federal poverty level (FPL).
- Losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP).
- Meet the above requirements and have delivered a VLBW baby (less than 3 pounds and 5 ounces). These women qualify for the IPC program.

Components of the P4HB program

There are three components that women who qualify for the waiver are eligible to participate in:

- **Family Planning Only** which covers family planning and family planning related services only for eligible participants for the duration of the waiver.
- **Inter-pregnancy Care** which covers family planning and additional services for women who have delivered a VLBW baby.
- **Resource Mother Outreach** which offers a specially trained case manager to any women in other Medicaid plans who has delivered a VLBW baby.

Covered Services include:

Services	Notes/Limitations
Family planning initial or annual exams (one per year)	• Comprehensive family planning visit.
	• Laboratory tests performed during an initial family planning visit for contraception include: a Pap smear, screening tests for sexually transmitted infections (STI's)/ sexually-transmitted diseases (STDs), blood counts, and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider.
Contraceptive services and supplies	• Procedures or services clearly provided or performed for the primary purpose of family planning. • contraceptive initiation. • periodic or inter-periodic contraceptive management. • patient education and counseling.
Follow up family planning or family planning related service visits	• In order for a follow-up family planning visit to be reimbursed, it must carry a primary diagnosis or a modifier that specifically identifies it as a family. planning service. Services provided must be those that are generally performed as part of, or as follow-up to, a family planning service for contraception.
	Such services are provided because a "family planning-related" problem was identified/diagnosed during a routine/periodic family planning visit. Office visits, laboratory tests, and certain other procedures must also carry a primary diagnosis or modifier that specifically identifies them as a family planning service. During follow up visits, providers can: • Provide follow-up on abnormal testing. For example: • Rescreen for an abnormal pap smear. • Screen or rescreen for a STD. • Perform colposcopy (and procedures done with/during a colposcopy). • Perform a LEEP procedure. • Provide treatment/drugs for STI's, except for HIV/AIDS and hepatitis, when the STD's/STI's were identified/diagnosed during the routine/periodic family planning visit. • Provide treatment/drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, when these conditions were identified/diagnosed during the routine/periodic family planning visit.

Services	Notes/Limitations
Treatment of major complications related to family planning services such as:	• Treatment of a perforated uterus due to an intrauterine device insertion. • Treatment of severe menstrual bleeding caused by a Depo-Provera; injection requiring a dilation and curettage. • Treatment of surgical or anesthesia-related complications during a sterilization procedure.
P4HB Participant Counseling and referrals to:	• Social services, e.g. WIC. • Primary health care providers. Primary care services are not offered as part of the family planning visit. These primary care services are not covered for enrollees who are not in the IPC program. Women should be referred for conditions identified during a family planning visit to a primary health care provider. Each CMO is required to maintain an up-to-date list of available Providers affiliated with the Georgia Primary Care Association and other primary care Providers serving the uninsured and underinsured populations who are available to provide primary care services to P4HB Participants.

Tubal Ligation (Sterilization)	Sterilization procedures covered under the P4HB Program must meet the following minimum requirements:
	• The P4HB Participant is at least twenty-one (21) years of age at the time consent is obtained;
	• The Participant is mentally competent;
	• The Participant voluntarily gives informed consent in accordance with the State Policies and Procedures for Family Planning Clinic Services. This includes the completion of all applicable documentation:
	  • At least thirty (30) Calendar Days, but not more than one hundred and eight (180) Calendar Days, have passed between the date of informed consent and the date of sterilization.
	  • An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a P4HB Participant who is visually impaired, hearing impaired or otherwise disabled; and
	  • The Participant is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.
	  • A hysterectomy is not considered a covered service for P4HB Participants.
	  • Abortions or abortion-related services are not considered a covered service for Demonstration Participants.

Multi-Vitamins with Folic Acid/Folic Acid Supplements	• Providers should routinely prescribe multi vitamins with folic acid or folic acid supplments only to all women of reproductive age.
Hepatitis B and Tetanus Diphtheria vaccines for P4HB Participants aged 18, 19 and 20. Participants aged 18 should receive vaccines through the VFC program's vaccine stock.	• If the family planning provider is unable to provide these vaccines then the women should be referred to a network provider who can administer the vaccine.

Inter-pregnancy care (P4HB program)

In addition to the family planning and family planning-related services described above, women who are enrolled in the IPC component of the Program will be eligible for the benefits described in the table below.

Services	Notes/Limitations
Primary care	PCP coordinates care for the participant and makes referrals to CMO and non-CMO specialty care as needed.
Management and treatment of chronic diseases	By Primary Care Provider.
Substance abuse treatment (detoxification and intensive outpatient rehabilitation)	Participants can self-refer to an in-network provider for an initial mental health or substance abuse visit but prior authorization may be required for subsequent visits. Participants may also receive detoxification and intensive outpatient rehabilitation services only.
Case management/ Resource Mother Outreach	See below.
Limited Dental	For a list of benefits contact Member Services.
Prescription Drugs (non-family planning)	Medications to treat chronic conditions.
Non-Emergency transportation	For a list of benefits contact Member Services.

Resource Mother Outreach (P4HB program)

Women served under the IPC component of the P4HB Program and women enrolled in other Medicaid programs who have delivered a VLBW baby will have access to a Resource Mother. Peach State Health Plan employs or contracts with Resource Mothers who assist nurse case managers with the following:

- Increasing P4HB Participants' adoption of healthy behaviors such as healthy eating choices and smoking cessation;
- Supporting P4HB Participants' compliance with primary care medical appointments, including assisting with arranging non-emergency medical transportation;
- Assisting mothers of VLBW babies to obtain regular preventive health visits and appropriate immunizations for their child;
- Supporting P4HB Participants' compliance with medications to treat chronic health conditions;
- Assisting with coordination of social services support; and,
- Assisting with linking mothers to community resources such as the Special Supplemental Nutrition Program for Women, Infants, and Children.

Providers are encouraged to refer women to the P4HB Program who have delivered a VLBW infant to determine if they would be eligible to participate in the Inter-pregnancy Care or Resource Mother Outreach program components. Providers will be required to complete the necessary forms confirming that the woman delivered a VLBW baby.

Applying For The P4HB Program

Members can apply for the P4HB program either online using the website listed or by obtaining and submitting an application and required documents to the address and fax number below:

Online apply at www.gateway.ga.gov or

Obtain an application at the local:

- Public Health Departments.
- Department of Family and Children Services (DFCS).
- Applications are also available at Federally Qualified Health Centers.
- Or request to have one mailed directly to you by calling 877-P4H-B101 or 877-744-2101.

Completed applications and required documents should be faxed to:

- Fax: 912-632-0389.
- Or Mailed to:

  Planning for RSM Group
  426 West 12th Street
  Alma, GA 31510

Additional Information

Providers seeking additional information may use the following additional resources:

- www.dch.georgia.gov/p4hb
- www.planning4healthybabies.org
- 877-P4H-B101 or 877-744-2101
- Local Public Health departments
- Department of Family and Children Services (DFCS)
- Peach State Health Plan website

In-Office Lab Testing

Effective August 1, 2017, the lab services below can be performed and reimbursed in an office setting.
All other office-based lab services must be submitted through our contracted laboratory providers.

CPT	Description
G0306	Complete CBC, automated (HgB, HCT, RBC, WBC, without platelet count) and automated WBC differential count
G0307	Complete (CBC), automated (HgB, Hct, RBC, WBC; without platelet count)
G0480	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.
G0481	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed.
G0482	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed.)

CPT	Description
G0483	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed.
Q0111	Wet mounts, including preparations of vaginal, cervical or skin specimens
80048	Basic Metabolic panel
80051	Electrolyte Panel (must include Carbon Dioxide, Chloride, Potassium and Sodium)
80061	Lipid panel and this panel include: Cholesterol, Serum, Total Lipoprotein, Direct Measurement(82465), High Density cholesterol-HDL Cholesterol (83718) and Triglycerides (84478)
80305	Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
80306	Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) read by instrument-assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
80307	Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures by instrument chemistry analyzers (eg, utilizing immunoassay, eg IA, EIA, ELISA, EMIT, FPIA, KIMS, RIA) chromatography, (eg. GC, HPLC) and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GCMS/MS, ML- MS/MS, LDTD, MALDI, TOF) including sample validation when performed, per date of service.
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81002	UA dip stick/tablet reagent; w/o micro non-auto
81003	Automated, urine analysis without microscopy
81005	Urinalysis; qualitative or semi-quantitative, except immunoassays
81025	Urine pregnancy test, by visual color comparison methods
82043	Albumin; urine, microalbumin, quantitative
82044	Albumin; urine, microalbumin, semiquantitative (eg, reagent strip assay)
82247	Bilirubin; Total
82270	Blood, occult, by peroxidase activity (eg, guaiac); feces, 1-3 simultaneous
82272	Blood, occult, by peroxidase activity, single specimen
82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 13 simultaneous determinations
82465	Cholesterol, serum or whole blood, total
82565	Creatinine, Blood
82570	Creatinine; other source
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose; blood, reagent strip
82950	Post glucose dose (includes glucose)
82951	Glucose; tolerance test (GTT), 3 specimens (includes glucose)
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home
83036	HGA1c
83037	Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use
83655	Lead
83986	pH, body fluid, except blood

CPT	Description
84030	Phenylalanine (PKU), blood
84156	Protein, total, except by refractometry; urine
84520	Urea Nitrogen, Quantitative
84702	Quantitative HCG
84703	Gonadotropin, chorionic (HCG); qualitative
85004	Blood count; automated differential wbc count
85007	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)
85013	Blood count; spun micro-hematocrit
85014	Blood count; other than spun hematocrit
85018	Blood count; hemaglobin
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85032	Blood count; manual cell count (erythrocyte leukocyte or platelet) each
85049	Blood count; platelet automated
85610	Prothrombin time
85651	Sedimentation rate, erythrocyte; non-automated
85730	Thromboplastin time, partial (PTT); plasma or whole blood
86140	C-reactive protein:
86308	Heterophile antibodies; screening
86318	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step
86403	Particle agglutination; screen, each antibody
86580	Skin test; tuberculosis, intradermal
86677	H Pylori
86701	Antibody; HIC-1
86702	Antibody; HIC-2
86703	HIV-1/HIV-2 SINGLE RESULT
86710	Antibody; influenza virus
86756	Antibody; respiratory syncytial virus
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates
87077	Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate
87081	Culture, presumptive, pathogenic organisms, screening only
87088	Culture, bacterial; with isolation and presumptive identification of isolates, urine
87101	DTM Culture
87110	Culture, chlamydia, any source
87177	Ova and parasites, direct smears, concentration and identification
87205	Smear, primary source with interpretation, Gram or Giemsa stain for bacteria, fungi, or
87210	Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)
87220	KOH Prep
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis

CPT	Description
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis
87389	HIV-1 AG W/HIV-1 & HIV-2 AB
87390	Antibody; HIV-1 and HIV-2, single result
87391	HIV-2 AG IA
87400	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Influenza, A or B, each
87425	Rotavirus
87430	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Streptococcus, group A
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
87492	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification
87501	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, reverse transcription and amplified probe technique, each type or subtype
87502	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, multiplex reverse transcription and amplified probe technique, first 2 types or sub-types
87503	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, multiplex reverse transcription and amplified probe technique, each additional influenza virus type or sub-type beyond 2 (List separately in addition to code for primary procedure)
87660	Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique
87802	Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group B
87803	Infectious agent antigen detection by immunoassay with direct opticalobservation; Clostridium difficile toxin A
87804	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza
87807	Infectious agent antigen detection by immunoassay with direct optical observation; respiratory syncytial virus
87808	Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis
87810	Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis
87880	Infectious agent detection by immunoassay with direct optical observation; Streptococcus, group A
87905	Infectious agent enzymatic activity other than virus (eg., sialidase activity in vaginal fluid)
88230	Tissue culture for non-neoplastic disorders; lymphocyte
88233	Tissue culture for non-neoplastic disorders; skin or other solid tissue biopsy
88235	Tissue culture for non-neoplastic disorders; amniotic fluid or chorionic villus cells
88237	Tissue culture for neoplastic disorders; bone marrow, blood cells
88239	Tissue culture for neoplastic disorders; solid tumor
88240	Cryopreservation, freezing and storage of cells, each cell line
88241	Thawing and expansion of frozen cells, each aliquot
88245	Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE), 20-25 cells
88248	Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (eg, for ataxia telangiectasia, Fanconi anemia, fragile X)
88249	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (eg, diepoxybutane, mitomycin C, ionizing radiation, UV radiation)
88261	Chromosome analysis; count 5 cells, 1 karyotype, with banding
88262	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding
88263	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding

CPT	Description
88264	Chromosome analysis; analyze 20-25 cells
88267	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding
88269	Chromosome analysis, in situ for amniotic fluid cells, count cells from 6-12 colonies, 1 karyotype, with banding
88271	Molecular cytogenetics; DNA probe, each (eg, FISH)
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (eg, for derivatives and markers)
88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (eg, for microdeletions)
88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells
88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells
88280	Chromosome analysis; additional karyotypes, each study
88283	Chromosome analysis; additional specialized banding technique (eg, NOR, Cbanding)
88285	Chromosome analysis; additional cells counted, each study
88289	Chromosome analysis; additional high resolution study
88291	Cytogenetics and molecular cytogenetics, interpretation and report
88720	Bilirubin
89051	Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood; with differential count
89190	Nasal smear for eosinophils

Note: All other office-based lab services must be submitted through our contracted laboratory providers. Specialty lab services will continue to be submitted through Doctors Laboratory, Genzyme Genetics, Finan Dermatopathology, Atlanta Dermatology and Pathology and Chatham County Board of Health Lab.
Note: Any service rendered by a non-contracted laboratory provider requires that the ordering provider obtain prior authorization for the service.

PCP Availability and Accessibility

The availability of our practitioner network is essential to member care and treatment outcomes. We evaluate the performance in meeting these standards and appreciate providers working with us to accommodate our members' clinical needs. In order to ensure appropriate care, we have adopted the geographic accessibility standards below.

Thank you for complying with this assessment and providing the highest quality of care for our members. Practitioner performance data may be used by the plan for the development of quality improvement activities.

Each participating physician shall maintain sufficient facilities and personnel to provide covered physician services and shall ensure that such services are available as needed twenty-four (24) hours a day, 365 days a year. The organization requires the hours of operation that practitioners offer to Medicaid Members to be no less than those offered to commercial members. Peach State Health Plan encourages PCPs to offer services after hours and on the weekends. Peach State Health Plan will monitor physicians' offices through scheduled and un-scheduled visits through our Provider Relations staff.

Provider Type	Urban	Rural
PCPs*	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Pediatricians	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Obstetric Providers	Two (2) within thirty (30) minutes or (30) miles	Two (2) within forty-five (45) minutes or forty-five (45) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within fifteen (15) minutes or fifteen (15) miles	One (1) twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within thirty (30) minutes or thirty (30) miles
Therapy: (Physical Therapists, Occupational Therapists and Speech Therapists)	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Vision Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles

PCP Coverage

The participating physician shall arrange for coverage with a physician who must have executed a contractual agreement with Peach State Health Plan. If the participating physician is capitated for professional services, compensation for the covering physician is considered to be included in the capitation payment. If the participating physician is on a fee-for-service agreement with Peach State Health Plan, the covering physician is compensated in accordance with the fee schedule in his/her agreement. Non-participating providers will be reviewed for medical necessity in the event a specialist is not in-network.

Appointment Availability

Appointment Availability Standards

Provider Type	Waiting Time
PCPs - Routine/Regular visit (Adult and Pediatric)	Not to exceed fourteen (14) calendar days
PCPs - Sick/Urgent (Adult)	Not to exceed twenty-four (24) clock hours
PCPs - Sick/Urgent (Pediatric)	Not to exceed twenty-four (24) clock hours
PCPs – initial Pediatric health/screening check	Not to exceed 90 calendar days of eligibility or within twenty-four (24) hours of birth (in the hospital) for all newborns

Provider Type	Waiting Time
OB (Maternity care) – · Pregnant Women - Initial visit · First Trimester · Second Trimester · Third Trimester	· Not to exceed fourteen (14) calendar days from enrollment · Not to exceed fourteen (14) calendar days · Not to exceed seven (7) calendar days · Not to exceed three (3) business days
Specialists	Not to exceed 30 calendar days
Therapy: Physical, Occupational, Speech, and Aquatic Therapists and Aquatic Therapists	Not to exceed thirty (30) calendar days
Vision	Not to exceed thirty (30) calendar days
Dental Providers Routine visit-(Delegated Vendor)	Not to exceed twenty-one (21) calendar days
Dental Providers-Urgent visit-(Delegated Vendor)	Not to exceed forty-eight (48) clock hours
Elective Hospitalizations	Thirty (30) calendar days
Mental Health (Delegated Vendor) provider	Fourteen (14) calendar days
Urgent Care provider	Not to exceed 24 clock hours
Emergency provider	Immediately (twenty-four (24) clock hours a day/seven (7) days a week) without prior authorization
High Volume specialist: Ob/ Gyn (excludes Ob/Maternity care visit requirement)	Not to exceed 30 calendar days
High Impact specialist: Oncology	Not to exceed 30 calendar days

The participating physician shall provide adequate capacity for initial visits for pregnant women within fourteen (14) calendar days and visits for EPSDT eligible children within ninety (90) calendar days of the members' enrollment in Peach State Health Plan.

Peach State Health Plan will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program.

Maximum Office Wait Time Standards

Scheduled Appointments	Waiting times shall not exceed 60 minutes. After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Walk-In Appointments	Waiting time shall not exceed 90 minutes. After 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

Provider Response Time For After Hour Calls

- Urgent Calls: Shall not exceed 20 minutes.
- Other Calls: Shall not exceed one hour.

Telephone Arrangements

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering the members telephone inquiries on a timely basis
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by a member.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, or for non-compliant individuals or those people with cognitive impairments).
- Response time for telephone call-back waiting times: same day for non-symptomatic concerns; crisis situations within fifteen (15) minutes.
- Scheduling continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours; Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member's medical record.
- An Auto Attendant/Answering system that advises the member that urgent calls will be returned within 20 minutes and all other calls will be returned within one hour and the option to page the physician; or
- A live attendant/Advice nurse and/or answering service that advises the member that urgent calls will be returned within 20 minutes and all other calls will be returned within one hour and the option to page the physician.

Note: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to member receiving urgent or emergent care.

Peach State Health Plan will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program.

Self-Referrals

The following services do not require PCP authorization or referral:

- Prescription drugs, including certain prescribed over-the-counter drugs.
- Emergency services including emergency ambulance transportation.
- OB/GYN Services, including those of a Certified Nurse Midwife.
- GYN Services, including those of a Certified Nurse Midwife.
- Women's health specialist covered services provided by a Federally Qualified Health Center (FQHC) or Certified Nurse Practitioner.
- Mental Health and Chemical Dependency/Substance Abuse services for the first six standard outpatient sessions per member per year.
- Family Planning Services and supplies from a qualified family planning provider.
- Routine Dental Services.
- Non-surgical routine vision care with Optometrist and Ophthalmologists.
- Podiatry Services as defined in the benefits section.

Except for emergency and family planning services, the above services must be obtained through network providers or prior authorized out-of-network providers.

Referrals

It is Peach State Health Plan's preference that the PCP coordinates healthcare services. However, members are allowed to self-refer for certain services (see above). PCPs are encouraged to refer a member when medically necessary care is needed that is beyond the scope of the PCP. Those referrals which require authorization by the plan can be located on the pshp.com website under the online Pre-Auth Needed Tool. For out-of network referrals see information described herein. A provider is also required to notify Peach State Health Plan promptly when they are rendering prenatal care to a Peach State Health Plan member.

If the PCP is capitated, referrals from a capitated PCP to another PCP will not be authorized or covered except for the following circumstances:

- Members who are auto-assigned to another PCP in the third trimester of their pregnancy when they become eligible for services under Peach State Health Plan (Medicaid members who are pregnant and not in the third trimester are subject to plan review and approval)
- Members having chronic medical conditions with ongoing healthcare needs that require continuity of care transition; Examples include, but not limited to, hemophilia, HIV/AIDS, sickle cell anemia, neoplasm, and organ transplant.
- Members who have other insurance coverage in which their primary provider is different from their Peach State Health Plan PCP.
- No paper referral is required for a referral or prior-authorization.
- Members who have moved thirty (30) miles or more from their previous residence, until a new PCP can be assigned.

To verify if an authorization is necessary visit the Peach State Health Plan website and utilize the online Pre-Auth Needed Tool. To obtain a prior authorization, enter the request on the

Department of Community Health
Centralized Prior Authorization Portal:
mmis.georgia.gov

Telemedicine

Peach State Health Plan has a relationship with Georgia Partnership for TeleHealth (GPT). The Georgia Partnership for TeleHealth (GPT) works to improve the availability and provision of specialized health care services in rural and underserved parts of Georgia through the use of telemedicine, health information exchange and TeleHealth technologies. The program's goal is to enable all rural Georgians to access specialty care within 30 mile of their homes.

The partnership provides Peach State Health Plan members and providers with access to one of the most comprehensive telemedicine networks in the nation, and enhances the level of and access to care for the significant rural populations that Peach State Health Plan serves throughout the state of Georgia. This collaborative relationship with one of the leading TeleHealth coordinators in the nation provides all Peach State Health Plan members with access to more than 40 specialties that can be delivered via telemedicine.

The Georgia Partnership for TeleHealth has become one of the most robust, comprehensive telemedicine networks in the nation. Recent expansion has included nursing homes, school-based clinics, jails, clinics and emergency rooms. The network now has more than 350 partners and locations and more than 175 specialists and health care providers. Providing access to health care via telemedicine has proven to cut costs on travel, work time and provides earlier access to care therefore preventing the large costs of untreated health care problems.

For more information, visit: http://www.gatelehealth.org. For additional information please contact Peach State Health Plan directly at 1-866-874-0633 from 7am to 7pm, Monday through Friday.
For scheduling assistance please contact GPT at 1-866-754-4325.

EPSDT

The EPSDT program is designed to ensure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The Program is designed to provide a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents. The EPSDT benefit is available to Peach State Health Plan Medicaid members under age 21 years old an PeachCare for Kids children less than 19 years old.

According to the AAP and Bright Futures "Recommendations for Pediatric Health Care" Periodicity Schedule (Bright Futures schedule), PCPs are also required to perform immunizations according to the Advisory Committee on Immunization Practices (ACIP) guidelines. All components of exams must be documented and included in the medical record of each EPSDT eligible member. EPSDT Preventive exams are to be completed within ninety (90) days of the initial effective date of membership. Please refer to the EPSDT section of this manual (page 68) for more information on EPSDT requirements.

Member Panel Capacity

All PCPs reserve the right to state the number of members they are willing to accept into their practice. Member assignment is based on the member's choice and auto assignment, therefore, Peach State Health Plan **DOES NOT** guarantee that any provider will receive a set number of members.

If a PCP does declare a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact the Peach State Provider Services Department at
1-866-874-0633. A PCP shall not refuse to treat members as long as the physician has not reached their requested panel size.

Provider shall notify Peach State Health Plan at least forty-five (45) days in advance of his or her inability to accept additional Medicaid covered persons under Peach State Health Plan agreements. Peach State Health Plan prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

Provider Termination

Providers should refer to their Peach State Health Plan contract for specific information about terminating from Peach State Health Plan.

Other PCP Responsibilities to Members

- Educate members on how to maintain healthy lifestyles and prevent serious illness.
- Provide culturally competent care.
- Provide follow up on emergency care.
- Maintain confidentiality of medical information.
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current Prior Authorization List, except for emergency services up to the point of stabilization.

Peach State Health Plan providers should refer to their contract for complete information regarding PCP obligation and mode of reimbursement. PCPs should accept Members for treatment, unless they have a full panel and are accepting no new Georgia Families or commercial patients.

Specialist Responsibilities

Selected specialty services require a formal referral from the PCP. The specialist may order diagnostic tests without PCP involvement by following Peach State Health Plan's referral guidelines. The specialist must abide by the prior authorization requirements when ordering diagnostic tests. However, the specialist may not refer to other specialists or admit to the hospital without the approval of a PCP, except in a true emergency situation. All non-emergency inpatient admissions require prior authorization
from Peach State Health Plan.

The specialist provider must:

- Maintain contact with the PCP.
- Obtain referral or authorization from the member's PCP and/or Peach State Health Plan Medical Management Department as needed before providing services.
- Coordinate the member's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five (5) business days.
- Be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of member care.
- Maintain the confidentiality of medical information.

Peach State Health Plan providers should refer to their contract for complete information regarding providers' obligations and mode of reimbursement.

Hospital Responsibilities

Peach State Health Plan utilizes a network of hospitals to provide services to Peach State Health Plan members.

Hospitals must:

- Notify Peach State Health Plan's Medical Management Department of all inpatient hospital admissions by the next business day of the admission with clinical information.
- Outpatient observation stays will not require notification. Outpatient observation stays over 24 hours will require retrospective medical record review for payment consideration.
- Submit notifications of newborn deliveries to the Department of Community Health Centralized Prior Authorization Portal at www.mmis.georgia.gov.
    - Member name and Medicaid number (mother).
    - Newborn name and Medicaid number (In the event, a name has not been selected at the time of discharge, please submit with the newborn's gender: Baby boy or Baby girl and Last Name (ex. Baby boy Smith).
    - Facility name, Physician name.
    - Admit date, delivery date, type of delivery.
    - Gender, weight, and Apgar score of the newborn, and gestational age of the newborn (if known).
- A Critical Access Hospital (CAH) must provide notice to Peach State Health Plan and the Department of Community Health (DCH) of any alleged breaches in its contract by the health plan.

Peach State Health Plan hospitals should refer to their contract for complete information regarding the hospitals' obligations and mode of reimbursement.

Hospital Statistical Reports (HS&R)

Effective July 1, 2008, HS&Rs will be generated by Peach State Health Plan and made available within thirty (30) days of receipt of a written request from the provider. HS&R requests may be submitted using one of two methods: a letter or an email. Effective February 15, 2010, you must adhere to the process outlined below when requesting HS&R reports.

- All requests for production of HS&R reports must be submitted via e-mail to the designated e-mail box or via certified mail to the address below.
- Please note: Any request submitted directly to an individual's attention will be returned to the requestor via email with instructions on how to submit the request via one of the methods identified below.
- Submit your e-mail request to:
  - HSRrequest@centene.com
  - SUBJECT: Request for HS&R Report
- Submit your written request via Certified mail to:

Peach State Health Plan
VP of Compliance
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA. 30339
ATTN: Request for HS&R Report

Reminder:

In order to generate your reports, you must provide the following information:

a. Hospital Name
b. Hospital Tax ID Number
c. Provider Medicaid ID Number
d. Hospital fiscal year or period service dates
e. Hospital fiscal year or period for paid through dates
f. Contact Information - including email

Advance Directives

Peach State Health Plan is committed to ensuring that its members know of and are able to avail themselves of their rights to execute advance directives. Peach State Health Plan is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs and physicians delivering care to Peach State Health Plan members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

Peach State Health Plan recommends to its PCPs and physicians that:

- The first point of contact in the PCP's office should ask if the member has executed an advance directive; the member's response should be documented in the medical record.
- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the PCP's office and document this request.
- An advance directive should be included as a part of the member's medical record, including mental health directives.
- If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Discussion should be documented in the medical record.
- If an advance directive has not been executed, the first point of contact within the office should ask the member if they desire more information about advance directives. You may obtain a copy online at www.aging.dhr.georgia.gov.

- If the member requests further information, member advance directive education/information should be provided.
- Member Services and CONNECTIONS representatives will assist members with questions regarding advance directives; However, no employee of Peach State Health Plan may serve as witness to an advance directive, or as a member's designated agent or representative.

If you have any questions regarding advance directives contact:

Provider Solutions Department
1-866-874-0633
www.pshp.com

If the member feels the advance directive is not being followed, they may file a complaint to:

Georgia Department of Community Health
Healthcare Facilities Regulations
2 Peachtree Street, NW
Atlanta, Georgia 30303
Toll free: 1-800-878-6442

Provider Assistance with Public Health Services

Peach State Health Plan is required to coordinate with public health entities regarding the provision of public health services. Providers must assist Peach State Health Plan in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.
- Assisting in the notification or referral of any communicable disease outbreaks involving members to the local public health entity, as defined by state law.
- Referring to the local public health entity for tuberculosis contact investigation, evaluation and the preventive treatment of persons with whom the member has come into contact.
- Referring to the local public health entity for STD/HIV contact investigation, evaluation and preventive treatment of persons with whom the member has come into contact.
- Referring for Women, Infant and Children (WIC) services and information sharing as appropriate.
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure.
- Assisting in the collection and verification of race/ethnicity and primary language data.

Additional Reporting Requirements

Peach State Health Plan in accordance with its contract with DCH must report the existence of certain information regarding its membership. For example, if a member is involved in an accident or becomes injured, this information should be shared with us. This includes any incidents that occur prior to a member's coverage with Peach State Health Plan. To report this type of information, please call us at 1-866-874-0633. Please be prepared to supply as many details as possible including the date and the cause of the accident, the injuries sustained by a member and whether or not any legal proceedings have been initiated. In addition, you must immediately report the death of a Peach State Health Plan member.

The provider shall notify Peach State Health Plan of any member who is an expectant mother at least ninety (90) calendar days prior to the expected date of delivery. In the event an expectant mother does not enroll in Peach State Health Plan until she is already within ninety (90) calendar days of her expected due date, the provider shall notify Peach State Health Plan immediately by contacting the OB Case Management department at 1-800-504-8573.

Cultural Competency Overview

Cultural competency within the Peach State Health Plan Network is defined as **"A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members".**

Peach State Health Plan is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Peach State Health Plan as part of its credentialing and site visit process will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist provider's in developing culturally competent and culturally proficient practices.

Network providers must ensure the following:

- Members understand that they have access to medical interpreters, signers, and TTY services to facilitate communication without cost to them.
- Care is provided with consideration of the members' race/ethnicity and language and its impact/influence of the members' health or illness.
- Office staff that routinely come in contact with members have access to and participate in cultural competency training and development.
- Office staff responsible for data collection makes reasonable. attempts to collect race and language specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed and clinical guidelines are followed with consideration of the members race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Office sites have posted and printed materials as English, Spanish, and all other prevalent non-English languages if required by DCH, to include posting of signage in the languages of the commonly encountered group. Office sites also have forms available in preferred language. Forms are also available in preferred format, such as large print or braille.

Understanding the need for Culturally Competent Services

The Institute of Medicine report entitled "Unequal Treatment" along with numerous research projects reveal that when accessing the healthcare system, people of color are treated differently. Research also indicates that a person has better health outcomes when they experience culturally appropriate interactions with medical providers. The path to developing cultural competency begins with self-awareness and ends with the realization and acceptance that the goal of cultural competency is an ongoing process. Providers should note that the experience of a member begins at the front door. Failure to use culturally competent and linguistically competent practices could result in the following:

- Feelings of being insulted or treated rudely.
- Reluctance and fear of making future contact with the office.
- Confusion and misunderstanding.
- Non-compliance.
- Feelings of being uncared for, looked down on and devalued.
- Parents resisting to seek help for their children.

- Unfilled prescriptions.
- Missed appointments.
- Misdiagnosis due to lack of information sharing.
- Wasted time.
- Increased grievances or complaints.

Preparing Cultural Competency Development

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Peach State Health Plan is committed to helping you reach this goal. For information on Peach State Health Plan's Cultural Competency Plan, please review the plan on our web site, www.pshp.com, or request a free copy of the plan by calling 800-874-0633. Please visit our web site for links to free on-line learning tools which address health literacy, cultural competency and limited English proficiency. For additional information on developing and meeting cultural competency standards within your practice, please review A Physician's Practical Guide to Culturally Competent Care at: https://cccm.thinkculturalhealth.org/.

Take into consideration the following as you provide care to the Peach State Health Plan Health Plan membership:

- What are your own cultural values and identity?
- How do or can cultural differences impact your relationship with your patients?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
- Do you embrace differences as allies in your patients' healing process?

Facts about Health Disparities [1]

- Persons with lower income and less education face many barriers to receiving timely care.
- Households headed by Hispanics are more likely to report difficulty in obtaining care.
- Many minorities are more likely to experience long wait times to see healthcare providers.
- African Americans experience longer waits in emergency departments and are more likely to leave without being seen.
- Many racial and ethnic minorities of lower socioeconomic position are less likely to receive timely prenatal care, more likely to have low birth weight babies and have higher infant and maternal mortality.
- Racial and ethnic low-income minority children are less likely to receive childhood immunizations.
- Patient race, ethnicity, and socioeconomic status are important indicators of the effectiveness of healthcare.
- Health Disparities come at a personal and societal price.

[1] AHRQ "2003 National Healthcare Disparities Report"

Medical Records

Peach State Health Plan providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Peach State Health Plan to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Peach State Health Plan requires providers to maintain all records for members for at least seven (7) years.

Required Information

Medical records means the complete, comprehensive records of a member including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable DCH rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages.
- Personal/biographical data is present (i.e. spouse, home telephone number, employer etc.).
- All entries must be legible.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An immunization record is established for pediatric members or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Peach State Health Plan's practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is consistent with diagnosis.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the ordering practitioner to signify review.
- Referrals to specialists and ancillary providers are documented, including follow-up of outcomes and summaries of treatment rendered elsewhere.
- Health teaching and/or counseling is documented.
- For members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried).Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records are protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.
- Records are organized and easily accessible each visit and kept in a secure location.

Medical Records Release

All medical records of members shall be confidential and shall not be released without the written authorization of covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis. Written authorization is required for the transmission of the medical record information of a current Peach State

Health Plan member or former Peach State Health Plan member to any physician not connected with Peach State Health Plan.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain old medical records for all new Peach State Health Plan members. If the member or member's guardian is unable to remember where they obtained medical care or are unable to provide an appropriate address, then this should also be noted in the medical record.

Medical Records Audits

Medical records may be audited to determine compliance with Peach State Health Plan's standards for documentation. The coordination of care and services provided to members including over/under utilization of specialists as well as the outcome of such services may also be assessed during a medical record audit.

Peach State Health Plan's Providers shall provide copies with prior notice of such records at no expense to Peach State Health Plan and Peach State Health Plan's delegated vendor. Medical Records are used to ensure compliance with State and Federal Regulatory Requirements and accreditation guidelines.

Medical Management

Overview and Medical necessity

The Peach State Health Plan Medical Management Department hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 5:30 p.m. For prior-authorizations during business hours, the provider should contact:

Medical Management
1-800-704-1483
Web address: www.pshp.com
DCH Centralized Web Portal (CWP): mmis.georgia.gov
(Effective July 1, 2017 all authorizations must be submitted via the state CWP)

Authorizations that require review for Medical Necessity will be reviewed and screened by a Nurse.

Medical Necessity:

Medically Necessary services are based upon generally accepted medical practices provided in light of conditions present at the time of treatment. Medically Necessary are services that are:

- Required to correct or ameliorate a defect, physical or mental illness, or a condition.
- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition.
- Compatible with the standards of acceptable medical practice in the community.
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and severity of the symptoms.
- Not provided solely for the convenience of the member or the convenience of the healthcare provider or hospital.
- Not primarily custodial care unless custodial care is a covered service or benefit under the members evidence of coverage.
- There must be no other effective and more conservative or substantially less costly treatment, service and setting available.

In addition in keeping with Georgia State Medicaid Plan policies and procedures, in no instance shall Peach State Health Plan cover experimental, investigational or cosmetic procedures.

To ensure the well being of the member, authorizations may be granted outside of the benefit plan when Medically Necessary

Information necessary for authorization may include but is not limited to:

- Member's name, ID number.
- Physician's name and telephone number.
- Hospital name, if the request is for an inpatient admission or outpatient services.
- Reason for admission – primary and secondary diagnoses, surgical procedures, surgery date.
- Relevant clinical information – past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed.
- Admission date or proposed date of surgery, if the request is for an inpatient admission.
- Requested length of stay, if the request is for an inpatient admission
- Discharge plans, if the request is for an inpatient admission.
- For obstetrical admissions, the date and method of delivery and information related to the newborn or neonate, Baby's Medicaid ID number.

If more information is required, the Nurse will notify the caller for the specific information needed to complete the authorization process.

Failure to obtain authorization may result in payment denials.

Affirmative Statement

Peach State Health Plan does not reward or pay its group of providers, or employees for completing medical use reviews. They do not pay its group of providers or employees to deny reviews. Use decisions are based on the following reasons:

- Services are medically needed
- Services are covered in the member's plan

Our systems allow us and our partners to:

- Identify
- Track
- And monitor the care given

This process ensures that you (member) receive the right healthcare.
We care about your health and want you to get better. We use certain methods to make sure that you receive the best healthcare for your condition. Those processes are listed below:

- Watch for under and over use of services - best course of action is taken if this occurs.
- A system in place to support the study of medical use measurements
- Detect possible quality of care issues.
- Put into action intervention plans.
- And measures the success of the actions taken.
- A process to support stability of care across the health care field.

Communication With Utilization Management (UM) Staff

Members and providers may access the UM staff via toll-free phone lines that are open for UM related questions and or issues 24 hours a day, 7 days a week by calling 1-800-704-1483. From 8am to 5:30pm, Monday through Friday (excluding state holidays), calls are directed to the UM department. After normal business hours, and on state holidays, calls to the UM department are automatically routed to NurseWise (1-800-704-1483, Option 7). NurseWise

does not make authorization decisions. NurseWise staff will take authorization information for next business day response by the health plan or notify the Peach State on-call nurse in cases requiring immediate response. Outbound communications regarding UM inquiries are conducted during normal business hours, unless otherwise agreed upon. If you are initiating or returning calls regarding UM issues, all UM staff will identify themselves by name, title and organization. If Member Services receives a call regarding a specific UM case/issue (inquiries about decisions beyond the confirmation of approval or denial of care), the caller will be transferred to the appropriate UM staff/phone queue for direct access to UM staff about the UM decision or process.

Prior-Authorization

Preauthorization requires that the provider or practitioner make a formal medical necessity determination request to Peach State Health Plan prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health services proposed, including the setting in which the proposed care will take place.

Standard Service Authorization – Prior Authorization decisions for nonurgent services shall be made within three (3) Business Days, or otherestablished timeframe, of the request (generally submitted one week prior to the service or procedure). An extension may be granted for an additional fourteen (14) Calendar Days if the Member or the Provider requests an extension, or if the Peach State Health Plan justifies to DCH a need for additional information and the extension is in the Member's best interest.

When the extension is granted, both the provider and member will be notified. Peach State Health Plan will gather all pertinent clinical information to support the authorization request. If the clinical information is not received, a written notification to member and provider will be generated. The Member will receive written notice of the reasons for the decision to extend the timeframe and the right to file a Grievance if he or she disagrees with that decision. If the request for authorization is approved, the case manager or designee will notify the requesting provider of the approval by telephone, fax, or email within one business day after the decision is made, not to exceed the original authorization timeframe. The case manager will document the date and time of the notification in the authorization system. If the request for authorization is denied, or a limited authorization of a requested service, including the type and level of service, is proposed, the requesting provider will be notified orally within one business day, and the member and provider will be notified in writing, within two (2) business days of the verbal notification, not to exceed the original fourteen (14) day determination timeframe.

Expedited Service Authorization – In the event the Provider indicates, or Peach State Health Plan determines, that following the standard timeframe could seriously jeopardize the Member's life or health, Peach State Health Plan will make an expedited authorization determination within twenty-four (24) clock hours and provide notice as expeditiously as the Member's health condition requires and no later than three (3) business days after receipt of the request for service. Peach State Health Plan may extend the twenty-four (24) hour time period for up to five (5) business days if the member or the Provider requests an extension, or if Peach State Health Plan justifies to DCH a need for additional information and the extension is in the member's interest.

For proposed actions to terminate, suspend, or reduce previously authorized covered services, the Plan mails the Notice of Proposed Action 10 calendar days before the date of the proposed action or not later than the date of the proposed action in the event of one of the following exceptions:

- Peach State Health Plan has factual information confirming the death of a member.
- Peach State Health Plan receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.
- The member's whereabouts are unknown and the post office returns the Peach State Health Plan mail directed to the member indicating no forwarding address.

- The member's provider prescribes a change in the level of medical care.
- The date of action will occur in less than 10 calendar days in accordance with 42 CFR 483.12(a)(5)(ii).

Peach State Health Plan may shorten the period of advance notice to five calendar days before the date of action if the Plan has facts indicating that action should be taken because of probable member fraud and the facts have been verified, if possible, through secondary sources.

Peach State Health Plan's Medical Management Department may be contacted by phone at:

Medical Management
1-800-704-1483
Web address: www.pshp.com

Referral Process

The PCP should coordinate healthcare services. PCP's should refer members when medically necessary services are beyond their scope of practice. To verify is an authorization is necessary visit the Peach State Health Plans website and utilize the online Pre-Auth Needed Tool. To obtain a prior authorization, enter the request on the Department of Community Health Centralized Prior Authorization Portal: mmis.georgia.gov. Members are allowed to self-refer for certain specific services (for example, family planning, dental and vision) as stated in this manual.

Peach State Health Plan encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate their members' care, and to make sure the specialist being referred is a participating provider with Peach State Health Plan.

Providers must notify Peach State Health Plan's Case Management Department promptly of any pregnant member, but in no case later than ninety (90) calendar days prior to the expected date of delivery (unless the member is enrolled within 90 days of the expected delivery date, in which case provider notice to Peach State Health Plan must be immediate).

For access to out-of-network providers, the network provider must call Peach State Health Plan for a prior authorization for any service from an out of network or non-participating provider or facility.

Peach State Health Plan does not use paper referrals. Should a provider desire a standing referral, or access to a specialty care center for a life-threatening condition or certain prolonged conditions, the provider must contact Peach State Health Plan's Utilization Management Department.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship.

Inpatient Notification Process

Inpatient facilities are required to notify Peach State Health Plan for emergent and urgent inpatient admissions by the next business day of the admission with clinical information. Admissions made on the weekend require notification the next business day. Notification of newborn delivery is required by the discharge date. The following information is required once the delivery is complete in order to receive the claim reimbursement approval:

- Member name and Medicaid number (mother).
- Newborn name (In the event, a name has not been selected at the time of discharge, please submit with the newborn's gender: Baby boy or Baby girl and Last Name (ex. Baby boy Smith).
- Newborn's Medicaid number.
- Facility name, Physician name.

- Admit date, delivery date, type of delivery.
- Gender, weight, and Apgar score of the newborn, and gestational age of the newborn.

Notification is required to track inpatient utilization, enable care coordination, discharge planning, and ensure timely claim payment. To provide
notification and when applicable obtain prior authorization, please submit the information on the Department of Community Health Centralized Prior Authorization Portal: ***mmis.georgia.gov***

Concurrent Review

The Peach State Health Plan Medical Management Department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning Departments and when necessary, the member's attending physician. An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment. The review will include evaluation of the member's current status, proposed plan of care, discharge plans, and any subsequent diagnostic testing or procedures.

The Peach State Health Plan Medical Management Department may contact the member's admitting physician's office prior to the discharge date established during the authorization process, to check on the member's progress, and to make certain that the member receives
medically necessary follow up services.

Discharge Planning

Discharge planning activities are expected to be initiated upon admission. The Peach State Health Plan Medical Management Department will coordinate the discharge planning efforts with the hospital's Utilization and Discharge Planning Departments and when necessary the member's attending physician/PCP in order to ensure that Peach State Health Plan members receive appropriate post hospital discharge care.

Retrospective Review

Retrospective or postservice review is an initial review of services that have been performed. For untimely requests for authorizations, providers and facilities are advised to submit the claim for processing. The claim will be denied for "services not authorized" at which time the provider may initiate the appeal process. A decision is made within thirty (30) calendar days of receipt of the request.

Utilization Management Criteria

Peach State Health Plan has adopted utilization review criteria developed by McKesson InterQual Products. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physician members of the Peach State Health Plan Utilization Management Committee. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Criteria are used for the approval of medical necessity but not for the denial of services. The Medical Director reviews all potential denials of medical necessity decision.

Providers may obtain the criteria used to make a specific decision by contacting the Medical Management Department at **1-800-704-1483.**

Providers and members have the right to request a copy of the review criteria or benefit provision utilized to make a denial decision. Copies of the criteria can be obtained by submitting your request in writing to:

Medical Management
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA. 30339
Attn: IQ Criteria

Physicians can discuss denial decisions with the physician reviewer who made the decision by calling the Medical Management Department at 1-800-704-1483, Monday - Friday, between the hours of 8am and 5:30 pm.

Appeal Process

An Appeal is a request for review of an action as "action" is defined below. The Appeal Process includes Step 1 which is an Administrative Review Process and Step 2 which is an Administrative Law Hearing (Medicaid members) or Formal Appeal Process (PeachCare for Kids® members).

Filing an Administrative Review (Appeal)
An adverse benefit determination is the denial or limited authorization of a requested service including the type or level of service including determination based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (2016 CFR SubPart F Grievance & Appeal System), the reduction, suspension or termination of a previously authorized service, the denial in whole or in part of payment for a service, the failure to provide services in a timely manner or the failure of the health plan to act within timeframes for grievances and appeals. Providers may request on behalf of a member an Administrative Review of a Proposed Action. The provider must obtain and provide to Peach State Health Plan a written consent of the member to file an Administrative Review on behalf of the member.

Who may file an Administrative Review?

- Peach State Health Plan member.
- A person named by the Peach State Health Plan member.
- A provider with written member consent.
- A legal representative of a deceased member's estate.

Standard requests for administrative review (including written member consent) must be received by Peach State Health Plan within 30 calendar days of the date of the Proposed Action. Written requests for administrative review should be submitted to:

Peach State Health Plan
Administrative Review
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339
1-866-532-8855

Administrative Review Process

An Administrative Review (also known as an appeal) is a request for review of an adverse benefit determination. An Administrative Review is a formal reconsideration of a service which has been denied or a previously authorized service which has been suspended, terminated, or reduced. A request for Administrative Review must be sent

to Peach State Health Plan within thirty (30) calendar days from the date of the Notice of Proposed Action. If the request is not received within thirty (30) calendar days from the date of Notice of Proposed Action, it is considered untimely. If this occurs, you will receive written notice and the request will be closed.

As a provider, you may request an Administrative Review on behalf of a member but must obtain and provide to Peach State Health Plan a member's written consent.

A member may make request for Administrative Review by phone or in person by calling Member Services toll free at 1-800-704-1484. If the member is hearing impaired they can call 1-800-659-7487. The member must also send Peach State Health Plan a signed letter confirming their request within 30 calendar days of their oral request. If Peach State Health Plan does not receive a written request within 30 calendar days from the date of the member's oral request, the administrative review will be closed. Upon receipt of the administrative review request, we will send the provider and the member a letter within 10 business days letting you know we received an administrative review request. A health care provider who was not involved in the previous decision-making and who has appropriate clinical training and experience in treating the member's condition or disease will review the administrative review. We will send you and the member a letter that will include the decision and reason for the decision. We will do this within 30 calendar days for preservice administrative review request or within 30 calendar days of the postservice administrative review request or as expeditiously as the member's health requires and it will be written in the language in which the administrative review request is received.

You can provide additional information and receive a copy of the documents used in the administrative review at any time during the administrative review process.

Peach State Health Plan may request a 14 calendar day extension if there is need for additional information and the delay would be in the member's interest. If this occurs, we will notify you and the member in writing. If the member feels they may need more time to complete the review, they may call Member Services at 1-800-704-1484 and ask for an extension for up to
14 calendar days.

Peach State Health Plan will ensure that no punitive action is taken against the member, member's authozied representative, legal representative for a deceased member's estate or provider who requests an expedited resolution or supports the members administrative review.

The member can request continuation of benefits until the Administative Review is completed, which can be up to 30 calendar days. The member's request for the benefits to continue must be made within ten (10) calendar days from the date we mailed the Notice of Proposed Action letter or
before the effective date of the action. The member may have to pay for this care if the decision is not in their favor. Please see the section
Continuation of Benefits

Expedited Administrative Review

If a decision on an Administrative Review is required immediately due to the member's health needs, providers may request an expedited Administrative Review. Requests for expedited administrative review should be submitted electronically through the Peach State Health Plan website or by calling 1-866-874-0633. Peach State Health Plan's decision will be provided within 72 hours for the review or as expeditiously as the member's health condition requires. We will send you a letter with the decision within 72 hours or sooner if the member's health condition requires it.

If we do not agree that the request of an expedited administrative review is necessary, we will call you right away. We will send you a letter within 2 calendar days letting you know that the administrative review will be reviewed through the standard review process. The member may file a grievance if they do not agree with this decision by calling our Member Services department.

Peach State Health Plan may request a 14 calendar day extension if needed. If this occurs, we will notify you and the member in writing. If the member feels they may need more time before your expedited administrative review is completed, they may call 1-800-704-1484 and ask for the appeals department to request an extension for up to 14 calendar days.

Members Right to an Administrative Law Hearing or Formal Appeal Committee

Medicaid Eligible Members:
The State will maintain an independent Administrative Law Hearing process as defined in the Georgia Administrative Procedure Act (O.C.G.A Title 50, Chapter 13) and as required by federal law, 42 CFR 431.200 et seq. The Administrative Law Hearing process shall provide Medicaid Members an opportunity for a hearing before an Administrative Law Judge.

A member, member's authorized representative, or legal representative of a deceased member's estate, upon receipt of an adverse determination regarding an administrative review, has the right to request an Administrative Law Hearing. A provider cannot request an Administrative Law Hearing on behalf of a member. The Peach State Health Plan Administrative Review processes must be exhausted prior to requesting an Administrative Law Hearing. The request must be in writing and a copy of the adverse action letter must be received by the Plan within 30 calendar days of Peach State Health Plan mailing the Notice of Adverse Action. The request for the Administrative Law Hearing should be mailed to the following address:

Peach State Health Plan
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339
Attn: Administrative Law Hearing Coordinator

The parties to the Administrative Law Hearing shall include Peach State Health Plan, the member or member's authorized representative, or legal representative of a deceased member's estate.

Information regarding the date, time, and place of the hearing is sent by the Office of State Administrative Hearings. An Administrative Law Judge will preside over the hearing. The member has the right to present evidence, obtain representation for him or herself during the hearing, and have access to the case files. The decision reached by the Adminstrative Law Hearing is final. Peach State Health Plan will comply with the Administrative Law Hearing decision

PeachCare for Kids® Eligible Members:
PeachCare for Kids® (PCK) members do not have access to the Medicaid Administrative Law Hearing process. If a PeachCare for Kids® member or parent of a member is dissatisfied with a Notice of Adverse Action issued through a Peach State Health Plan Administrative Review, the member or parent of the member may submit a written request for a review of the decision by the State Formal Appeal Committee. The Administrative Review process must be completed before proceeding to the Formal Appeal Committee. A request for State Review must be made in writing within thirty (30) calendar days from the date of the Administrative Review Decision Notice. A provider cannot request a Formal Appeal Committee review on a member's behalf unless you are appointed as their authorized representative. The request along with a copy of the Notice of Adverse action should be mailed to:

Department of Community Health
PeachCare for Kids®
2 Peachtree Street, NW
Atlanta, GA 30303-3159

The member or parent of the member has the opportunity to represent themselves or designate a representative in the process at the Formal Appeal Committee level. The member or parent of the member has the right to review the files related to the case and fully participate in the review process. The Formal Appeal Committee will inform the member or parent of the member of the appeal process timeframes upon receipt of the request for a Formal Grievance Appeal.

The State Formal Appeals Committee will review the Plan's decision. No further recourse will be available to the member or parents of the member after the State Formal Appeals Committee reviews and renders a decision.

The decision reached by the Formal Appeal Committee is final. Peach State Health Plan will comply with the Formal Appeal Committee decision

During the Administrative Law Hearing or Formal Appeal Committee process, the member may request a continuation of benefits. Please refer to the Continuation of Benefits section.

Continuation of Benefits

A member may request benefits to continue while awaiting the completion of the Administrative Review, Administrative Law Hearing, or Formal Appeal Committee process. The member must request a continuation of care on or before the later of the following:

- Within ten (10) calendar days from the date we mailed the notice that we would not cover or pay for a service.
- Before the intended effective date of the proposed action

Peach State Health Plan will continue the benefit if:

- The review must be about termination, suspension or reduction of a previously authorized course of treatment.
- The appeal was filed timely.
- The member requested the continuation of benefits.
- The services were ordered by an authorized Provider.
- The original period covered by the original authorization has not expired

Peach State Health Plan will continue benefits until:

- The member withdraws the Administrative Review, Administrative Law Hearing, or the Formal Appeal Committee request.
- Ten calendar days pass after Peach State Health Plan's mails the Notice of Adverse Action, unless the member, within 10 calendar days request an Adminstrative Law Hearing or Formal Committee review with continuation of benefits until a decision is made.
- A decision is made during the Administrative Review, Administrative Law Hearing or Formal Appeal Committee and is not in your favor.
- The time period or service limits of a previously authorized service has been met.

The member may have to pay for the cost of continuation of their benefits if the final decision is not in their favor. If the decision is made in their favor, Peach State Health Plan will approve and pay for the requested services that are needed but were not received during the review of their case as quickly as possible. If the decision is made in the member's favor and the member did receive continuation of benefits during the review of their case, Peach State Health Plan will pay for those services.

Assistance and Contacting Peach State Health Plan

Medicaid /Peach Care for Kids® members may obtain assistance with or initiate a Grievance, Administrative Review, Administrative Law Hearing or State Formal Appeal by contacting the Peach State Health Plan Appeals and Grievance Coordinator at 1-800-704-1484 (or TDD/TTY 1-800-659-7487).

Second Opinion

A member, a member's representative or healthcare professional with member's consent may request and receive a second opinion from a qualified professional within Peach State Health Plan's network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network and in-network specialty provider types on the prior authorization list will require prior authorization.

Assistant Surgeon

Reimbursement is provided to assistant surgeons when medically necessary. Peach State Health Plan utilizes guidelines for assistant surgeons as set forth by the American College of Surgeons.

Hospital medical staff by-laws that require an Assistant Surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff by-laws alone do not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests an Assistant Surgeon be present for the surgery. Coverage and subsequent reimbursement for an Assistant Surgeon's service is based on the medical necessity of the procedure itself and the Assistant Surgeon's presence at the time of the procedure.

Continuity of Care

In some instances Peach State Health Plan will authorize payment for a provider other than the Peach State Health Plan PCP to coordinate the member's care. The services initiated prior to the member's enrollment with Peach State Health Plan must have been covered under a previous carrier. These services shall be continued until the member is evaluated by their PCP and a new plan of care is established. Authorization is typically for a period of 90 days, or until a participating provider with equivalent expertise can be identified. All services should be coordinated with the plan to ensure continuity and quality of care. A Transition of Care form can be requested from the Medical Management department at 1-800-704-1483 or the Peach State Health Plan website, in the Forms section.

Peach State Health Plan Case Management Services

Definition of Case Management Services

Case Management or Care Coordination is a collaborative process of assessment, planning, coordination, monitoring, and evaluation of the services required to meet an individual's needs. Case Management serves as a means for achieving member wellness and autonomy through advocacy, communication, education, identification of services resource and service facilitation. The goal of Case Management is provision of quality health care along a continuum, decreased fragmentation of care across settings, enhancement of the member's quality of life, and efficient utilization of patient care resources.

Although it is the Provider's responsibility to serve as the ongoing source of primary and preventative care, the Case Manager, working in collaboration with the Provider, helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner.

Criteria for determining which members might benefit from Case Management:
A key objective of Peach State Health Plan's Complex CM Program is early identification of those members who have the greatest need for Care Coordination and Case Management. This includes but is not limited to those who are classified as children or adults with special health care needs; have catastrophic, high-cost, and high-risk or co morbid conditions; have been non-compliant in less intensive programs; or are frail and elderly, disabled, or at the end of life. Identifying members for Complex Case Management may be conducted through, but not limited to, claim or encounter data, hospital discharge data, pharmacy data, or data collected at any time through the UM process. Members may also be referred directly to the case management program through self referrals or family, DM program, hospital discharge planner, Provider, hospital case management staff, Peach State Health Plan's CONNECTION staff, Peach State Health Plan Utilization Management staff or other Peach State Health Plan Staff. These multiple referral avenues can help to minimize the time between need and initiation of care management services.

The Provider maintains an ongoing responsibility identifying members who may meet Peach State Health Plan's case management criteria.

Health Risk Assessment and Case Management Plan:
Once identified, the CM team uses various assessment tools to determine whether coordination of services will result in more appropriate and cost effective care through treatment Peach State Health Plan intervention. During this assessment of the member's risk factors, patient information including cultural and linguistic needs, current health status, potential barriers to complying with the care treatment plan, and other pertinent information may be obtained from the member, family support system, Provider and other healthcare practitioners. Assessment, care treatment, care treatment plan and all interaction with the member is documented in TruCare which facilitates automatic documentation of the individual and the date and time when the CM team acted on the care or interacted with the member. The clinical documentation system (CDS) supports evidence-based clinical guidelines to conduct assessment and management and allows the CM to generate reminder prompts for follow-up according to the care management care plan.

The Case Manager develops a proposed care treatment plan in conjunction with the member, the Provider, and authorized family members or guardians when possible. This proposed case management plan is based on medical necessity, appropriateness of the discharge plan, patient/family/support systems to assist the patient in the home setting, community resources/services available and patient compliance with the prescribed care treatment plan. This care treatment plan includes short and long term goals, identifies barriers to meeting goals, provides schedules for follow-up and communication with members, and includes self-management planning and an assessment of progress against the plans and goals, with modification as needed.
The case management plan is implemented when the member, provider, case manager and /or other health care team agree to the plan. Checkpoints are put into place to evaluate and monitor the effectiveness of care coordination/case management services and the quality of care provided, and to trigger timely revisions to the care treatment plan when necessary. Behavioral health care coordination is incorporated in the treatment plan. The case manager also assists the member in transitioning to other care when benefits end.

Referring a Member to Peach State Health Plan Case Management:
Providers are asked to contact a Peach State Health Plan Case Manager to refer a member identified in need of case management intervention:

Case Management @ 1-800-504-8573
Or
TTY users @ 1-800-659-7487

Medical case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes. Care coordination/management is a member-centered, goal-

oriented, culturally relevant and logically managed process to help ensure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

Peach State Health Plan's Case Manager supports the physician by tracking compliance with the case management plan, and facilitating communication between the PCP, member, managing physician, and the case management team. The Case Manager also facilitates referrals and linkages to community providers, such as local health departments and school-based clinics. The managing physician maintains responsibility for the patient's ongoing care needs. The Peach State Health Plan case manager will contact the PCP and/or managing physician if the member is not following the plan of care or requires additional services.

Peach State Health Plan will provide individual case management services for members who have high-risk, high-cost, complex or catastrophic conditions. The Peach State Health Plan case manager will work with all involved providers to coordinate care, provide referral assistance and other care coordination as required.

Case and Disease Management Programs
In addition to general complex case management services, Peach State Health Plan also provides special needs case management programs as follows:

- Asthma
- Diabetes
- HIV / AIDS
- Sickle Cell Anemia
- Children with Special Health Care Needs
- ER Management
- High Risk Pregnancy

Perinatal/Hi-Risk Obstetrical

Pregnancy, labor and delivery account for a large proportion of care provided to Peach State Health Plan members. Those at high risk for complications of pregnancy and poor neonatal outcomes are provided care coordinati on services through our Perinatal Program. The goals of the program are to screen all pregnant women, identify, and coordinate care for pregnant women who are at high-risk for complications of pregnancy and assure that all members have access to appropriate care for diagnosis, monitoring, and treatment of pregnancy. Peach State Health Plan will provide educational opportunities to inform our Members about the benefits and risks associated with behaviors that may affect the outcome of their pregnancy and facilitate transitions to home when outcomes are less than ideal. We will provide educational opportunities and support for pregnant women and their partners about appropriate newborn care ,as well as identify pediatric providers, and access to care for their newborns.

When an event occurs resulting in an early delivery and resultant admission to a Neonatal Intensive Care Unit, our Case Manager will work with the hospital neonatal providers, discharge planners, and managing pediatric provider to ensure a smooth transition to home and coordination of ongoing follow-up care as needed.

Other disease case management programs will be developed based on the Georgia DCH requirements.

Providers are asked to contact a Peach State Health Plan Case Manager to refer a member identified in need of case management intervention:

Medical Management/Case Management
1-800-504-8573
Web address: www.pshp.com

Lead Case Management

Peach State Health Plan will provide Case Management services to all eligible children with blood lead levels (BLL) _> 10 ug/dL. Services will include family education about lead poisoning, assistance in obtaining lead abatement, coordination of testing of sibling of those children identified with high blood lead levels, scheduling of appointments, and transportation when needed. In addition, our CONNECTIONS Program provides direct outreach to parents/guardians to educate them on blood lead poisoning.

Peach State Health Plan Disease Management Programs

As a part of the Peach State Health Plan medical management quality improvement efforts, disease management programs are offered to members. Components of the programs available include but are not limited to:

- Increasing coordination between the medical, social and educational communities.
- Assuring that referrals are made to proper providers, including dental and/ or behavioral health providers.
- Improving levels of screening at birth and more consistent referrals to and from Early Intervention Programs.
- Encouraging family participation.
- Ensuring active and coordinated physician/ specialist participation.
- Identifying modes of delivery for coordinated care services such as, home visits, clinic visits, and phone contacts depending on the circumstances and needs of the child and his/her family.
- Increasing the member's and member's caregiver ability to self-manage chronic conditions.
- Provide appropriate education regarding the member's condition to promote understanding and adherence.
- Through appropriate education, coaching and encouragement of adherence to the physician's plan of care, increase the ability of the member and member's care giver to self-manage chronic conditions.

Chronic and Complex Conditions

Peach State Health Plan provides individual case management services for members who have chronic, complex, high-risk, high-cost or other catastrophic conditions. The Peach State Health Plan case manager will work with all involved providers to coordinate care, provide referral assistance, and other support as required. Peach State Health Plan also uses disease management programs and associated practice guidelines and protocols for members with chronic conditions, including conditions such as asthma and diabetes.
Members who qualify for chronic or complex case management services have an ongoing physical, behavioral or cognitive disorder, including chronic illnesses, impairments and disabilities.

The Peach State Health Plan case manager will coordinate care needs including behavioral health needs, assist in identifying and obtaining supportive community resources, and arrange for long-term referral services as needed. The case manager may identify (and a member may request) a specialist with whom a member with a chronic condition has an on-going relationship who may serve as the PCP and coordinate services on the member's behalf.

A member's PCP will develop a treatment plan with the member's participation and in consultation with any specialists caring for the member. The Peach State Health Plan Medical Director oversees these processes in accordance with state standards.

Peach State Health Plan encourages all PCPs and physicians to notify Peach State Health Plan Case Management when a member is identified that meets the criteria for a chronic or complex condition.

Asthma Program

The asthma disease management program targets all members with the diagnosis of asthma and members with asthma who are inappropriately using rescue medications, who are having repeated visits to the ER or are being admitted to the hospital for additional case management and support from the medial management department. Based on an assessment, the severity of the member's condition is determined. All members with the diagnosis of asthma receive educational materials; the greater severity of the member's condition, the greater the frequency of contacts and the number and complexity of interventions. Additional education and coordination of care with the member's PCP are key factors in this program. The goals of this program include increasing positive clinical outcomes for the member and controlling the asthma in order to improve the quality of life for the member.

Diabetes Program

This program targets Peach State Health Plan members who have been diagnosed and treated for diabetes mellitus. Members are then stratified based on the severity of their illness so that interventions can be targeted to the appropriate population. Through this program, Peach State Health Plan members can receive additional education, case management, and support from the medical management team to enhance positive clinical outcomes.

Practice GuIdelines and Protocols, Including Chronic Care

Peach State Health Plan clinical practice guidelines are based on the health needs and opportunities for improvement identified as part of the Quality Assessment Performance Improvement (QAPI) Program. The guidelines are based on valid and reliable clinical evidence formulated by nationally recognized professional organizations or government institutions, such as the NIH or a consensus of health care professionals in the applicable field. The guidelines consider the needs of the Members, are adopted in consultation with network providers, and are reviewed and updated periodically and at least every two years. The following Peach State Health Plan clinical practice guidelines available on the website include (but are not limited to) Asthma, Diabetes, Hypertension, Treatment of School-aged Children with ADHD and Depression. For a complete listing and access to the guidelines, please access our website, www.pshp.com. The guidelines are available upon request to members and providers.

New Technology

Peach State Health Plan evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and or Medical Management staff may identify relevant topics for review pertinent to Peach State Health Plan population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

In the instance where the request is made for coverage for new technology, which has not been reviewed by the CPC, the Peach State Health Plan Medical Director will review all information and make a determination within three (3) business days of receipt of all information. This new
technology request will then be reviewed at the next regular meeting of the CPC. If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management Department at 1-800-704-1483.

The DCH will be notified in writing thirty (30) days following any material change to the Medical Management Program.

Routine, Urgent and Emergency Services

Routine, Urgent and Emergency Care Services Defined

Members are encouraged to contact their PCP prior to seeking care, except in an emergency.

The following are definitions for **routine**, **urgent**, and **emergency services**.

Routine - Services to treat a condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting (e.g., physician's office) or by the patient. Examples include treatment of a cold, flu, or mild sprain.

Urgent* - Services furnished to treat an injury, illness, or another type of condition, including a behavioral health condition, usually not considered life threatening which should be treated within twenty-four (24) hours.

Emergency* - Services furnished to evaluate and/or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. An Emergency Medical Condition is a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious harm to self or others due to an alcohol or drug abuse emergency.
- Injury to self or bodily harm to others; or.
- With respect to a pregnant woman having contractions; (i) that there is not adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or unborn child.

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

Post-Stabilization Services: Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.

Post stabilization services will be considered complete when the following occurs:

- A plan physician with privileges at the treating hosipital assumes responisibility for the enrollee's (member) care.
- A plan physician assumes responsibility for the enrollee's (member) care through transfer.
- Or the enrollee (member) is discharged.

Stabilized: With respect to an emergency medical condition; that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to a woman in labor, the woman has delivered (including the placenta).

Discharge: Point at which member is formally released from hospital, by treating physician, an authorized member of the physician's staff or by the member after they have indicated in writing, their decision to leave the hospital contrary to the advice of their treating physician.

*Urgent, Emergency, or/and Post Stabilization Services does not require prior authorization or pre-certification. Emergency and Post Stabilization Services can be provided by a qualified Provider regardless of network participation. Peach State Health Plan is financially responsible for emergency and post stabilization regardless of network participation. Notification is require by next business day for members admitted in to the hospital, no prior authorization is required.

The PCP plays a major role in educating Peach State Health Plan members about appropriate and inappropriate use of hospital emergency rooms. The PCP is responsible to follow up on members who receive emergency care from other providers.

For billing information please refer to the General Billing Information and Guidelines section.

The attending emergency room physician, or the Provider actually treating the member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on Peach State Health Plan. However, Peach State Health Plan may establish arrangements with a hospital whereby Peach State Health Plan may send one of its own physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the member, provided that such arrangement does not delay the provision of emergency services.

Peach State Health Plan will not retroactively deny a physician claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. However, the prudent layperson test will be applied to the payment to the facility for charges which fall outside of the diagnoses codes identified by DCH as an emergency.

When a member is admitted from the emergency room, notification and clinical information is required by the next business day of the admission. For specific necessary information to submit, see the Inpatient Notification section of this manual.

Eligibility and Enrollment

Eligibility for the Peach State Health Plan Program

The State of Georgia has the sole responsibility for determining eligibility for the Medicaid program and whether Medicaid beneficiaries are eligible for enrollment in Georgia Families (GF). DCH or its Agent will determine eligibility for PeachCare for Kids® and will collect applicable premiums eligibility. Individuals that are not enrolled in the Georgia Medicaid program and are interested in applying for the Peach State Health Plan Program should be referred to the local DFCS office in the county in which the individual lives.

The member has an opportunity to select a primary care provider (PCP) with the assistance of a Selection Counselor. Individuals who do not make a voluntary PCP selection are assigned to a PCP via an automated assignment process that links the member with an appropriate PCP.

Member eligibility in Peach State Health Plan is effective at 12:01 a.m. on the first (1st) Calendar Day after the Member's selection or Auto Assignment to Peach State and may be confirmed by any of the Eligibility Verification systems described below. Eligibility categories are as follows:

- Low Income Families.
- Transitional Medicaid.
- Pregnant Women (Right from the Start Medicaid – RSM).
- Children (Right from the Start Medicaid – RSM).
- Children (newborn).
- Women Eligible Due to Breast and Cervical Cancer .
- Refugees – Individuals, as defined under O.C.G.A. § 38-3-3, including but not limited to those who have the required Immigration and Naturalization Service (INS) documentation.
- Planning for Health Babies 1115 Demonstration Waiver Participant.s
- PeachCare for Kids® – The Children's Health Insurance Program (CHIP) in Georgia.

Verifying Enrollment

Providers are responsible for verifying eligibility every time a member schedules an appointment, and when they arrive for services. PCPs should also verify that a member is their assigned member. To verify enrollment call the Provider Services Department at 1-866-874-0633

72 Hour Eligibility Rule

Providers will be required to verify member eligibility via the MMIS web portal at https://www.mmis.georgia.gov/portal/ prior to providing services to Peach State Health Plan members. Providers that verify eligibility and submit claims for services within 72 hours after the verification process will have their claims honored. Listed below are instructions and procedures that must be followed in order to comply with this policy:

- Eligibility verification must be completed via the MMIS web portal https://www.mmis.georgia.gov/portal/.
- Providers must print and maintain a valid copy of the eligibility screen shot and provide the information to the plan in the event that a claim reconsideration or appeal is required to process the claim. The screen shot must contain a date/time stamp in order to be considered valid.
- In order to reimburse providers for these services, in most case you will need to initiate an appeal and supply the plan with proof that verification was obtained via the GHP web portal within the 72 hour time frame.

Appeals should be submitted to:
Peach State Health Plan
P.O. Box 3000
Farmington, MO 63640-3812

Please Note: This policy only applies if the steps identified above are followed. As a reminder, Medicaid is the payer of last resort; therefore this policy does not supersede the CMS guidelines related to

Peach State Health Plan has the capability to receive an ANSI X12N 270 health plan eligibility inquiry and generate an ANSI X12N 271 health plan eligibility response transactions through Peach State Health Plan. Providers also may verify member enrollment through Peach State Health Plan's website at www.pshp.com. For more information on conducting these transactions electronically contact:

Peach State Health Plan
C/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at:
EDI@centene.com

Until the actual date of enrollment with Peach State Health Plan, Peach State Health Plan is not financially responsible for services the prospective member receives. In addition, Peach State Health Plan is not financially responsible for services members receive after their coverage has been terminated. However, Peach State Health Plan is responsible for those individuals who are Peach State Health Plan members at the time of a hospital inpatient admission and change health plans during that confinement.

Newborn Enrollment

Providers are encouraged to refer the mother to Peach State Health Plan to select a PCP for their newborn. A newborn enrollment packet will be mailed to all Peach State Health Plan expectant mothers. If the mother does not select a PCP after delivery, the mother's PCP will automatically be assigned to the newborn, unless the PCP is not accepting new members or the provider has age restrictions.

To make a PCP selection for the newborn, members should be referred to:

Member Services Department
1-800-704-1484
TDD/TTY 1-800-659-7487

All providers are also encouraged to direct the mother to her county caseworker to ensure the newborn is officially deemed eligible for the Peach State Health Plan program.

Newborn Payment Responsibility

Peach State Health Plan is responsible for payment of services for newborn infants born to Peach State Health Plan enrolled mothers until the newborn is discharged to a home environment. Listed below is additional information regarding payment responsibility for newborns: unless the mother chooses a different Medicaid plan.

- Inpatient care for newborns born on or after their mothers' effective date will be the responsibility of the mothers' assigned plan.
- Members that are enrolled with Peach State Health Plan and are hospitalized in an inpatient facility (acute care settings) will remain the responsibility of the plan until they are discharged to a home environment, even if they change to a different Medicaid Plan, or they become eligible for coverage under the FFS or another category of Medicaid eligibility during their inpatient stay. These members will remain the responsibility of their assigned plan for all covered service, even if the start date for eligibility is made retroactive to a date prior to the hospitalization.

- The payment responsibility includes services requiring the newborn to be transported to another healthcare facility for authorized treatment/care and subsequently returned to the original facility.

Frequently, Peach State Health Plan receives a claim(s) for a newborn prior to the state sending the member's eligibility information. Peach State Health Plan is committed to researching the newborn claims that are received to ensure that a claim is NOT denied for eligibility when the newborn is a Peach State Health Plan member.
In addition to other procedures that apply to claims, the following guidelines are used by Peach State Health Plan to help ensure that newborn claims do not deny for payment:

1. When the claims department receives a claim, the newborn's eligibility is verified. If no newborn eligibility is found, the claim is pended for thirty (30) days. The claims department will verify eligibility each day until the newborn's information is received from the state.

2. If after thirty (30) days there is still no record of the newborn information, then the claims department will notify the Eligibility Specialist.

3. The Eligibility Specialist will contact the state to obtain the information on the newborn.

4. At that time one of the following actions will be taken:
   - If the newborn is eligible with Peach State Health Plan per the state's portal, then the Eligibility Specialist will enter the newborn information manually and instruct the claims department to process the claim.
   - If the newborn is NOT eligible with Peach State Health Plan then the Eligibility Specialist will instruct the claims department to return the claim with a notice of newborn ineligibility.

The above describes Peach State Health Plan's general approach and is subject to modification in accordance with DCH policies.

Enrollment/Marketing Guidelines for Peach State Health Plan Providers

The Peach State Health Plan Provider agreement requires Providers to submit to Peach State Health Plan samples of any marketing materials they intend to distribute, and to obtain state approval prior to distribution or display. Peach State Health Plan's Provider Relations staff will submit these materials to DCH within two (2) business days of receipt, and will send Providers written notice of approval or of any changes required by DCH within two business days of receiving notice from DCH.

Peach State Health Plan providers must adhere to enrollment/marketing guidelines as outlined by DCH. Those guidelines include the following:

Providers cannot:

- Influence a member to choose one health plan over another.
- Influence members based upon reimbursement rates or methodology used by a particular plan.
- Enroll members in a plan unless the physicians' office, clinic or site has been designated by the state as an enrollment center.
- Distribute any marketing materials to a Peach State Health Plan member without prior approval from Peach State Health Plan and DCH.

Providers may:

- Stock and distribute only state approved Peach State Health Plan member educational materials to Peach State

Health Plan members.
- Inform the members of particular hospital services, specialists, or specialty care available in the Peach State Health Plan network.
- Assist a member in contacting Peach State Health Plan to determine if a particular specialist or service is available.
- Directly contact only Peach State Health Plan members with whom they have an established relationship.
- Encourage pregnant Peach State Health Plan members to select a PCP for their baby before the baby is born.

Non-Compliant Patients

There may be instances when a PCP feels that a member should be removed from his or her panel. All requests to remove a member from a panel must be made in writing, contain detailed documentation and must be directed to:

Peach State Health Plan
Member Services Department
Attention: Member Services Director
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA. 30339
1-800-866-0633
Fax: 1-800-659-7518
TDD/TTY 1-800-255-0056

Upon receipt of such request, the Member Services Director may:

- Interview the provider or their staff that are requesting the disenrollment, as well as any additional relevant providers
- Interview the member.
- Review any relevant medical records.
- Involve other Peach State Health Plan departments as appropriate to resolve the issue.

An example of a reason that a PCP may request to remove a member from their panel could include, but not be limited to:

A member is disruptive, unruly, threatening, or uncooperative to the extent that the member seriously impairs the provider's ability to provide services to the member or to other members and the member's behavior is not caused by a physical or behavioral condition.

A PCP should never request a member be disenrolled for any of the following reasons:

- Adverse change in the members health status or utilization of services which are medically necessary for the treatment of a member's condition.
- On the basis of the member's race, color, national origin, sex, age, disability, political beliefs or religion.
- Previous inability to pay medical bills or previous outstanding account balances prior to the member's enrollment with Peach State Health Plan.

Covered Services and Benefits for Peach State Health Plan Members

Peach State Health Plan is required to provide specific medically necessary services to its members. The following list provides an overview of covered services. Please refer to the current Georgia State Medicaid Plan and Georgia Medicaid Policies and Procedures Manual and DCH Bulletins and Banner Pages for further information on limitations and exclusions.

Covered services include:

This Information applies to Medicaid and PeachCare Kids® members

Service	Coverage Limits
Outpatient Surgical Services	
Hearing Services	Not covered for members age 21 or older. They are offered under EPSDT/Health Check.
Childbirth Education	
Preventive Dental Care • Fillings • Teeth cleaning • Bitewing X-rays Simple extractions	**Include:** Teeth cleaning for adults
Durable medical equipment ordered by a doctor. **This includes:** • Wheelchairs • Crutches • Walkers • Enteral products • Nebulizers • Medical supplies	Non-covered products under DME 1. Shakes 2. Meal Bars 3. Snack Bars 4. Supplement Thickeners 5. Cereals 6. Pudding 7. Vitamins/Minerals 8. Blended or pureed food in a personal care or LTC facility 9. Nutritional products as part of a reduced calorie diet for Diabetes, Gastric Bypass, Obesity or Bariatric Surgery 10. No separate reimbursement will be provided for facilities receiving per diem reimbursement
Early and Periodic Screening, Diagnostic and Treatment Services or EPSDT/Health Check	
Emergency Ambulance	
Emergency Services	
Family Planning Services	
Federally Qualified Health Centers	May have limits. Check the service you want in this chart.
Dialysis and services for end-stage renal disease. (Renal means kidney.)	

Service	Coverage Limits
Home health services or supplies received in your home. Services include: • Part-time nursing • Physical therapy • Home health aides	Must be ordered by a doctor. Services not covered are: • Social services • Chore services • Meals on wheels • Hearing services at home
Hospice care provided by a Medicaid hospice provider	Covered if the member is expected to live no longer than six (6) months.
Inpatient hospital services. Services include room and board. They also include drugs, lab tests and other services.	
Exams and treatments for children, which includes shots.	
Laboratory and Radiological Services	Not covered when they are: • Portable x-ray services. • Done by a business not certified to perform them. • Services must be done at a lab or x-ray facility.
Cenpatico Behavioral Health	Available as part of a written plan. Contact Cenpatico Behavioral Health for more information.
Nursing Midwife Services	
Nurse Practitioner Services	
Nursing Facilities	• 30 day or less when medically necessary. • Not covered: Long-term nursing facility (over 30 Consecutive Days)
Nurse visits in the home after the baby is born, if needed	
Obstetrical Services	
Pediatric Private Duty Home Nursing Services	When medically necessary for children approved for the Georgia Assistance Pediatric Program (GAPP) between hospital discharge and the start of GAPP coverage.
Occupational Therapy	These services are covered for children under age 21 as medically necessary. Therapy Services are covered for adults age 21 and older when medically necessary in the treatment of acute illness, injury or impairment when the condition is less than 90 days duration.
Vision Care	• Routine refractive services. • Optical devices. • One eye exam each year for members age 21 and over • Glasses once per year for members age 21 and over • Does not include contact lenses
Non-Emergency Transportation	Peach State Health Plan will set up rides for PeachCare for Kids® members.
Orthotic and Prosthetic. This includes artificial limbs and replacement devices.	Orthopedic shoes and support devices are covered when part of a leg brace. Hearing aids are not covered for members age 21 and older.

Service	Coverage Limits
Oral Surgery	Prior authorization is required
Outpatient Hospital Services. This means services you receive when you do not stay overnight.	Prior authorization may be required
Prescription Drugs	Certain drugs are not covered. Some over the counter drugs may be covered.
Physical Therapy	These services are covered for children under the age 21 as medically necessary Therapy Services are covered for adults age 21 and older when medically necessary in the treatment of acute illness, injury or impairment when the condition is less than 90 days duration.
Doctor and nurses' office visits. Visits must be for checkups, lab tests, exams or treatment.	
Podiatric Services	**The following are not covered:** • Flat feet (Unless authorized as a follow-up after surgery). • Subluxation. • Routine foot care. • Support devices. • Orthopedic shoes other than shoes that are an integral part of a brace • Preventative health care (Members under age 21 may receive this care through the EPSDT screening process.)
Pregnancy Services	
Private Duty Nursing Services	
Rural Health Clinic Services	
Second Medical Opinions	Must be provided by a doctor in the network. This is provided at no cost to the member.
Speech Therapy Services	These services are covered for children under the age 21 as medically necessary. Therapy Services are covered for adults age 21 and older when medically necessary in the treatment of acute illness, injury or impairment when the condition is less than 90 days duration.
Substance Abuse Treatment. Services include hospital care to stop drug or alcohol use.	Treatment is covered as part of a written plan. It includes inpatient and outpatient care.
Swing Bed Services	
Case Management Services	
Transplants – all recognized, non-experimental organ transplants are covered if deemed medically necessary for members under the age of 21.	These are not covered for members age 21 or older: • Heart • Lungs • Heart-lung

If you have any questions about these services or additional benefits, please contact:

Peach State Health Plan Provider Services
1-866-874-0633

Individuals with Disabilities Education Act (IDEA) and Individualized Education Plan (IEP) Services are only covered by Peach State Health Plan for members through the age of three (3) years old.

For members four (4) years or older requiring IDEA and IEP services benefits will be provided by traditional Medicaid.

*All Family Planning services should be provided on a voluntary and confidential basis to all members including those that are less than eighteen (18) years of age.

Role of a Dental Home

A dental home serves as the member's primary care dentist (PCD) for all aspects of oral health care. The PCD has an ongoing relationship with the member to provide comprehensive, continually accessible, coordinated and family-centered care. The PCD also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers, individuals who are general dentists, and pediatric dentists can serve as main dental homes.

All Members under age twenty-one (21) have access to Dentists within thirty (30) minutes or thirty (30) miles of the Member's home address for urban areas and within forty-five (45) minutes or forty-five (45) miles for rural areas who will serve as the Members' Dental Home. The Dental Home is inclusive of all aspects of oral health and involves parents, the patient, dentists, dental professionals, and non-dental professionals. The Dental Home is the Primary Dental Provider who has accepted the responsibility for providing or coordinating the provision of all dental care services covered under Peach State Health Plan.

Value Added Benefits for Peach State Health Plan Members

Peach State Health Plan has developed a package of Value Added Services for Medicaid and PeachCare for Kids® that will enhance member benefits beyond the DCH Covered Services. The Value Added Services below exceed DCH benefits and were designed to improve members' wellbeing, encourage responsible and prudent use of health care benefits, and enhance the cost effectiveness of the Georgia Families and PeachCare for Kids® programs.

NurseWise is Peach State Health Plan's 24-hour, toll-free nurse triage and education phone service through which callers can reach both customer service and bilingual nursing staff. The hotline provides access to a broad range of services including health education, urgent pharmacy refills, and transportation for treatment and crisis interventions. It promotes member responsibility and prudent use of healthcare resources and improves the overall quality of member care. Integration of NurseWise and Peach State Health Plan telecommunications systems, tracking software, databases, and business processes facilitate speedy and seamless member and provider after hour's hotline services.

START SMART for Your Baby®

START SMART for Your Baby (START SMART) is our special program for women who are pregnant. This program provides educational materials that tackle the most critical issues affecting the child's development during pregnancy. START SMART offers a preventive approach that encourages prenatal education for the expectant mother in an effort to achieve the best possible outcome. START SMART encourages pregnant women to keep their prenatal care appointments; educates members and their families about pregnancy; identifies members who may be at high risk for developing complications; and provides support in dealing with medical, socioeconomic and environmental issues that may contribute to complications.

Identifying pregnant members as early as possible, providing them with adequate prenatal care and guidance as well as addressing complications as effectively as possible should result in improved outcomes for both the mother and the newborn.

Dental Services

Peach State Health Plan will provide emergency dental services for members age 21 and older.

Vision Services

Peach State Health Plan covers vision care for members. We have improved this benefit. Once a year, Peach State Health Plan will pay $40 towards new eye glasses. The member will have to pay the costs over this amount.

Services include:

- Free eye exam and one pair of standard glasses once a year for members with no co-pay.
- Free office visits. No office copay for PeachCare for Kids® members age six and under.
- 20% discount on a second pair of glasses or sunglasses.
- $50 allowance towards glasses, or broken frames in addition to what is covered by Medicaid.
- Free vision supplies. This includes eye drops as well as other preventative over the counter supplies. Contacts lenses are only covered when they are medically necessary.

Transportation Services

To arrange transportation for a Medicaid or PeachCare for Kids® member, the member should contact the Non-Emergency Transportation (NET) vendor that services the member's home county.

Urgent same day or next day transportation is available for an acute
sick visit to the primary care provider (PCP) or urgent care center, or if discharged from the hospital. In situations where urgent transportation
is needed and cannot be coordinated with the NET vendor in a timely fashion, Peach State Health Plan Member Services Representatives will coordinate transportation arrangements.

Member Services Department
1-800-704-1484
TDD/TYY 1-800-659-7487

NET regions and contact information:

Atlanta: 404-209-4000 (Southeastrans)
Central: 1-888-224-7981 (LogistiCare)
Southwest: 1-888-224-7985 (LogistiCare)
North: 1-866-388-9844 (Southeastrans)
Southeast: 1-888-224-7988 (LogistiCare)
East: 1-888-224-7988 (LogistiCare)
PeachCare for Kids® provides transportation for members in all of the six regions. Call Southeastrans at 1-800-657-9965 at least 3 days before your appointment to schedule transportation. Urgent same day or next day transportation is available for acute sick visit to primary care provider (PCP) or urgent care center, or if discharged from the hospital.

Domestic Violence

Peach State Health Plan's members may include individuals at risk for becoming victims of domestic violence. Thus, it is especially important that providers are vigilant in identifying these members. Member Services can help members identify resources to protect them from further domestic violence.

For Georgia residents, you may refer victims of domestic violence to the Georgia Domestic Violence Network hotline, at **1-800-33-HAVEN (334-2836)** for information about local domestic violence programs and shelters within the state of Georgia.

Providers should report all suspected domestic violence as described. State law requires reporting by any person if he or she has "reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse". Such reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Report any suspected child abuse or neglect immediately to Children's Services at the appropriate county.

EPSDT

Georgia EPSDT Services and Standards

EPSDT, otherwise known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, is a program of comprehensive preventive health services available to Medicaid recipients less than 21 years of age and PeachCare for Kids® children less than 19 years of age. The program is designed to maintain health by providing early intervention to discover and treat health problems. Peach State Health Plan's EPSDT benefit provides preventive services and medically necessary diagnostic and treatment services to include medical, hearing, vision, dental, mental and substance abuse services.

Preventive health is a major principal on which care management organizations are based, measured, and held accountable. It is the responsibility of Peach State Health Plan to encourage EPSDT eligible Peach State Health Plan covered recipients to participate in the EPSDT program. Peach State Health Plan provides information and education about the need for an EPSDT preventive medical and dental examination to all EPSDT eligible members. EPSDT services include:

- Outreach and informing.
- Screening in accordance with the Bright Futures schedule and ACIP schedule.
- Tracking compliance with EPSDT requirements.
- Diagnostic and treatment services.

Education includes (but is not limited to) the need for each EPSDT preventive health visit to include:

- A comprehensive health and developmental history (including assessment of both physical and mental health development).
- A comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate exam).
- Appropriate immunizations (according to the schedules established by the ACIP for individuals 0 – 18 years of age and nineteen (19) and older).
- Laboratory tests (including blood lead level assessment appropriate to age and risk screening).
- Health education (including anticipatory guidance).
- Measurements (including head circumference for infants and body mass index).
- Sensory screening (vision and hearing).
- Oral health assessment.
- Sexually Transmitted Infection/ Human Immunodeficiency Virus (STI/HIV) screening.
- Screening for mental health and substance abuse.

Peach State Health Plan provides to each PCP on a monthly basis, a list of the PCP's EPSDT eligible children that have not had an encounter during the initial ninety (90) calendar days of Peach State Health Plan enrollment, and/or are not in compliance with the Bright Futures periodicity schedule. PCPs are required to outreach to members via phone/ mail to encourage them to schedule and keep their preventive visits and/or follow up visit appointments.

PCPs are required to perform EPSDT preventive medical check-ups in their entirety and at the required intervals in accordance with the most current Peach State Health Plan adopted Bright Futures Schedule. All components of exams must be documented and included in the medical record of each EPSDT eligible member. Initial EPSDT preventive medical exams are to be completed within ninety (90) days of the initial effective date of membership and within twenty-four (24) hours of birth and prior to discharge for all newborns. PCPs should provide inter-periodic screens, which are screens that occur between the complete periodic screens and are Medically Necessary to determine the existence of suspected physical or mental illnesses or conditions. This includes at a minimum vision and hearing services. An inter-periodic visit may be performed only for vision or hearing services. EPSDT services are free.

The frequencies of these visits are as follows:

- Ten (10) EPSDT preventive medical exams should be provided from birth through the day before the child's second birthday. Seven (7) of those exams should be performed from birth through the day before the child's first birthday. The other three (3) exams should be performed at 12 months, 15 months and 18 months of age.
- From the child's third birthday and up to the day prior to the individual's 21st birthday, an EPSDT preventive medical exam should be provided annually or one per **AGE**.

Immunizations

Children must be immunized during medical checkups according to the current Advisory Committee for Immunization Practices (ACIP) Schedule. The current 0 – 6 years, 7 – 18 and older and the "catch-up" schedule can be found at the following website: http://www.cdc.gov/vaccines/schedules. Peach State requires all EPSDT eligible members to be immunized by their PCP unless medically contraindicated. Providers must report all immunizations to the Georgia Registry of Immunization Transactions and Services (GRITS) in accordance with Georgia law.

Peach State Health Plan follows the current American Academy of Pediatric Dentistry (AAPD) dental periodicity schedule (Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents). PCPs should refer children to a dentist at the first tooth eruption and no later than 12 months of age.

Vaccines for Children (VFC)

Vaccines for Children (VFC) is a vaccine supply program, which is state operated and federally funded. VFC supplies federally purchased vaccines at no cost to VFC-enrolled providers to be administered to members ages birth through 18 years of age. Peach State Health Plan providers must enroll in VFC and must use VFC vaccines for members who are eligible for them. An administration fee is the only reimbursement a provider will receive for administering vaccines otherwise available through the VFC program. PeachCare for Kids® members must receive state purchased vaccines. Members 19 years of age and older are not eligible to receive vaccine supplies through the VFC program. VFC provider enrollment is conducted directly by the VFC program and an enrollment package can be obtained by contacting VFC by phone at 404-657-5013 or 1-800-848-3868, or by fax at 404-657-5736 or 1-800-372-3627.

To view the most recent list of VFC covered vaccine codes, please refer to The Department of Community Health "Part II Policies and Procedures for EPSDT Services" Appendix C.

For members nineteen (19) years of age through twenty (20) years of age, VFC stock is not available. Providers must use their own stock of vaccines for these Peach State Health Plan eligible members. Peach State Health Plan reimburses for the vaccine product and for administration when vaccines are administered to members nineteen (19) years of age through twenty (20) years of age.

Blood Lead Screening

Since 1989, Federal law has required that children enrolled in Medicaid and PeachCare for Kids must have their blood lead level measured at **12 and 24 months of age.** Children between the ages of **36 and 72 months of age** must receive a blood lead test immediately if they have not been previously tested for lead poisoning.
A blood lead test, capillary or venous, must be used when screening children. A capillary Blood Lead Test that is elevated (≥ 10ug/dL reported by a certified lab or ≥ 6ug/dL with the Lead Care II analyzer) must be confirmed with a repeat Blood Lead Test (confirmatory venous specimen is preferred) at a certified laboratory.

Please note that completing a lead risk assessment questionnaire does not count as a blood lead screening.
PCP's should refer any EPSDT eligible member with a positive blood lead test equal to or greater than ten (10) micrograms per deciliter to Peach State Health Plan's case management services.

Referrals for Treatment

When a preventive health screening examination indicates the need for further evaluation of a Member's health, the Referral for diagnosis must be made without delay. The PCP must either treat (if qualified) or refer all members with abnormal findings for treatment. Follow-up is required to ensure that the Member receives a complete diagnostic evaluation.

EPSDT Records Submission

Peach State Health Plan providers may submit medical record evidence to the plan to demonstrate member compliance with EPSDT services that are identified as non-compliant. This can be done using the Provider Secure Portal (Portico) or through fax. Please submit (faxed) Medical records to Peach State Health Plan EPSDT Department.
Medical Records Submission (Fax): 1-877-250-5497

EPSDT Services Manual

For complete requirements and expectations, please refer to The
Department of Community Health "Part II Policies and Procedures for EPSDT Services (EPSDT)" Manual. This manual is updated quarterly and can be found at the below link: www.mmis.georgia.gov

Behavioral Health Services

Peach State Health Plan offers our members access to all covered, medically necessary behavioral health services through Envolve PeopleCare™.

Peach State Health Plan members seeking mental health or substance abuse services may self-refer to a network provider for thirty (30) standard outpatient sessions per member but prior authorization is required for subsequent visits. For assistance in identifying a behavioral health provider or for prior authorization for inpatient or outpatient services, Envolve PeopleCare™ may be reached at **1-800-947-0633**.

In the event that the Community Service Board, physician, or practitioner is unable to provide timely access for a member, CBH will assist in securing authorization to a physician or practitioner to meet the member's needs in a timely manner.

Communication with the Primary Care Provider

Peach State Health Plan will require Cenpatico Behavioral Health providers to send initial and quarterly (or more frequently if clinically necessary) summary reports of a member's behavioral health status to the PCP, with the member's or the member's legal guardian's consent. The coordination of care for a member should be clearly documented in the member's chart. Reports such as this, will be reviewed during quality audits conducted by Cenpatico.

Cenpatico encourages primary care providers (PCPs) to consult with their members' mental health providers. In many cases the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required.

Providers can identify the name and number for a member's PCP on the front-side of the Member ID Card. Providers should refer members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment.

Providers should communicate not only with the member's PCP whenever there is a behavioral health problem or treatment plan that can affect the member's medical condition or the treatment being rendered by the PCP, but also with other behavioral health clinicians who may also be providing service to the member. Examples of some of the items to be communicated include:

- Prescription medication, especially when the medication has potential side effects, such as weight gain, that could complicate medical conditions, such as diabetes;
- The member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment;
- The member has lab work indicating need for PCP review and consult
- The member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (panic symptoms can be confused with heart attack symptoms); and
- The member's progress toward meeting the goals established in their treatment plan.

Cenpatico provides a form for your convenience in communicating with a member's PCP and other providers, which is available on the Cenpatico website. Cenpatico recommends that you use all available communications means to coordinate treatment for members in your care. All communication attempts and coordination activities must be clearly documented in the member's medical record.

Cenpatico requires that providers report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the provider's responsibility to keep the member's PCP abreast of the member's treatment status and progress in a consistent and reliable manner. When applicable, such consent shall meet the requirements set forth in 42 CFR 2.00 et seq. If the member requests this information not be given to their PCP, the provider must document this refusal in the member's treatment record, and if possible, the reason why.

The following information should be included in the report to the PCP:

- A copy or summary of the intake assessment.
- Written notification of member's noncompliance with treatment plan (if applicable).
- Member's completion of treatment.
- The results of an initial psychiatric evaluation, and initiation of and major changes in psychotropic medication(s) within fourteen (14) days of the visit or medication order.
- The results of functional assessments.

Caution must be exercised in conveying information regarding substance use disorders, which is protected under separate federal law. Cenpatico monitors communication with the PCP and other caregivers through audits. Failure to adhere to these requirements can be cause for termination from the network.

Coordination of Care

Cenpatico's coordination of care process is designed to ensure the coordination and continuity of care during the movement between providers and settings. During transitions, patients with complex medical needs are at risk for poorer outcomes due to medication errors and other errors of communication among the involved providers and between providers and patients/caregivers.

Continuity of healthcare means different things to different types of caregivers, and can be of several types:

- Continuity of information. It includes that information on prior events is used to give care that is appropriate to the patient's current circumstance.
- Continuity of personal relationships. It includes recognizing that an ongoing relationship between patients and providers is the foundation that connects care over time and bridges discontinuous events.
- Continuity of clinical management.

General Billing Information and Guidelines

Physicians, other licensed health professionals, facilities, and ancillary provider's contract directly with Peach State Health Plan for payment of covered services.

It is important that providers ensure Peach State Health Plan has accurate billing information on file. Please confirm with your Provider Relations Department that the following information is current in our files:

- Provider Name (as noted on his/her current W-9 form).
- Valid, unique GA Medicaid ID Number for each practicing location.
- Physical location address (as noted on current W-9 form).
- Billing name and address (if different).
- Tax Identification Number.
- Provider NPI.

Providers must bill with both their provider Taxonomy Code and NPI in box 24J. In addition, you must include your ID qualifier in box 24I for the Taxonomy Code. Peach State Health Plan will return claims when billing information does not match the information that is currently in our files. Claims missing the requirements in bold will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be entered into the system.

We recommend that providers notify Peach State Health Plan in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's Tax Identification Number and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service.
- The service provided is a covered benefit under the member's contract on the date of service.
- Referral and prior authorization processes were followed.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual.

Reimbursement Policies

Peach State Health Plan considers a variety of resources when developing its reimbursement policies including Department of Community Health guidelines, Centers for Medicare & Medicaid Services (CMS) guidelines, National Correct Coding Initiative standards, Industry-Standard Reimbursement Logic and other Correct Coding Methodology. Peach State Health Plan reimbursement policies apply to all professionals who deliver health care services to Peach State Health Plan members.

Peach State Health Plan routinely reviews its reimbursement policies to ensure providers are reimbursed for services rendered based on regulatory requirements and industry standards. Peach State Health Plan may modify reimbursement policies periodically by publishing a new version of the policy on Peach State Health Plan website. Providers are encouraged to routinely refer to the Peach State Health Plan website for information regarding current health plan reimbursement policies, billing guidelines and for updates regarding reimbursement policy changes. To review Peach State Health Plan's current Reimbursement policies visit the Peach State Health Plan Payment Policy Library located at: http://www.pshpgeorgia.com/for-providers/provider-resources/provider-manuals/.

Timely Filing Requirements

All claims must be received by the plan within six (6) months from the month the service was provided in order to be considered for payment. Claims received after this time frame will be denied for failure to file timely.

Claims that have been denied due to erroneous or missing information must be received within six (6) months from the month in which the service was rendered or within three (3) months of the month in which the denial occurred, whichever is later. In order to be considered the denied claim must be resubmitted with corrected information electronically or via paper. When resubmitting a denied claim the appropriate corrected claim resubmission code and original claim number must be included. Corrected claims should be submitted as follows:

- CMS-1500 should be submitted with the appropriate resubmission code (value of 7) in Box 22 of the paper claim with the original claim number of the corrected claim and a copy of the original Explanation of Payment (EOP). EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.
- UB-04 should be submitted with the appropriate resubmission code in the third digit of the bill type (for corrected claim this will be 7), the original claim number in Box 64 of the paper claim and a copy of the original EOP. EDI 837I data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

Claim Adjustment

Providers may resubmit a claim(s) to correct a simple billing error or to request an adjustment if you believe the payment made by the plan is incorrect. In order to be considered for payment claims in this category must be received within six (6) months from the month in which the service was rendered or within three (3) months of the month of payment on the EOP, which is later. When submitting a claim adjustment ensure that the appropriate corrected claim resubmission code and original claim number are included on the claim to help us identify that this is a resubmission of an existing claim. A Provider Adjustment form must be completed for all resubmission requests along with the supporting documentation. Your claim will be reviewed and a decision rendered based on the information provided. The filing limit may be extended for newborn claims, when Peach State Health Plan is the secondary payor.

The filing limit may be extended for newborn claims where the eligibility has been retroactively received by Peach State Health Plan, up to a maximum of 365 days.

Electronic Claims Submission

Network providers are encouraged to participate in Peach State Health Plan's Electronic Claims/Encounter Filing Program through Centene. Centene has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, Centene has the capability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). For more information on electronic filing, contact:

Peach State Health Plan
c/o Centene EDI Department
1-800-225-2573, extension 25525
Or by e-mail at:
EDI@centene.com

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims.

Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Peach State Health Plan dental claims should be submitted to:

Envolve Dental - GA Claims
P. O. Box 22085
Tampa, FL 33622-2085
Dental Provider Services - 1-844-464-5632

Peach State Health Plan vision claims should be submitted to:

Claims Submissions
Vision Claims Department
P.O. Box 7548
Rocky Mount, NC 27804
Vision Provider Services – 866-458-2139

Cenpatico Behavioral Health claims should be submitted to:

Peach State Health Plan
P.O. Box 6700
Farmington, MO 6340-3816

Peach State Health Plan
c/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at: EDI@centene.com

Paper Claims Submission

For Peach State Health Plan members, all claims and encounters, with the exception of those services listed as "carve outs" i.e., routine dental services, routine vision services, outpatient mental health services, outpatient chemical dependency and outpatient substance abuse services should be submitted to:

Peach State Health Plan
P.O. BOX 3030
Farmington, MO 63640-3805
ATTN: CLAIMS DEPARTMENT

Peach State Health Plan dental claims should be submitted to:

Envolve Dental - GA Claims
P. O. Box 22085
Tampa, FL 33622-2085
Dental Provider Services - 1-844-464-5632

Peach State Health Plan vision claims should be submitted to:

Claims Submissions
Vision Claims Department
P.O. Box 7548
Rocky Mount, NC 27804
Vision Provider Services – 866-458-2139

Cenpatico Behavioral Health claims should be submitted to:

Peach State Health Plan
P.O. Box 6700
Farmington, MO 63640-3816

Imaging Requirements

Peach State Health Plan uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's

- Do use the correct PO Box number.
- Do submit all claims in a 9" x 12", or larger envelope.
- Do type all fields completely and correctly.
- Do use black or blue ink only.
- Do submit on a proper form . . . CMS 1500 or UB 04.

Don'ts

- Don't submit handwritten claim forms.
- Don't use red ink on claim forms.
- Don't circle any data on claim forms.
- Don't add extraneous information to any claim form field.
- Don't use highlighter on any claim form field.
- Don't submit photocopied claim forms.
- Don't submit carbon copied claim forms.
- Don't submit claim forms via fax.

Clean Claim Definition

Peach State Health Plan uses DCH's definition of a clean claim. A clean claim means a claim received by Peach State Health Plan for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Peach State Health Plan. The following exceptions apply to this definition: (a) a claim for payment of expenses incurred during a period of time for which premiums are delinquent; (b) a claim for which fraud is suspected; and (c) a claim for which a Third Party Resource should be responsible.

Non-Clean Claim Definition

Non-clean claims are submitted claims that require further investigation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

What is an Encounter Versus a Claim?

You are required to submit an encounter or claim for each service that you render to a Peach State Health Plan member. See the definitions below:

- If you are the PCP for a Peach State Health Plan member and receive a monthly capitation amount for services, you must file a "proxy claim" (also referred to as an "encounter") on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the "proxy claim" or "encounter" is paid at zero dollar amounts. It is mandatory that your office submits all encounter data. Peach State Health Plan utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by the State of Georgia and by Centers for Medicare and Medicaid Services (CMS).
- A claim is a request for reimbursement submitted either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an Explanation of Payment (EOP) will be mailed to the provider who submitted the original claim.

Claims and Encounter Codes

Providers must follow the submission procedures outlined in the Georgia EPSDT Policies and Procedures Manual located on the DCH website.

- Providers are required to utilize standard claims and encounter codes listed in the State manual. A list of EPSDT codes is provided in Appendix C of the DCH Georgia EPSDT Policies and Procedures Manual.
- Peach State Health Plan will NOT accept homegrown codes. Claims that are submitted with homegrown codes will be denied.
- PCPs must provide an initial visit for all pregnant Members within fourteen (14) calendar days as required by DCH regulations.
- PCPs must demonstrate compliance with the EPSDT periodicity schedule and screening requirements (including blood lead screening) for at least 80% of their eligible members, in accordance with the methodology prescribed by the Centers for Medicare and Medicaid Services.

Providers should pay particular attention to the following items when submitting EPSDT Claims and encounter data. These items will ensure your claim/encounter data is complete and promptly processed.

- Box 14 on the CMS 1500 should be used for the provider to indicate the date of the last menstrual period (LMP) for pregnant members.
- Pregnant members are exempt from co-payments, therefore when billing for care provided to pregnant Peach State Health Plan members you must include the following information:

  Place a "P" in field 24h of the CMS 1500 Form and
  Place a "P" in field 80 of the UB-04.
  Billing with the "P" is required to ensure that a co-payment is not deducted for pregnant members in accordance with the Georgia Medicaid guidelines.
  For additional information regarding this requirement, please visit www.ghp.ga.gov and reference Banner Message ACSBNR07082005_3, Changes to Member Co-payments, dated July 08, 2005. Additional information is also available in Appendix Q of the Part II Policies and Procedures for Physicians Services Manual, also located on the GHP website.
- Administration codes (for vaccines) themselves are not reimbursable. The provider must bill the vaccine code, and is paid a rate based on the type of vaccine administered (single or multi-antigen).
- Claims submitted with an Administration code will be denied for payment.

Procedures for Filing a Claim/Encounter Data

Peach State Health Plan encourages all providers to file claims/encounters electronically. See "Electronic Claims Submission" in this section for more information on how to initiate electronic claims/encounters.

Please remember the following when filing your claim/encounter:

- All documentation must be legible.
- PCPs and all participating providers must submit claims or encounter data for every member visit, even though they may receive a monthly capitation payment.
- Provider must ensure that all data and documents submitted to Peach State Health Plan, to the best of your knowledge, information, and belief, are accurate, complete, and truthful.
- All claims and encounter data must be submitted on either form CMS 1500, UB 04, or by electronic media in an approved format.
- Review and retain a copy of the error report that is received for claims that have been submitted electronically, then correct any errors and resubmit with your next batch of claims.
- All claims must be received by the plan within six (6) months from the month the service was provided in order to be considered for payment. Claims received after this time frame will be denied for failure to file timely.

Timely Resubmission

Claims that have been denied due to erroneous or missing information must be received within six (6) months from the month in which the service was rendered or within three (3) months of the month in which the denial occurred, whichever is later.

In order to be considered the denied claim must be resubmitted with corrected information via the website or via paper. When resubmitting a denied claim on paper more than six (6) months after the month of service, a copy of the EOP with the denial must be attached to demonstrate that the original claim was submitted timely.

Claim Adjustment

Providers may resubmit a claim(s) to correct a simple billing error or to request an adjustment if you believe the payment made by the plan is incorrect. In order to be considered for payment claims in this category must be received within six (6) months from the month in which the service was rendered or within three (3) months of the month of payment on the EOP, which is later.

Please include the appropriate corrected claim resubmission code and original claim number are included on the claim to help us identify that this is a resubmission of an existing claim. A Provider Adjustment form must be completed for all resubmission requests along with the supporting documentation. Your claim will be reviewed and a decision rendered based on the information provided.

COB Timely Filing

Claims originally filed timely with a third party carrier must be received within 180 days of the date of the primary carrier's EOP, but never more than twelve (12) months from the month of service.

Common Billing Errors

In order to avoid rejected claims or encounters always remember to:

- Use SPECIFIC CPT-4 or HCPCS codes. Avoid the use of non-specific or "catch-all" codes (i.e. 99070).
- Use the most current CPT-4 and HCPCS codes. Out-of-date codes will be denied.
- Use the 4th or 5th digit when required for all ICD-10 codes.
- Submit all claims/encounters with the proper provider number.
- Submit all claims/encounters with the member's complete Medicaid/PeachCare number or the member's Peach State Health Plan ID number.
- Verify other insurance information entered on claim.
- The 11 digit National Drug Code (NDC) must be reported on all qualifying claim forms when injectable drugs are administered in the office/outpatient setting; excluding applicable vaccines/immunizations. Failure to submit the exact applicable NDC (do not report 99999999999 to bypass edit) administered to the member will result in front-end rejection and/or denial of claims. When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug for the specified detail line.
  - Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.
  - If you are given an NDC that is less than 11 digits, add the missing digits as follows:
    - For a 4-4-2 digit number, add a 0 to the beginning.
    - For a 5-3-2 digit number, add a 0 as the sixth digit.
    - For a 5-4-1 digit number, add a 0 as the tenth digit.
  - Example: N412345678901UN2000.

Code Auditing and Editing

Peach State Health Plan uses HIPAA compliant code-auditing software to assist in improving accuracy and efficiency in claims processing, payment, and reporting. The code auditing software will detect, correct, and document coding errors on provider claims prior to payment. Our software will analyze HCPCS Level 1/CPT-4 codes (5-digit numeric coding system which applies to medical services delivered); HCPCS Level II codes (alpha-numeric codes which apply to ambulance services, medical equipment, supplies and prosthetics); CPT Category II ("F" codes used for tracking purposes) and CPT Category III ("T" codes or temporary codes used for new and emerging technologies) and healthcare industry standard modifiers against correct coding guidelines. These guidelines have been established by the American Medical Association (CPT, CPT Assistant, and CPT Insider View) and the Centers for Medicare and Medicaid Services (CMS).

In order to maintain its high standard of clinical accuracy, credibility and physician acceptance, our code-auditing software's audit it logic is reviewed on a regular basis to keep current with medical practice, coding practices, revisions to the CPT Manual, CMS updates and universally accepted specialty society guidance.

Inherent within the code auditing software product is the clinical knowledge base or edit logic which is used to determine reimbursement recommendations. The clinical knowledge base contains the definitions, rules, functions and auditing logic which is based on generally accepted principles of coding medical services for reimbursement. Our code-auditing software is not designed to make reimbursement or payment decisions. Instead, the software will offer a recommendation (auditing action) that is applied to the claim when a provider's coding pattern is unsupported by a coding principle.

Reimbursement/payment decisions will continue to be based on the fee schedules and contract agreements between the provider and the Plan. Furthermore, while the code-auditing software has been designed to assist in evaluating the accuracy of procedure coding; it will not evaluate medical necessity. Peach State Health Plan may request medical records or other documentation to assist in the determination of medical necessity, appropriateness of the coding submitted, or review of the procedure billed.

When an edit recommendation is made on your submitted code(s), we will provide a general explanation of the reason for the edit which will be detailed on your Explanation of Payment (or remittance advice). The following list gives examples of conditions where the code-auditing software will make a recommendation on submitted codes:

Unbundling: Procedure unbundling occurs when a provider submits a global CPT/HCPCS code along with other CPT/HCPCS codes that are considered included in the global code billed.

Fragmentation: The separate billing of component codes of a procedure without listing the more comprehensive code.

Modifier to Procedure Code Validation: Claim lines submitted with modifiers invalid for the submitted procedure codes listed on the claim.

Age/Gender: Submitting procedure codes inappropriate for the member's age or gender because of the nature of the procedure.

Assistant Surgeon: Procedure codes submitted with an assistant surgeon modifier, 80, 81, and 82 or AS that typically do not require an assistant surgeon.
Add on Without Base Code: Submitting an add-on procedure code as a stand-alone code without the primary procedure code billed on the claim or a historical claim.

Duplicate Procedure Edits: CPT codes that contain terminology that does not warrant multiple submissions of the code (i.e., unilateral, unilateral/bilateral, single/multiple) or procedure codes which would not normally be reported in duplicate.

Bilateral: Identifies a claim line where a procedure code has been billed with/without a modifier 50, where a historical claim was found that was billed with the same procedure code, and with the modifier 50. The software will recommend a denial of the second submission.

Global Surgical Period (pre-op, post-op and same day rules):
Addresses payment/non-payment of evaluation and management services billed during the global surgical period of another procedure.

Evaluation and Management Editing: Identifies certain diagnostic tests/studies which are a component of the E/M service billed and should not be reported separately.

Modifier Additions: Identifies professional services that should have been billed with the 26 modifier for the procedure performed and the place of service.

Knowledge Base Auditing and Rules

Peach State Health Plan's code-auditing software audits against both professional claims and outpatient facility claims. The software's "knowledge base" contains auditing logic and rules based on accepted principles regarding the manner by which medical services should be coded for reimbursement. That being said, if the software recommends an auditing action (edit) against a claim line, a rule is fired which corresponds to a coding principle. The code auditing software's knowledge base contains coding principles based on coding standards developed by the Center for Medicare and Medicaid Services (CMS); the American Medical Association's Current Procedural Terminology (CPT Manual, CPT Assistant, CPT Insider View); specialty society guidelines such as the American College of Surgeons, American College of Radiology, and the American Academy of Orthopedic Surgeons.

Using a comprehensive set of rules, the code auditing software provides consistent and objective claims review by:

- Accurately applying coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology and anesthesiology as outlined by the American Medical Association's (AMA) CPT-4 manual.

- Evaluating the CPT-4 and HCPCs codes submitted by detecting, correcting and documenting coding inaccuracies including, but not limited to, unbundling, upcoding, fragmentation, duplicate coding, invalid codes, and mutually exclusive procedures.
- Incorporating Historical Claims Auditing (HCA) functionality which links multiple claims found in a patient's claims history to current claims to ensure consistent review across all dates of service.

Billing Codes

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent denial in payment. Submit professional claims with current, valid CPT-4, HCPCS and ICD-10 codes. Submit institutional claims with valid Revenue codes and CPT-4 or HCPCS (when applicable), ICD-10 and DRG codes (when applicable).

Providers will also improve the efficiency of their reimbursement through proper coding of a patient's diagnosis. We require the use of valid ICD-10 diagnosis codes, to the ultimate specificity, for all claims. The highest degree of specificity or detail, can be determined by using the Tabular list (Volume One) of the ICD-10 code manual in addition to the Alphabetic List (Volume Two) when locating and designating diagnosis codes.

In addition, written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Peach State Health Plan.

Claim Payment

Non-clean claims will be adjudicated (finalized as paid or denied) within thirty (30), business days from the date of the original submission. Non-clean claims will be adjudicated (finalized as paid or denied) within thirty (30) days of receipt of the electronic claim.

No later than the fifteenth (15th) business day after the receipt of a provider claim that does not meet Clean Claim requirements, Peach State Health Plan will pend the claim and request additional information through the Peach State Health Plan Website or Explanation of Benefits for all outstanding information such that the claim can be deemed clean. Upon receipt of all the requested information from the provider, Peach State Health Plan will complete processing of the claim within fifteen (15) business days.

Claims pended for additional information must be closed (paid or denied) by the thirtieth (30") calendar day following the date the claim is pended if all requested information is not received prior to the expiration of the 30-day period. Peach State Health Plan will send providers written notification via the Website or an Explanation of Benefits for each claim that is denied, including the reason(s) for the denial, the date contractor received the claim, and a reiteration of the outstanding information required from the provider to adjudicate the claim.

Peach State Health Plan shall process, and finalize, all appealed claims to a paid or denied status within thirty, (30) days from the date of denial of claim payment.

Note: It is the provider's responsibility to check their audit report to verify that Peach State Health Plan has accepted their electronically submitted claim.

Clean claims will be adjudicated (finalized as paid or denied) within fifteen (15) business days of the receipt of the claim. Non-clean claims will be adjudicated (finalized as paid or denied) within thirty (30) days of receipt of the electronic claim.

Claims pended for additional information must be closed (paid or denied) by the thirtieth (30") calendar day

following the date the claim is pended if all requested information is not received prior to the expiration of the 30-day period. Peach State Health Plan will send providers written notification via the website or an Explanation of Benefits for each claim that is denied, including the reason(s) for the denial, the date contractor received the claim, and a reiteration of the outstanding information required from the provider to adjudicate the claim.

Unsatisfactory Claim Payment

If a provider has a question or is not satisfied with the information they have received related to a claim, they should contact: Provider Services Department 1-866-874-0633

- When submitting a paper claim for review or reconsideration of the claims disposition, the claim must contain the appropriate resubmission code (value of 7) and the original claim number in box 22 of the CMS-1500. The UB-04 must be submitted with the appropriate resubmission code in the third digit of the bill type and the original claim number in box 64. Additionally, both the CMS-1500 and UB-04 claim forms should be free of handwritten verbiage.
- Providers may discuss questions with Peach State Health Plan. Provider Services Representatives regarding amount reimbursed or denial of a particular service; Providers may also submit in writing, with all necessary documentation, including the Explanation of Payment (EOP) for consideration of additional reimbursement.
- Any response to approved adjustments will be provided by way of check with accompanying explanation of payment.

All disputed claims will be processed in compliance with the claims payment resolution procedure as described herein.

For an explanation regarding how to request an informal claim payment adjustment or file a complaint refer to the process described herein.

Billing Forms

Providers submit claims using standardized claim forms whether filing on paper or electronically.
Submit claims for professional services and durable medical equipment on a CMS 1500. The following areas of information on CMS 1500 claim forms are common submission requirements of a clean claim accepted for processing:

- Full member name
- member's date of birth
- A valid member identification number
- Complete service level information:
  - Date of Service
  - Diagnosis
  - Place of Service
  - Procedure Code (appropriate CPT-4, ICD-10 codes)
  - Charge Information and units
- Servicing provider's name, address, taxonomy code, and NPI number
- Provider's federal tax identification number
- All mandatory fields must be complete and accurate

Submit claims for hospital based inpatient and outpatient services as well as swing bed services on a UB 04.

Completing a CMS 1500 Form

All medical claims are to be submitted on the CMS 1500.

The CMS 1500 claim form is required for:

- All professional services "including specialists"
- Individual practitioners
- Non-hospital outpatient clinics
- Transportation providers
- Ancillary Services
- Durable Medical Equipment
- Non-institutional expenses
- Professional and/or technical components of hospital based physicians and Certified Registered Nurse Anesthetists (CRNAs)
- Home Health Services

The CMS 1500 **must** provide all requested information to receive payment for services rendered. Failure to do so may result in delayed or denied reimbursement.

Peach State Health Plan requires all **CAPITALIZED, BOLD TYPE FIELDS** to be completed. Failure to complete these fields may cause the claim or encounter to be rejected. An asterisk next to a capitalized, bold type (required) field indicates required if applicable. Listed below are the field numbers and names, along with explanations of the fields.

R=Required
C=Conditionally required/if applicable
Blank=Not required

Peach State Health Plan accepts all nationally approved and recognized coding as defined by CMS national correct coding initiatives and guidelines.

CMS 1500 Standard Place of Service Codes

Place of Service Codes

00 -10	Not in Use
11	Office
12	Home
13 - 20	Not in Use
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
27 - 30	Not in Use
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35 – 40	Not in Use
41	Not Valid
42	Not Valid
43 – 50	Not in Use
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Immediate Care Facility/Mentally Retarded

55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57 - 60	Not in Use
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63, 64	Not in Use
65	End Stage Renal Disease Treatment Facility
66 – 70	Not in Use
71	State or Local Public Health Clinic
72	Rural Health Clinic
73 – 80	Not in Use
81	Independent Laboratory
82 - 98	Not in Use
99	Other Unlisted Facility

Completing a UB 04 Claim Form

A UB 04 is the only acceptable claim form for submitting inpatient or outpatient hospital (technical services only) charges for reimbursement by Peach State Health Plan. In addition, a UB 04 is required when billing for nursing home services, swing bed services with revenue and occurrence codes, inpatient hospice services, ambulatory surgery centers (ASC) and dialysis services.

Incomplete or inaccurate information will result in the claim/encounter being rejected or denied for corrections.

R=Required
C=Conditionally required/if applicable
Blank=Not required

UB 04 Inpatient Documentation

The following information should be submitted along with the UB 04:

- Consent forms for hysterectomies, abortions, and sterilizations.
- Specific additional information upon request by Peach State Health Plan.

UB 04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500 claim form.
- Include the appropriate CPT-4 code next to each revenue code.

UB 04 Claim Instructions

Peach State Health Plan requires all **CAPITALIZED, BOLD TYPE FIELDS** to be completed. Failure to complete these fields may cause the encounter
to be rejected. An asterisk next to a capitalized, bold type (required)
field indicates required if applicable.

Billing the Member

Peach State Health Plan reimburses only services that are medically necessary and covered through Medicaid. Providers can bill a member only if they provide proof that they attempted to obtain member insurance identification information within one hundred and eighty (180) days of service. See the Georgia DCH Provider Manual for additional explanation and instruction regarding member co-payment services.

Applicable Co-payments

Children under age six (6), pregnant women, nursing facility residents, Hospice care members and children who are American Indian or Alaska Native are NOT required to make copayments.

However, there are no co-payments for these services:

- Emergency services.
- Preventive Care Services (routine check-ups for your child).
- Immunizations.
- Routine preventive and diagnostic dental services (such as oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays).
- EPSDT Preventive Care Services provided in RHC/FQHC setting.

SERVICES CANNOT BE DENIED TO ANYONE BASED ON THE INABILITY TO PAY THESE CO-PAYMENTS.

Co-Payments for PeachCare for Kids® Members

We want to let you know about updates to the PeachCare for Kids® copay amount you pay for services. The charts below show co-pay amounts listed by services.

Type of Service	Co-Payment Amount
Durable Medical Equipment	$1.00 or $3.00 (service based)
Federally Qualified Health Centers	$2.00
Free Standing Rural Health Clinic	$2.00
Home Health Services	$3.00
Hospital-based Rural Health Center	$2.00
Inpatient Hospital Services	$12.50
Oral Maxillofacial Surgery	Co-pay amount based on cost of service* *See chart below.*
Orthotics and Prosthetics	$3.00
Outpatient Hospital Services	$3.00
Pharmacy – Preferred Drugs	$0.50
Pharmacy – Non-Preferred Drugs	Co-pay amount based on cost of service* *See chart below.*
Physician Services	Co-pay amount based on cost of service* *See chart below.*
Podiatry	Co-pay amount based on cost of service* *See chart below.*
Vision Care	Co-pay amount based on cost of service* *See chart below.*

***The co-payment amounts below are for the following services:** Oral Maxillofacial Surgery, Pharmacy – Non-Preferred Drugs, Physician Assistant Services, Physician Services (Doctor's office visits), Podiatry and Vision Care.

Cost of Service Co-Payments*

Cost of Service	Co-Payment Amount
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

If you have any questions about the co-payments, please contact Peach State Health Plan's Member Services Department toll free at 1-800-704-1484. You can call Monday through Friday from 7:00 a.m. to 7:00 p.m. Eastern Time. If you are hearing impaired, please call TDD/TTY 1-800-255-0056.

Member Acknowledgement Statement

A provider may bill a member for a claim denied as not being medically necessary, not a covered benefit, or the member has exceeded the program limitations for a particular service only if the following condition is met:

Prior to the service being rendered, the provider has obtained and kept a written Member Acknowledgement Statement signed by the client that states:

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Georgia Department of Community Health as being reasonable and medically necessary for my care. I understand that Peach State Health Plan through its contract with the Department of Community Health determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

Emergency Department Hospital Claims Adjudication Process

Purpose

This process describes the methodology to be used by Peach State Health Plan for managing the Emergency Services benefit in compliance with directives from Centers for Medicare and Medicaid Services (CMS) and the applicable State Agencies. This process delineates only adjudication of Emergency Department claims. Peach State Health Plan intends to work with physicians and hospitals to decrease the need for Emergency Services through proactive strategies that address chronic conditions such as asthma and to redirect, the member to their primary care provider (PCP). In addition, Peach State Health Plan provides Emergency Department (ED) post-discharge follow up and continuity of care services.

Peach State Health Plan is dedicated to providing its members with high-quality healthcare. This includes immediate access to Emergency Services when required. At the same time, Peach State Health Plan recognizes that it is not in the member's best interests to receive routine (non-emergent) episodic care in the ED and that members are best served by receiving such care from their PCP's.

Background

The federal Balanced Budget Act (BBA) of 1997 and the Medicaid statute has established the definition of "Emergency Medical Condition (EMC)" as follows:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any body organ or part.

The contract agreement between Peach State Health Plan and the Georgia Department of Community Health contains essentially the same definition of an EMC as in the federal statute. It states:

> Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the
> absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.

The agreement further delineates that an EMC is a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part ;
- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others.

With respect to a pregnant woman having contractions: (i) that there is not adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or unborn child

CMS has issued specific guidelines to State Medicaid Directors regarding that agency's expectations of how the Medicaid Emergency Services benefit is to be administered utilizing the prudent layperson (PLP) standard as defined above. These guidelines are contained in letters to the State Medicaid Directors dated February 20, 1998, April 5, 2000 and April 18, 2000. The following statements from the April 18, 2000 letter have a direct bearing on the Hospital Claims Adjudication Process.

> "The BBA requires that a Medicaid beneficiary be permitted to obtain emergency services immediately at the nearest provider when the need arises. When the prudent layperson standard is met, no restriction may be placed on access to emergency care. Limits on the number of visits are not allowed. The determination of whether the prudent layperson standard is met must be made on a case-by-case basis. The only exceptions to this general rule are that payers may approve coverage on the basis of an ICD-10 code, and payers may set reasonable claim payment deadlines (taking into account delays resulting from missing documents from the initial claim). Note that payers may not deny coverage solely on the basis of ICD-10 codes. Payers are also barred from denying coverage on the basis of ICD-10 codes and then requiring resubmission of the claim as part of an appeal process. This bar applies even if the process is not labeled as an appeal. Whenever a payer (whether an MCO or a State) denies coverage or modifies a claim for payment, the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional)."

ED claims coded with a diagnosis that represents certain diagnoses or conditions (e.g., status asthmaticus or fractured femur) that are recognized as a medical emergency will result in the claims being treated and reimbursed as an emergency based on the rate negotiated with the hospital. Claims for emergency services submitted with a diagnosis that represents a disease or condition that is not recognized as an emergency situation (e.g., upper respiratory infection), will be reimbursed at the triage rate or the hospital's contracted rate, whichever is applicable. In these cases the hospital may submit a written request for reconsideration within three (3) months of the month of payment. An ED reconsideration request received outside the three (3) month time frame will be denied as untimely.

All requests for reconsideration of an ED claim paid at the triage rate must be submitted in writing to the following address along with the medical records and other clinical rationale (i.e., presenting symptoms, patient age, date, and time of arrival) that supports overturning the triage rate. A Medical Director or his designee will review the information.

Peach State Health Plan
ATTN: Peach State Health Plan PLP Appeals
PO Box 3000
Farmington, MO 63640-3800

Peach State Health Plan will automatically reprocess the claim at the contracted rate, if the decision is made to overturn the triage rate. If the decision is made to uphold the triage rate, you may request a formal appeal by submitting the claim and any additional documentation for consideration under the appeals process. You will receive written notification of the decision once the final appeal determination has been made. Please contact the Provider Solutions department at 866-874-0633 if you have questions or if you need additional information regarding the ED claim review process.

ICD-10 Diagnosis Code Auditing and Review

ICD-10 codes are reviewed and may be moved to different diagnosis categories based on actual adjudication experience. For example, if it is discovered that claims with an ICD-10 diagnosis code that is designated as a non-obvious emergency is being paid 90 percent of the time, the ICD-10 diagnosis code may be moved to a more appropriate classification. Peach State Health Plan will consider any requests for reclassifying specific ICD-10 diagnosis codes if the hospital believes Peach State Health Plan has misclassified the diagnosis code. If after review, it is determined that an ICD-10 diagnosis code qualifies for reclassification, the reclassification will apply to all hospitals.

Third Party Liability and Coordination of Benefits (COB) Guidelines

Third Party Liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the health care expenses of the member.

Coordination of Benefits (COB) refers to members with two or more types of insurance coverage. The plan that is primary pays its full benefits first. The primary insurance carrier's explanation of benefits (EOB) is then sent to the secondary carrier/Peach State Health Plan, for coordination of benefits. The primary EOB information will explain the primary's payment or denial process.

Medicaid is the payor of last resort, therefore Peach State Health Plan will make every effort to cost avoid claims or services that are subject to payment from a third party health insurance carrier, and may deny a service if the third party health insurance carrier provides the service. **Cost avoidance applies to all covered services except claims for EPSDT and non-institutional pregnancy related services.**

- Peach State Health Plan complies with Georgia Medicaid COB policies and utilizes the "Pay and Chase" approach as required.
- Providers must make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Peach State Health Plan members and must bill the primary payor prior to billing Peach State Health Plan (see exceptions above).
- When a provider bills the claim to the primary carrier and files the claims with the EOP, Peach State Health Plan will coordinate with the primary payor to pay the claim up to the plan's allowable amount, but we will not exceed the amount we would have paid had we paid as the primary coverage.
- If a third party health insurance carrier requires the member to pay cost-sharing amounts (e.g. co-payments, coinsurance, and deductible), Peach State Health Plan will pay the cost sharing amount but we will not exceed the amount we would have paid had we paid as the primary coverage.
- Providers will receive written notification along with primary payor information prior to Peach State Health Plan initiating a recoupment. Recovery efforts will apply only to claims that are less than twelve months from the date the claims was paid.

- Information regarding the other liability coverage is available through our call center, and via the secure web portal.
- Claims originally filed timely with a third party carrier must be received within 180 days of the date of the primary carrier's EOP, but never more than twelve (12) months from the month of service.
- To the extent permitted by state and federal law, Peach State Health Plan will use cost avoidance processes as required by DCH.

Inquiry, Claims Adjustments and Provider Appeals

Inquiry, Claims Adjustment, Administrative Review, and Provider Appeals

Claims-Specific Processes
Providers should exhaust each level of the claims inquiry and resolution process before initiating the next level.

Status inquiries
To check the status of previously submitted claim(s), providers should contact the Peach State Health Plan Provider Services Department at 1-866-874-0633, Monday through Friday 7:00 a.m. to 7:00 p.m. Providers should have the servicing provider's name, member name, member ID number, date of birth, date of service and claim number, if applicable.

Resubmitted Claims

Timely Resubmission
Claims that have been denied due to erroneous or missing information must be received within six (6) months from the month in which the service was rendered or within three (3) months of the month in which the denial occurred, whichever is later. In order to be considered the denied claim must be resubmitted with corrected information via the website or via paper. When resubmitting a denied claim on paper more than six (6) months after the month of service, a copy of the EOP with the denial must be attached to demonstrate that the original claim was submitted timely. Please include the appropriate corrected claim resubmission code and original claim number are included on the claim to help us identify that this is a resubmission of an existing claim.

Resubmitted claims should be sent to:

Peach State Health Plan
PO Box 3030
Farmington, MO 63640-3812

Providers resubmitting claims must attach a statement along with documentation, including the EOP explaining the reason for resubmission.

Reasons for resubmission include but are not limited to:

- Provider has corrected the claim (for example, previously submitted wrong diagnosis, etc.)
- Denial for other insurance
- Problem with electronic filing, now sending paper claim
- No payment received within 30 days of initial filing of claim. Providers must wait at least 30 days from the initial submission before resubmitting the claim. The claim must include the appropriate corrected claim resubmission code and original claim number. This will help to ensure that the claim is not denied as a duplicate.

Claim Adjustment
Providers may resubmit a claim(s) to correct a simple billing error or to request an adjustment if you believe the payment made by the plan is incorrect. In order to be considered for payment claims in this category must be received within six (6) months from the month in which the service was rendered or within three (3) months from the end of the month of payment on the EOP, whichever is later. Please be sure to include the appropriate resubmission code and original claim number on the claim form to help us identify that this is a resubmission of an existing claim. A Provider Adjustment form must be completed for all resubmission requests along with the supporting documentation. This form is located in the Provider Forms section of the Peach State Health Plan website, www.pshp.com. Your claim will be reviewed and a decision rendered based on the information provided.

Claim Appeal
Claim appeals must be filed within thirty (30) Calendar days after the date of the claim denial. All Claim appeals require a Provider Appeal Request Form that must be completed and submitted with supporting documentation. This form is located in the Provider Forms section of the Peach State Health Plan website, www.pshp.com. An acknowledgement letter will be sent within ten (10) business days of receipt of the Claim appeal. If the initial claim determination is upheld, the provider will be notified in writing within thirty (30) Calendar days of Peach State Health Plan's receipt of the claim appeal. If the initial claim determination is overturned, the provider will be notified through a newly issued EOP. If the Provider is still not satisfied with the decision, you have the option of choosing an Administrative Law Hearing or Binding Arbitration. The request for an Administrative Law Hearing or Binding Arbitration must be submitted within fifteen (15) business days of receipt of the plan's decision. Requests received after this time frame will not be considered.

Providers with questions regarding provider appeals should call the Provider Services Department at 1-866-874-0633.

Peach State Health Plan shall allow a provider that has exhausted the internal appeals process related to a denied or underpaid claim or group of claims bundled for appeal, the option either to pursue the administrative law hearing or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the Peach State Health Plan and the provider are unable to agree on association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to O.C.G.A. § 49-4-153 shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected, unless the plan and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

You must exhaust all of the Plan's internal appeals processes prior to requesting an Administrative Law Hearing. All arbitration costs will be shared by the Plan and the Provider. Requests should be mailed to:

Peach State Health Plan
Attn: Administrative Law Hearing Coordinator
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339

Reimbursement for Outlier Cases
Criteria for Outlier DRG Calculation:
(a) A case meets the outlier DRG criteria when it meets two (2) conditions:
1. It would normally be paid through the inlier DRG payment mechanism.
2. The operating cost of the case is more than the assigned DRG cost threshold.

(b) In addition, a hospital must request that a claim be reviewed to assess manually if it meets the above two (2) conditions.

The hospital must submit the information listed below with the request. All requests submitted without the required documentation will not be accepted. If the request and all required documentation is not received by the plan within three (3) months from the month in which Peach State Health Plan reimburses the case rate (inlier payment) he outlier payment request will be denied for failure to request payment reconsideration in a timely manner. Once an outlier request has been submitted to Peach State Health Plan for review, the providers Can Not void the claim via the web. **Providers who repeatedly request adjustments or voids generating the need for a positive adjustment may be subject to adverse action by the Plan.**

Facilities requesting outlier payment consideration must submit the following documents with the request:

a) **1. Itemized Charges for Admission each page of the itemization must be numbered.**
b) **The itemization must be listed by revenue code order, subtotaling each revenue code.**
c) **Each item must contain the description, quantity (units) billed, and the charge for that item. Itemizations that reflect rolled up charges into one line item will be denied.**

2. Utilization review notes signed and dated physician's orders, physician's progress notes, discharge summary, physical therapy notes, inhalation therapy notes, occupation therapy notes, speech therapy notes, and operative notes. Utilization review notes must indicate the severity of illness/intensity of service (SI/IS) that was met for medical necessity of the hospital stay. Failure to document the SI/IS criteria in the utilization review notes may result in the denial of your DRG outlier request. All notes must be organized and each section labeled. Only required documentation should be submitted. If the entire medical record is submitted, the request will be denied.
3. Copies of all UB-04 claims on the admission.
4. Copies of all paid remittances on the admission.
5. Copies of the Medicare Explanation(s) of Benefits when the member is Medicare eligible.
6. A cover letter must be submitted indicating the request is for outlier with **a contact person, physical address (for mailing purposes), and phone number for each case.**

All charges to be considered for additional reimbursement must be in a paid status in the claims processing system prior to submission of the outlier request. Claims for which a third party pays at or in excess of the DRG payment should not be billed to Peach State Health Plan; therefore, cost outlier reimbursement for such claims is not available. Any services listed on the itemized charges and not billed to Peach State Health Plan must be identified by the hospital. The billed amount on the itemized charges, the UB claim form, and the EOP must agree.

Hospital utilization review programs must include review of the medical necessity for admission, the appropriateness of services and the medical necessity for continued stay.

In some cases more information is required to complete the review process. When additional information not identified above is requested, it must be received within thirty (30) days of the date of request. If the additional information is not received by the due date, the request for outlier payment will be denied. Please ensure that the request is clearly marked: **Outlier Payment Request and mailed to:**

Peach State Health Plan
P.O. Box 3030
Farmington, MO 63640-3812

It is the responsibility of the provider to assure that each and every outlier claim and all information necessary to complete the review is received by Peach State Health Plan. Information regarding outlier status may be obtained by Peach State Health Plan's Provider Services line at 1-866-874-0633.

The following items must be submitted as outlined below for Outlier review. Only required chart documents should be submitted for review. If the entire chart is submitted the record will not be reviewed and the provider must resubmit the Outlier record with only the required documents.

- Cover Letter naming Contact Person
- Copy of the original claim(s)
- Copy of EOP
- Detailed Itemized Charges with Revenue Codes
- Charts documented on itemized bill correlate with UB-04
- Itemized bill is numbered by provider and quantities.
- Billed documented
- Total charges and DOS match on itemized bill, EOP and UB-04 unless a HAC/Never Event is present
- Charges documented in the itemized bill but not billed on the UB-04 are identified and marked through on the itemized bill
- Utilization Review Notes documenting severity of illness and intersity of service criteria met; Notes signed and dated
- Physician Progress Notes
- Physician Discharge Summary
- Physician orders
- OR Procedure Notes (if applicable)
- Physical/Occupational/Speech/Respiratory Therapy Notes (if applicable)
- Chart is organized and labeled for review and only documents required are submitted
- Request submitted within 90 day deadline of paid EOP
- No charges on the itemized bill that has a charge of zero. No "whitening out" or striking through of items with a zero charge.
- Hospital Acquired Conditions/Never Events deleted from itemized claim unless on exception list.

All requests for outlier consideration will be processed in a timely manner. Notification of the decision will appear on the EOP or a letter if the claim does not qualify for outlier consideration.

Claims Audits

Peach State Health Plan uses claims audits to ensure accuracy of the claims payment process.

Provider Complaints

Peach State Health Plan's provider complaint system permits providers to dispute Peach State Health Plan's policies, procedures, or any aspect of Peach State Health Plan administrative functions (including the process by which Peach State Health Plan handles Proposed Actions and Explanation of Payment), other than the specific claims and administrative review matters described above.

Providers may consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint.

Providers may contact Peach State Health Plan's Provider Services Department via telephone, electronic mail, or in person, to ask questions, file a provider complaint inquire about a provider complaint and resolve problems related to a provider complaint.

Provider complaints must be submitted in writing (or via the Peach State Health Plan website) within thirty (30)

Calendar Days of receipt of the Notice of Proposed Action, Explanation of Payment or administrative function to the Peach State Health Plan Provider Complaint Coordinator at the address below:

Peach State Health Plan
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339
Attn: Provider Complaint Coordinator

The provider's complaint must be clearly documented. The Peach State Health Plan Provider Complaint Coordinator will issue an acknowledgment letter within ten (10) business days of receipt of the complaint. If the initial determination is upheld, the provider will be notified in writing within thirty (30) calendar days of Peach State Health Plan's receipt of the complaint.

Peach State Health Plan shall allow a provider that has exhausted the internal appeals process related to a denied or underpaid claim or group of claims bundled for appeal, the option either to pursue the administrative law hearing or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the plan and the provider are unable to agree on association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section 49-4-153 shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected, unless the plan and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

Provider requests for Administrative Law Hearing or Binding Arbitration should be mailed within **15 business days** to:

Peach State Health Plan
Attn: Administrative Law Hearing Coordinator
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339

Requests Administrative Law Hearing or Binding Arbitration received after this time frame will not be considered.

Claim Payment Audits

Peach State Health Plan audit review nurses will perform retrospective review of claims paid to providers to ensure accuracy of the payment process. If a claim is found to be overpaid, the amount will be recouped against future claim payments. A letter will be sent to the provider notifying them of the reason for the recoupment and the amount.

Post Processing Claims Audit

Background

Peach State Health Plan is contractually obligated to have procedures in place to detect waste, fraud, and abuse. This is achieved through:

- Claims editing
- Post-processing review of claims
- Provider profiling and credentialing
- Quality control
- Utilization management

As accountable and fiscally responsible stewards of public funds, we take the prevention and detection of waste, fraud, and abuse very seriously. Peach State Health Plan has a management contract with its parent organization, Centene Corporation (Centene) in which Centene conducts routine post-processing claims audits on behalf of Peach State Health Plan. These audits are designed to ensure that billing codes and practices are correct and that Peach State Health Plan has paid health care providers appropriately. In addition to provider reviews, Centene also investigates members who appear to be abusing the Medicaid and PeachCare for Kids® programs.

Post Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Centene Auditors request medical records for a defined review period. Providers have two weeks to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. **If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Peach State Health Plan will recover all amounts paid for the services in question.**

Centene Auditors review cases for potential unbundling, upcoding, mutually exclusive procedures, incorrect procedures and/or diagnosis for member's age, duplicates, incorrect modifier usage, and other billing irregularities. They consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report which identifies all records reviewed during the audit. If the Auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Peach State Health Plan will seek recovery of all overpayments.

Depending on the number of services provided during the review period, Peach State Health Plan may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998). To ensure accurate application of the extrapolated methodology, Centene uses RAT-STATS 2007 Version 2, the OIG's statistical software tool, to select random samples, assist in evaluating audit results, and calculate projected overpayments.

Providers who contest the overpayment methodology or wish to calculate an exact overpayment figure may request a full, on-site chart audit of all services rendered during the review period. A full chart audit may take four to eight weeks to complete. On-site audits are performed by Peach State Health Plan's contracted vendor, HMS. Per the terms of your contract, you may be liable for the cost of an on-site audit.

Audit findings are reported to the Department of Community Health and may also be reported to the Georgia Healthcare Fraud Control Unit.

Additional information regarding Peach State Health Plan's Waste, Fraud, and Abuse program may be found in the Provider Manual. To report wasteful, abusive, or fraudulent activity, please contact Peach State Health Plan's Confidential Hotline at 1-866-685-8664.

Credentialing

Credentialing Requirements

Effective 8/1/2015, the Georgia Department of Community Health (DCH) will require all Medicaid providers seeking to enroll in the Peach State Health Plan Provider Network or any other CMO network to be credentialed by the new Centralized Credentialing Verification Organization (CVO). Therefore, it will also be necessary for providers to submit an online credentialing application to the CVO prior to your acceptance into our Provider Network.

For further information regarding the new CVO credentialing process, please visit the DCH provider portal: www.mmis.georgia.gov or contact HP Provider Call Center at 1-800-766-4456.

Notice: In order to maintain a current provider profile, providers are required to notify Peach State Health Plan of any relevant changes to their credentialing file in a timely manner.

Quality Improvement

Quality Assessment and Performance Improvement (QAPI)

The scope of Peach State Health Plan's Quality Assessment and Performance Improvement (QAPI) Program is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service. The scope of the QAPI Program ensures that all demographic groups, care settings, and services are included in QAPI activities. The scope may include, but is not limited to, monitoring of the following:

- Compliance with preventive health guidelines and clinical practice guidelines.
- Acute and chronic case management.
- Behavioral healthcare.
- Continuity and coordination of care.
- Under and over utilization.
- Appointment availability.
- After hours telephone accessibility.
- Member satisfaction.
- Provider satisfaction.
- Complaints and appeals.
- Performance monitoring and performance improvement projects of clinical and service related measures.

Additional information on the QAPI Program is available online at www.pshp.com. Providers may also call 1-866-874-0633 to request hard copies of Quality Assessment and Performance Improvement (QAPI) documents.

Health Management Program Needs Analysis

In order to ensure that Peach State Health Plan provides care to all demographic groups, the program includes monitoring and evaluation of healthcare services provided to Peach State members, including those members having special needs. The demographic and health characteristics, including disease categories and risk status of the membership, are reported and analyzed to guide the monitoring and evaluation of clinical issues. Indicators are selected and monitored for a variety of demographic groups including:

- Infants and children
- Pregnant women
- Adult males and females
- High-risk members

The first step of our Quality Assessment methodology includes the analysis of demographic and health profiles of our membership including high volume diagnoses, age and gender analysis, language analysis and ethnicity analysis. This analysis is conducted at least annually and includes:

- Age/sex/race distribution.
- Hospitalizations by principal diagnosis or DRG.
- Hospitalizations or post-hospitalization outcomes (e.g., re-admissions, complications).
- Primary care visits by principal diagnosis.
- Specialty visits by principal diagnosis.
- Prescriptions by therapeutic category.
- Complaints and appeals by type.
- Member satisfaction surveys.

The demographic and health profile is presented to the Quality Oversight Committee (QOC) for review. This profile is utilized in the selection of study topics relevant to the members served by Peach State Health Plan.

In addition to the annual demographic analysis, Peach State Health Plan monitors and evaluates the care received by members in all care settings. To accomplish this review Peach State Health Plan audits the various types of care settings, including:

- Inpatient hospitalization.
- Ambulatory care.
- Physician office (primary and specialty).
- Home care.

Performance Improvement Process

The Peach State Health Plan Quality Assessment and Performance Improvement (QAPI) Program allows for continuous performance of quality improvement activities, and has established mechanisms to track issues over time.

Annually, Peach State Health Plan develops a Quality Improvement (QAPI) Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QAPI activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the Quality Oversight Committee (QOC) as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

The QAPI Work Plan is used by Peach State Health Plan to manage projects and by the clinical quality committees, sub-committees and Peach State Board of Directors to monitor progress. The Work Plan is modified and enhanced throughout the year and updates are provided to the QOC. Modifications are reported to the Board of Directors and other appropriate committees. Additionally, Peach State Health Plan tracks open issues to ensure follow-up of specific issues or corrective actions requiring tracking over time. The QAPI Work Plan is used by Peach State Health Plan to prepare agendas for the QOC to ensure continued follow-up of issues and corrective action plans.

Provider Review

The QAPI Program includes review of processes followed in the provision of health services, through oversight of the Quality Oversight Committee (QOC). The QOC contains participating physicians from varying specialty areas including Family Practice, Pediatrics, Obstetrics & Gynecology, and Psychiatry. The ad hoc members of the QOC include representatives from other departments of Peach State Health Plan.

Feedback on Physician Specific Performance

As part of the re-credentialing process, performance data on each provider is reviewed and evaluated by the Credentialing Committee. This review of provider specific performance data may include, but is not limited to:

- Site evaluation results including medical record audit, appointment availability, afterhours access, cultural proficiency and in office waiting time.
- Preventive care, including EPSDT preventive medical exams, immunizations, lead screening, and screening for detection of kidney disease.
- Prenatal care.
- Complaint and appeal data.
- Utilization management data including referrals/1000 and bed days/1000 reports.
- Sentinel events and/or adverse outcomes.
- Compliance with clinical practice guidelines.

Feedback of Aggregate Results

Aggregate results of studies and guideline compliance audits may be presented to the QOC. Participating physician members of the QOC provide input into action plans and serve as a liaison with physicians in the community.

At least annually, a provider relations specialist meets with primary care providers and high volume specialists to review policies, guidelines, indicators, medical record standards, and provide feedback of audit/study results. These sessions are also an opportunity for providers to suggest revisions to existing materials and recommend priorities for further initiatives. When a guideline, indicator, or standard is developed in response to a documented quality of care deficiency, Peach State Health Plan disseminates the materials through an in-service training program to upgrade providers' knowledge and skills. The Peach State Health Plan Medical Directors and Pharmacist also conduct special training and meetings to assist physicians and other providers with quality and service improvement efforts.

Quality Oversight Committees

The Peach State Health Plan Board of Directors is the governing body for Peach State Health Plan. The Board of Directors has ultimate responsibility for quality improvement and meets quarterly to review and act upon reports reflecting the status of QAPI Program implementation.

In Peach State Health Plan's QAPI Program approved by the Peach State Board of Directors, the Board of Directors has designated the QOC and the Vice President of Medical Affairs/Chief Medical Director to provide oversight of the Peach State Health Plan QAPI Work Plan.

Governing body responsibilities for monitoring, evaluating, and making improvements to care and service include:

- Review, evaluate, and approve the QAPI Program description, the QAPI Work Plan and the annual QAPI Program Evaluation.
- Review regular reports delineating actions taken and improvements made as part of the QAPI Program.
- Ensure that the QAPI Program and QAPI Work Plan are implemented effectively and result in improvements in care and service.
- Provide written feedback to the Plan as appropriate, when program goals are not being met.

The QAPI Program Description delineates the structure and personnel responsible for performing QAPI functions within the organization. The Program's Committee structure consists of the following committees and subcommittees:

- QQOC
- Credentialing Committee (Delegation Oversight)

- Physician Practice Advisor Committee
- Specialty Advisory Committee
- Peer Review Committee
- Utilization Management Committee
- Pharmacy and Therapeutics Committee
- Delegated Vendor Oversight Committee
- Cultural Competence Committee
- Member and Advisory Committee

These committees meet on a regular basis in order to oversee QAPI Program activities and allow sufficient follow-up on findings and required actions. The Chairperson of each committee may increase or decrease the frequency based on findings and resolutions.

Waste Abuse and Fraud (WAF) System

Peach State Health Plan takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a WAF program that complies with state and federal laws. Peach State Health Plan, in conjunction with its management company, Centene Corporation, successfully operates a billing errors/waste, abuse and fraud unit. If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664. Peach State Health Plan and/or Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.

Authority and Responsibility

The Peach State Health Plan Vice President of Compliance has overall responsibility and authority for carrying out the provisions of the compliance program.

Peach State Health Plan is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The Peach State Health Plan provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations, at Peach State Health Plan or the subcontractor's own expense.

These are the primary agencies to which incidents or practices of abuse and/or fraud are to be reported:

Peach State Health Plan Office of Compliance
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339

Department of Community Health
Program Integrity Unit
Two Peachtree Street, NW-40th Floor
Atlanta, Georgia 30303-3159
1-800-533-0686

Member Services

Peach State Health Plan is committed to providing its members with information about the health benefits that are available to them through the Peach State Health Plan program. Peach State Health Plan encourages members to take responsibility for their healthcare by providing them with basic information to assist them with making decisions about their healthcare choices.

Peach State Health Plan has developed targeted programs to address the needs of its members. Members may attend classes; receive specific disease management bulletins and treatment updates, appointment reminder cards, and informational mailings.

As a provider for Peach State Health Plan, please remember that it is your obligation to identify any Peach State Health Plan member who requires translation, interpretation, or sign language services. Peach State Health Plan will pay for these services whenever you need them to effectively communicate with a Peach State Health Plan member. Peach State Health Plan members are not to be held liable for these services. To arrange for any of the above services, please call the Peach State Health Plan Provider Services Department at **1-866-874-0633.**

Connections Program

Peach State Health Plan recognizes the special needs of the population it serves. In response to these special needs, the CONNECTIONS program has been developed to address the challenges in member outreach, member education, and in member's understanding of the managed care health system.

CONNECTIONS is an educational and outreach program that brings our members a special personal-touch service. The program is designed to promote preventive health practices and connect members to quality healthcare and community social services. By assigning CONNECTIONS representatives to individual members, CONNECTIONS creates a special link between members and Peach State Health Plan providers.

CONNECTIONS representatives will:

- Contact new members by telephone to welcome them to Peach State Health Plan
- Introduce members to Peach State Health Plan managed care and assist them in understanding their available options for preventive healthcare in the Peach State Health Plan network and how to
- access services appropriately
- Conduct home visits and monthly member orientation sessions for basic member education about Peach State Health Plan and services available through the Peach State Health Plan network
- Participate in community activities centered on health education
- Counsel members on accessing appropriate levels of care and non-compliance issues
- Assist members in making appointments
- Advise members of their rights and responsibilities

CONNECTIONS serves as a link between the member, PCP and Peach State Health Plan. This is encouraged through face-to-face activities such as new Peach State Health Plan mom visits and member orientation sessions. Watch for activities that CONNECTIONS may be hosting in the Peach State Health Plan provider mailings. Participating Peach State Health Plan providers can contact the Member Services Department at 1-800-704-1484 to request that a home visit be completed when a Peach State Health Plan member is found to be non-compliant, (for example missing medical appointments) with recommended medical treatment or has other identified issues or high risk factors (for example frequent emergency room visits for routine medical care) that negatively impact the member's health status. Peach State Health Plan members who require additional coaching to learn how to access the system appropriately can be referred by the Peach State Health Plan PCP to have a visit from the CONNECTIONS representative.

Member Materials

Members will receive various pieces of information from Peach State Health Plan through mailings and through face-to-face contact. These materials are printed in English and Spanish and can be requested in Spanish or other languages identified by the state. These materials include:

- Quarterly Newsletters
- Targeted Disease Management Brochures
- Provider Directory
- NurseWise information
- Emergency Room Information
- Member Handbook which includes:
  - Benefit information, including pharmacy network information, transportation information, and so on
  - Member rights and responsibilities

Providers interested in receiving any of these materials may contact:

Member Services Department
1-800-704-1484
TDD/TYY 1-800-659-7487

Member Rights and Responsibilities

Peach State Health Plan provides covered services to all members without regard to:

1. Age
2. Disability
3. Marital Status
4. Race
5. Sex
6. Income
7. Health Status
8. Arrest or Conviction
9. Religion
10. Sexual Preference
11. Color
12. Birth Nation
13. Military Participation
14. Language

All services that are covered and medically necessary may be obtained. All services are provided in the same way to all members.

Peach State Health Plan providers who refer members for care do so the same way for all.

Translation services are available if you need them. This includes sign language. This service is free.

The right to appeal any denied service according to state guidelines.

The Member has the right:

- To have all your personal information including your medical records kept private.
- To be given choices about your healthcare. To know all of your options.
- To never worry about someone forcing you to do something because it makes his or her job easier.

- To talk with your doctor about your medical records; ask for and receive a copy of your medical records; ask for a summary of your record; request that your medical records be changed or corrected; and have your records kept private.
- To be able to request information on the Quality Assessment Performance Improvement Program (QAPI). The QAPI program assures that all members receive quality care and appropriate care. The QAPI program focuses on improving clinical care and non-clincal care which will result in positive health outcomes.
- To file a complaint against a doctor, hospital, the service/care you received, or Peach State Health Plan. If you file a complaint, no one can stop you from continuing to get services.
- To file an appeal when you are unhappy about the outcome of a complaint or decision.
- To know how to file an administrative review for a decision not to pay fro a service or limit coverage.
- To know that you or your doctor will not be penelized for filing a compliant or administrative review.
- To not pay if Peach State Health Plan runs out of money to pay their bills.
- To not pay for healthcare even if Medicaid or PeachCare for Kids and Peach State Health Plan does not pay the doctor who treated you.
- To have medical services available to you under your Peach State Health Plan plan in accordance to 42 CFR 438.20 through 438.210 which are the federal QAPI access standards.
- To be free from any Peach State Health Plan debts in the event of insolvency and liability for covered services in which the state does not pay Peach State Health Plan.
- To never pay more than what Peach State Health Plan would charge, if Peach State Health Plan has to have someone else manage your care.
- To only have a small co-payment and/or deductible, as allowed by state laws and DCH regulations as described in the Member Handbook.
- To only be billed by a provider if you have agreed to the following:
    - You signed a Member Acknowledgement Statement which makes you responsible for services not covered by Peach State Health Plan.
    - You agreed ahead of time to pay for services that are not covered by Peach State Health Plan or Medicaid.
    - You agreed ahead of time to pay for services from a provider who is not in the network and/or did not receive a prior authorization ahead of time, and requested the service anyway.
- To not be billed for any service covered by Medicaid. If you get a bill for services Peach State Health Plan should have paid, call Member Services at 1-800-704-1484. When you call, give the Member Services Staff:
    - Date of service.
    - Name of provider.
    - Total amount of the bill.
    - Phone number on the bill.
- To be free from receiving bills from providers for medically needed services that were authorized or covered by Peach State Health Plan.
- To be treated with dignity, respect and privacy from Peach State Health Plan staff, providers, physicians and their office staff.
- To have access to a PCP 24 hours a day, 365 days a year for urgent care.
- To choose a Peach State Health Plan doctor (PCP) and be told which hospitals to use.
- To change your doctor without a reason.
- To know about other doctors who can help you with treatment.
- To know your rights and responsibilities with Peach State Health Plan and to call if you have questions or comments or want to make recommendations about our member rights and responsibilities policy.
- To get information about Peach State Health Plan's organization and services, providers, physicians, hospitals, policies and procedures, your rights and responsibilities and any changes made.
- To get a second opinion

- To know about all the services you will get. This includes:
  - Hours of operation.
  - How to get emergency care after hours.
  - How to get services if you are out of town.
  - What may not be covered.
  - What has limited coverage.
- To be told if your services change. To be told if we cancel a service.
- To be told if your doctor is no longer available.
- To tell us and your doctor if you need help talking to your doctor. You will not have to pay if you are hearing impaired or if you do not speak English.
- To know all information about your doctor(s) so they can care for you.
- To tell your doctor what you like and don't like about your care.
- To speak with your physician about decisions related to your health care including the right to refuse medical or surgical treatment to the extent of the law and to refuse to take part in medical research.
- To help set treatment plans with your physician, talk to your physician openly and understand your health care options: regardless of cost or benefit coverage.
- To understand your health problems and to speak with your physician about your treatment plans which you and your doctor agree.
- Decide ahead of time the kind of care you want if you become sick, injured or serisouly ill by making a living will or advance directive.
- Decide ahead time the person you want to make decisions about your care if you are not able to by making a durable power of attorney.
- To be free from any form of restraint or seclusion as a means of force, discipline, convenience or revenge.

To exercise these rights. Also, to know if you do, it will not change how you are treated by the plan, its doctors and providers.

Member Responsibilities

The member has a responsibility:

- To give information about yourself to the Peach State Health Plan organization, providers, physicians, and hospitals in order to help set treatment goals.
- To give information about you and your health to your PCP.
- To understand your health problems and how to take your medicines the right way.
- To ask questions about your health care.
- To follow your instructions for care agreed upon by you and your physician or hospital.
- To help set treatment goals with your PCP.
- To read the Member Handbook to understand how [Peach State Health Plan] works.
- To call Peach State Health Plan and ask questions when you don't understand.
- To always carry your Peach State Health Plan Member ID card.
- To always carry your Medicaid or PeachCare for Kids Member ID card.
- To show your ID cards to each provider.
- To schedule appointments for care with your doctor.
- To go to the emergency room when you have an emergency.
- To notify Peach State Health Plan as soon as possible if you go to the emergency room.
- To get a referral from your PCP for specialty care.
- To cooperate with people providing your health care.
- To be on time for appointments.
- To notify the doctor's office if you need to cancel an appointment.

- To notify the doctor's office if you need to change your appointment time.
- To respect the rights of all providers.
- To respect the property of all providers.
- To respect the rights of other patients.
- To not be disruptive in your doctor's office.
- To keep all your appointments. To be on time and cancel within twenty-four (24) hours if you cannot make it.
- To treat your provider with dignity and respect.

Member Grievances

A grievance is an expression of dissatisfaction with any aspect of Peach State Health Plan's or a provider's operation, provision of healthcare services, activities, or behaviors, other than a adverse benefit determination. A member or member's authorized representative may file a grievance either orally or in writing. Peach State Health Plan will notify the member or authorized representative that the grievance has been received in writing within 10 business days of receipt of the grievance. A provider cannot file a grievance on behalf of a member. Members or their authorized representative may file a grievance by contacting Member Services at: 1-800-704-1484 or by submitting written notification to:

Peach State Health Plan
Grievance and Appeals Coordinator
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA. 30339

Peach State Health Plan will resolve to all issues raised by members within 90 calendar days of receipt of the grievance.

Special Services to Assist With Members

Peach State Health Plan has designed its programs and trained its staff to ensure that each member's cultural needs are considered in carrying out Peach State Health Plan operations. Providers should remain cognizant of the diverse Peach State Health Plan population. Members' needs may vary depending on their gender, ethnicity, age, beliefs, etc. We ask that you recognize these needs in serving your members. Peach State Health Plan is always available to assist your office in providing the best care possible to the members.

There are several services that are also available to the members to assist with their everyday needs. Members can contact the below number to obtain information about these services.

Member Services Department
1-800-704-1484
TDD/TYY 1-800-659-7487

Interpreter/Translation Services

Peach State Health Plan is committed to ensuring that staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its members. In order to meet this need, Peach State Health Plan is committed to the following:

- Having individuals available who are trained professional interpreters for Spanish and American Sign Language, and who will be available on site or via telephone to assist providers with discussing technical, medical, or treatment information with members as needed.

- Providing free Language Line services that will be available twenty-four (24) hours a day, seven (7) days a week in 140 languages to assist providers and members in communicating with each other when there are no other translators available for the language.
- In-person interpreter services are made available when Peach State Health Plan is notified in advance of the member's scheduled appointment in order to allow for a more positive encounter between the member and provider; telephonic services are available for those encounters involving urgent/emergent situations, as well as non-urgent/emergent appointments as requested at no charge to the member.
- Providing TTY access for members who are hearing impaired through 1-800-659-7487.
- Peach State Health Plan's medical advice line, NurseWise, provides 24 hour access, seven days a week for interpretation of Spanish or the coordination of non-English/Spanish needs via the Language Line.
- Providing or making available Peach State Health Plan Member Services and Health Education materials in alternative formats as needed to meet the needs of the members, such as audio tapes or language translation; all alternative methods must be requested by the member or designee.

Providers must call Member Services at 1-800-704-1484 if interpreter services are needed. Please have the member's ID number; date/time service is requested and any other documentation that would assist in scheduling interpreter services.

Nursewise

Our members have many questions about their health, their primary care provider and access to emergency care. Our health plan offers a nurse triage service to encourage members to talk with their physician and to promote education and preventive care.

NurseWise is our 24-hour nurse line for members. The Registered Nurses provide basic health education, nurse triage and answer questions about urgent or emergency access, all day long.

The staff often answers questions about pregnancy and newborn care. In addition, members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use NurseWise to request information about providers and services available in your community after the health plan is closed. Providers can use it to verify eligibility any time of the day. The NurseWise staff is conversant in both English and Spanish and can offer the Language Line for additional translation services. The nurses document their calls in a web-based data system using Barton Schmitt, M.D. triage protocols for pediatrics and McKesson proprietary suite of products to perform triage services for adults. These protocols are widely used in nurse call centers and have been reviewed and approved by physicians from around the country.

We provide this service to support your practice and offer our members' access to a RN every day. If you have any additional questions, please call Provider Services or NurseWise at **1-800-704-1484, option #7.**

Provider Relations Assistance

Provider Relations Department

The Provider Relations Department at Peach State Health Plan is designed around the concept of making your experience with Peach State a positive one by being your advocate within Peach State Health Plan. Provider Relations is responsible for providing the services listed below which include but are not limited to:

- Contracting.
- Maintenance of existing Peach State Health Plan Provider Manual.
- Eligibility distribution.
- Development of alternative reimbursement strategies.
- Researching of trends in claims inquiries to the Peach State Health Plan.
- Pool settlement updates/status.
- Network performance profiling.
- Individual physician performance profiling.
- Physician and office staff orientation.
- Hospital and ancillary staff orientation.
- Ongoing provider education, updates, and training.

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Peach State Health Plan enrolled membership. To contact the provider relations specialist for your area contact:

Provider Services Department
1-866-874-0633

The Provider Services toll free help line staff is available to you and your staff to answer questions, listen to your concerns, assist with members, respond to your Peach State Health Plan inquiries, connect you to the Peach State Health Plan Provider Relations Specialist for your area, etc.

Provider Services Representatives are dedicated to serving the Peach State Health Plan provider network. Provider Services Representatives work with Provider Relations Specialists to serve as your advocates to ensure that you receive necessary assistance and maintain satisfaction with Peach State Health Plan.

Pharmacy

The Peach State Health Plan preferred drug list (PDL) is designed to assist contracted healthcare prescribers with selecting the most clinically and cost-effective medications available. The Peach State Health Plan PDL does not:

a) Require or prohibit the prescribing or dispensing of any medication.
b) Substitute for the professional judgment of the physician or pharmacist.
c) Relieve the physician or pharmacist of any obligation to the member.

The Peach State Health Plan PDL will be approved initially by the Peach State Health Plan Pharmacy and Therapeutics Committee (P&T), led by the Peach State Health Plan Pharmacist and Medical Director, with support from community based primary care providers and specialists. Once established, the Peach State Health Plan preferred drug list will be maintained by the P&T Committee, using quarterly meetings, to ensure that Peach State Health Plan members receive the most appropriate medications.

The Peach State Health Plan PDL contains those medications that the P&T Committee has chosen based on their safety and effectiveness. If a physician feels that a certain medication merits addition to the list, the Peach State Health Plan PDL Change Request form can be used to submit for consideration. The Peach State Health Plan P&T Committee would review the request, along with supporting clinical data, to determine if the drug meets the safety and efficacy standards established by the committee. Some self-administered injectable medications are included on the Peach State Health Plan PDL and may require prior authorization reviewed by the health plan pharmacy department. Copies of the PDL and PDL Change Request Form are available on our website, www.pshp.com. Providers may also call 1-866-874-0633 to request hard copies of the PDL.

Grandfathering

Peach State Health Plan is committed to maintaining continuity of care for its members, especially with the pharmacy benefit. For those members moving to Peach State Health Plan from Medicaid FFS or another CMO who are currently stabilized on medications not listed in the Peach State Health Plan PDL, Peach State Health Plan will allow those members to initially continue receiving those medications as Peach State Health Plan members for the first 30 days of membership. This 30 day period is provided to allow the physician time to prescribe an alternative medication that is included in the Peach State Health Plan PDL or to request prior authorization for the member to remain on the current drug.

Injectables

Self-administered injectables that are included in the Peach State Health Plan PDL are covered under the Peach State Health Plan pharmacy program. Provider-administered specialty injectables such as Synagis or Xolair need to be prior authorized by Peach State Health Plan before administering to the member. Most self-administered specialty pharmaceuticals are dispensed by Acaria Health, the specialty pharmacy vendor. US Script is the pharmacy benefit manager for Peach State Health Plan. For a complete list of specialty injectable drugs requiring authorization and a description of the Biopharmaceutical Program, please refer to the Biopharmaceutical Pharmacy Program document on our website, www.pshp.com.

Non-Covered Drugs

The following drugs and medical services are not a part of the Peach State Health Plan Pharmacy benefit:

PHARMACY BENEFIT EXCLUSIONS

- Drugs used for anorexia, weight gain, or obesity.
- Drugs used to promote fertility or infertility.
- Drugs prescribed for any non FDA approved indication, unless there is compelling clinical evidence to support the experimental use Barbiturates, except Seconal, Phenobarbital and Mebaral.
- Prescription vitamin and mineral products except prenatal vitamins for women, fluoride preparations that are not in combination with other vitamins and children's multiple vitamins with fluoride for members ≤ 21 years of age.
- Nonprescription drugs (Over-the-Counter) except for those listed on the Peach State Health Plan Preferred Drug List (PDL). Those listed on the PDL will be covered if the doctor writes a prescription for the drug (see examples below):
    - Generic Multivitamins < 21 years of age.
    - Generic Multivitamins w/Iron < 21 years of age.
    - Generic Ibuprofen suspension < 21 years of age.
    - Enteric coated aspirin.
    - Pin-X.
    - Generic OTC Diphenhydramine.

    - Insulin, insulin syringes and urine test strips.
    - Generic OTC Iron.
    - Lice treatment.
    - Generic OTC Meclizine.
    - Generic OTC non-sedating antihistamines (Loratadine and Cetirizine).
    - Generic OTC H2 receptor antagonists.
    - Generic OTC topical antifungals.
    - Generic OTC proton pump inhibitors.
- Topical vitamin A derivatives for members ≥ 21 years of age.
- Drugs to treat sexual or erectile dysfunction.
- Drugs identified by CMS as less than effective (DESI) or drugs that may have been determined to be identical, similar or related.
- Medical supplies and DME (except those listed in the PDL).
- Topical Minoxidil or any other drug used for hair growth.
- Nutritional and Dietary supplements(unless listed on the PDL).

Medical Pharmacy Benefits

- Peach State Health Plan members over the age of 19 can receive vaccinations as a medical benefit through their physician or at a participating retail pharmacy. For more information on retail pharmacy vaccinations and ImmunityConnect, visit the Pharmacy page of the website at www.pshp.com.
- Botox is a medical pharmacy benefit covered with a prior authorization for non-cosmetic purposes only.
- Blood and blood products are medical benefits.

Physician administered injectables are covered as a medical benefit; they require prior authorization from Peach State Health Plan. For a complete list of physician injectable drugs requiring authorization and a description of the Biopharmaceutical Program, please refer to the Biopharmaceutical
Pharmacy Program document on our website, www.pshp.com.

Prior Authorization

Any drug not appearing on the PDL will require Prior Authorization from US Script.

For prior authorization call 1-866-399-0928 or fax a prior authorization form to 1-866-399-0929. In the event US Script is unavailable, or while waiting for a prior authorization determination, the pharmacy may request an immediate authorization to dispense a 72-hour supply of the prescribed drug. Prior authorization requests will be answered by US Script within twenty-four (24) hours. Please refer to the Notice of Proposed Action Letter for instructions if a pharmacy prior authorization needs to be resubmitted, or to initiate the provider appeals process.

All injectable drugs listed on the Peach State Health Plan Biopharmaceutical Pharmacy Program document (found on our website at www.pshp.com) require a prior authorization request be faxed for review to the Peach State Health Plan pharmacy department at **1-866-374-1579.**

Injectable drugs provided in a physician's office may require prior authorization and are not covered under the retail pharmacy benefit. These injectables must be billed on a physician claim.

Pharmacy Lock-In Program

Peach State Health Plan is required to have a Lock-In program by the Department of Community Health (DCH). The Lock-In program is for the protection of our members. Peach State Health Plan reviews members that receive medical services. This review makes sure that benefits are used properly. In our review, we look to see if members have any of the following:

- Prescriptions written on a stolen, fake, or changed prescription blank.
- Prescribed drugs that should not be used for the member's medical condition.
- Member has filled prescriptions at more than two pharmacies per month or more than five pharmacies per year.
- Member receives more than five different drugs per month.
- Member receives more than three controlled drugs (examples: pain medicine, medicine to help sleep, and medicine to control attention deficit disorder) per month.
- Member gets two or more drugs that work the same way from different providers.
- Member receives prescriptions from more than two doctors per month.
- Member has been seen in hospital emergency room more than two times per year.
- Member has diagnosis of drug poisoning or drug abuse on file.
- Number of prescriptions for controlled drugs exceeds 10 % of total number of prescriptions.

We receive information from providers and DCH. Pharmacies may also tell us about members that may need to have their use of drugs reviewed. If the member has one or more of the items above the member will be assigned to one pharmacy to fill all drugs. The member may also be restricted to one doctor to write for controlled drugs.

Members placed into the Pharmacy Lock-In Program will receive a certified letter detailing the pharmacy and or controlled substance prescriber that is selected for them. A copy of this notice is also sent to the Primary Care Physician on file, the Lock-In Pharmacy, and the Controlled Substance Prescriber.

This program lasts at least one year. Having one pharmacy fill all prescriptions can prevent a member from being harmed by drugs that do not work together.

We expect all pharmacies who manage lock-in patients to uphold the following:

- Verify controlled substance prescriptions by phone when multiple physicians are involved in the patient's care.
- Do not allow early refills on controlled substances.
- Make sure that all physicians writing prescriptions for controlled substances know that other physicians are also writing prescriptions for controlled substances for the same patient. This may not apply if the member is restricted to one provider for controlled substance prescriptions.

If a member has moved and their Pharmacy or Medical Provider is no longer within driving distance from the new home, they should be sure DCH has updated their records with the new address. Members can call Peach State member services at 1-800-704-1484 and request a provider change based on the new location.

The member or provider, acting with member's written consent, may appeal this decision or file a grievance pertaining specifically to the pharmacy or physician.

Value-Based Purchasing Program (VBP)

A VBP model is an enhanced approach to purchasing and program management that focuses on value over volume. It is part of a cohesive strategy that aligns incentives for Members, Providers, Peach State Health Plan and the State to achieve the program's overarching goals. The impact of initiatives is measured in terms of access, outcomes, quality of care and savings.

Georgia Health Information Network (GaHIN)

Peach State Health Plan has partnered with the Georgia Health Information Network (GaHIN) to improve the quality and efficiency of healthcare provided by our network providers. The GAHIN is a statewide health information exchange network that electronically connects Georgia hospitals, physicians and clinicians to safely and securely exchange patient health information.

Peach State Health Plan's partnership with the GaHIN will allow providers the ability to:

- Access a national network of health information that allows providers to enhance continuity of care by enhancing patient care coordination between network providers.
- Access a more complete view of their patients' health information directly from their electronic health record (EHR) systems, including health and pharmacy information, and immunization updates and reporting from the Georgia Registry of Immunization Transactions and Services (GRITS) registry.
- Securely exchange health information clinical data with Peach State Health Plan reducing the administration burden associated with fax submissions.

To learn more about the GaHIN, visit www.gahin.org. For additional information about Peach State Health Plan's partnership with the GaHIN, contact Peach State Health Plan Provider Services at 1-866-874-0633.