CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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INTRODUCTION

BabyCare is a program for eligible pregnant and postpartum women, and infants who are not enrolled in a Medicaid Managed Care Organization (MCO) program either because they have not yet been assigned to an MCO or they meet MCO enrollment exemption criteria. The BabyCare program ensures that these members are screened for behavioral health-related risks, and receive case management and expanded services as defined at 12VAC30-50-510.

Baby Care Services includes the following components:

- Behavioral health risk screens performed by a qualified physician, physician assistant or nurse practitioner. Provider qualifications are detailed in Chapter II of this manual;

- Case management services for high risk pregnant women and their infants up to two years of age, completed by a case manager who is a qualified licensed registered nurse or licensed social worker. Provider qualifications are defined in greater detail in Chapter II manual; and

- Expanded services for pregnant and postpartum women including individual education classes (including tobacco dependence education), nutrition services, homemaker services and substance use disorder (SUD) services performed by a DMAS approved provider. Provider approval requirements are detailed in Chapter II .

BabyCare services described in this chapter are covered under the Virginia Medical Assistance Program. Forms referenced in this chapter may be found athttps://vamedicaid.dmas.virginia.gov/pdf_chapter/baby-care#gsc.tab=0 Virginia Medicaid web portal, or Chapter IV of this manual under attachments.

ELIGIBILITY

BabyCare services are available for eligible women and infants who are enrolled in Fee-for-Service (FFS) Virginia Medicaid, FFS Family Access to Medical Insurance Security (FAMIS), FFS FAMIS Plus and FFS FAMIS MOMS programs.

Eligible women include pregnant women, and women who are within 12 months of giving birth (postpartum). Eligible infants include infants up to age two that have been determined by a qualified provider to be at risk for poor birth/health outcomes. Specific requirements for determining risk are detailed later in this chapter.

(Women covered under DMAS' FFS FAMIS Prenatal Coverage (a benefit for pregnant women who do not meet immigration status rules for other coverage) may qualify for BabyCare services during pregnancy and up to the end of the month following their 60th day post-partum.)

BabyCare services may be reimbursed for qualified eligible infants up to their second birthday.

Managed Care Organizations (MCOs)

This BabyCare program manual outlines requirements specific to providing services to members enrolled in DMAS' fee-for-service program. Members enrolled with one of DMAS' contracted MCOs may receive high risk maternity and infant services (services comparable to those identified in 12VAC30-50-410 and 12VAC30-50-510) through their MCO. Each MCO has established service authorization and approval requirements for these services. Providers of services to members enrolled with an MCO must contact the appropriate MCO about their requirements. A list of the MCO high risk maternity and infant program contact information for MCO members can be found as an attachment at the end of Chapter IV under Business Rules

ELIGIBLITY / CLAIM STATUS / SERVICE AUTHORIZATION

Virginia Medicaid Web Portal

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: https://vamedicaid.dmas.virginia.gov/#gsc.tab=0. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

SERVICES

Screening for Behavioral Health risks

DMAS' BabyCare Program reimburses qualified providers for administration and interpretation of the Behavioral Health Risks Screening Tool (DMAS 16-P (Provider). The purpose for this screening is to identify and assist pregnant women as well as new mothers who may be at risk for mental health, substance use or intimate partner violence as well as infants who may be at risk for developmental issues secondary to their family situation and mother's risks. Early identification and referral for intervention of these risks are paramount in helping improve the outcomes of pregnancy as well as health/well-being of the infant. BabyCare reimburses for administration of this instrument for pregnant/postpartum women and infants up to two years of age who are enrolled in a fee-for-service using Current Procedural Terminology (CPT) codes. 96160 and/or 96161. The procedure codes are as follows:

96160 – Administration of patient-focused maternal health risk assessment

instrument (e.g. health hazard appraisal) with scoring and documentation per standardized instrument, and/or;

96161- Administration of care-giver focused infant health risk assessment instrument (e.g. depression inventory) for the benefit of the patient, with scoring and documentation per standardized instrument.

The *Behavioral Health Risks Screening Tool* is located online under the Maternal and Child Health Services/ BabyCare section located: https://www.dmas.virginia.gov/for-providers/maternal-and-child-health/baby-care/ This tool is meant for a brief screening, not to assess the severity of the risks. The practitioner must determine the need for further review, referral and/or intervention as necessary.

For more information on behavioral health services available for FFS members, please reach out to Acentra Health (formerly Kepro) at https://dmas.kepro.com/.

Service Requirements and Limits for Screenings (96160 and/or 96161)

There is a limit of four units per pregnant member/per provider and four units per infant member/per provider that may be billed within a year. The provider would bill one unit of 96160 and/or 96161 for the administration and brief intervention of the *Behavioral Health Risks Screening Tool*.

Service Limits *(per provider)*	**CPT Code: 96160 and/or 96161**
Maternal	96160 4 per pregnancy (DMAS recommends one per trimester and one postpartum.)
Infant	96161 4 per year

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BabyCare Case Management Services

Case management includes services which help individuals gain access to needed medical, social, educational and other services and services designed to improve coordination of care. The specific activities allowed under case management are detailed in this section.

Initial Assessment for BabyCare Case Management

A qualified BabyCare case manager is either a licensed registered nurse or licensed social worker employed by a DMAS-enrolled service provider to provide care coordination services to eligible individuals. The RN must be licensed in Virginia and should have a minimum of one year of experience in community health nursing and experience in working with pregnant women. The Social Worker (MSW/BSW) must also be licensed in Virginia, have a minimum of one year of

experience in health and human services, and have experience in working with pregnant women and their families.

DMAS requires that the BabyCare case manager complete an initial assessment of the eligible individual and submit a copy of the completed relevant form, DMAS-50(M) for mothers or DMAS-50(I) for infants, to the Service Authorization contractor's online portal, Atrezzo Next Generation, which is often referred to as "ANG".

The assessment is of risk status and service needs, which can fall in one or more of the categories noted on the form: psychosocial, medical and/or nutritional. The case manager provides continuity of care by ensuring that services are scheduled/arranged, client education provided and that the service plan is followed.. Reference Chapter 2 of this manual for documentation requirements.

The assessment includes but is not limited to the following:
- Taking the individual's history and
- Identifying the needs of the individual.

The case manager may utilize other sources of information to complete the assessment, such as family members, medical providers, social workers, and educators.

Please note with documenting and billing for these comprehensive assessments that the service does not include performing medical or psychiatric screenings (e.g., Edinburgh Postnatal Depression Scale, Ages and Stages Questionnaire Developmental Screen) but does include making referrals for these screenings and the time spent in preparing/executing the referral.

Eligible Individual Agreement for BabyCare Case Management Services

The individual must agree to participate in the BabyCare case management program and document participation by completing a DMAS form titled "Letter of Agreement" (DMAS 55 or equivalent). The Letter of Agreement form is kept in the medical record for documentation purposes. DMAS does not require the BabyCare provider to submit the completed Letter of Agreement for authorization of BabyCare case management services but it must be available for reference if DMAS requests the document.

Service Authorizations for Baby Care Case Management

Effective November 2023, service authorization requests are submitted to Acentra for processing.

To get help with the system you can access information at https://dmas.kepro.com, or you can reach out to Acentra Health by phone at 888.827.2884.

The provider must contact the contractor prior to the Service Authorization end

date if services are to extend beyond the initial authorization period. The request will be denied untimely up to the date the request is received.

Retrospective review will be performed when a provider is notified of a member's retroactive eligibility for Virginia Medicaid coverage.

BabyCare case management services may not duplicate any other covered service provided under the Medicaid or FAMIS State Plans or other Medical Assistance programs. (For example: The BabyCare provider must not submit a BabyCare case management service authorization request for an individual that is residing in a specialized care nursing facility.)

If the BabyCare case manager is involved in the direct provision of medical or prenatal care services, the documentation must clearly differentiate the case management services from other service provisions.

More detailed BabyCare service authorization rules can be found as an attachment at the end of Chapter IV and they provide guidance for BabyCare providers in completing the assessment for BabyCare case management service authorization requests (DMAS – 50 (M) or (I) forms) for obtaining the BabyCare case management service authorization covered service authorization number. DMAS provides authorization for BabyCare case management services for Virginia Medicaid FFS only.

Providers should adhere to the following process for FFS BabyCare case management service authorization requests.

Eligibility Check:

- BabyCare providers must check eligibility prior to submitting the request to Acentra Health for authorization.
- It is the BabyCare provider's responsibility to verify eligibility to determine what program the individual is enrolled either FFS or MCO.
- Individuals often transition to a Virginia Medicaid MCO after enrollment for a brief period of time in FFS. For those individuals enrolled in a MCO, the BabyCare provider must have a contract with that MCO to receive authorization for covered services from the MCO.
- For those individuals enrolled in Medicaid FFS, the BabyCare provider submits the BabyCare case management service authorization request for covered services to Acentra Health.

Use Correct Forms:

- BabyCare providers must use the revised BabyCare case management service authorization request forms DMAS-50 Maternal (M) or DMAS-50 Infant (I).
- The forms can be found in the Memo/Bulletin Library on the Virginia Medicaid web portal at www.dmas.virginia.gov. Input the form number in the Search Tool (e.g., "DMAS-50").
- The BabyCare case management service authorization request forms must be fully completed. The form must include at a minimum: individual's name, Medicaid number, Agency name, Agency NPI number, for the pregnant

woman the estimated date of delivery (EDD) or for the infant the date of birth (DOB), case management assessment date, case manager name, title and date assessment completed.

Submitting Forms:

- The BabyCare provider must submit the BabyCare case management service authorization request, including the completed DMAS assessment form, fully completed to the online Atrezzo Next Generation (ANG) portal.
- The DMAS BabyCare Service Authorization request for case management services must be submitted to the Service Authorization Contractor within 30 calendar days from the date the face-to-face assessment was completed and documented on the DMAS-50(M) or DMAS-50(I), also known as the case management open dateThere are exceptions to the 30 calendar day's timely filing and those exceptions are for those individuals that have retroactive eligibility Performed when a provider is notified of a member's retroactive eligibility for Virginia Medicaid coverage. The 30 calendar day timely filing may be waived in these circumstances.

Access Authorization:

- Approved Service Authorization Requests will result in a system-generated letter sent to the requesting BabyCare Provider to include the approval determination, dates of service for the service authorization, and procedure codes requested. The notification letter provides the authorization for BabyCare case management services along with the service authorization number. The BabyCare provider can obtain the service authorization number from the Virginia Medicaid web portal accessible at https://dmas.kepro.com or by calling Medicall at 800-884-9730 or 800-772-9996.

How to use the Medicall system:

Call Medicall and follow the prompts:

- Once dialed in, enter the provider's National Provider Identifier (NPI);
- Select prompt #4 for service authorization status;
- Enter the member's 12 digit Medicaid number;
- Enter the date that the member was assessed by the provider and identified as the BabyCare case management open date;
- Select pound (#) (skip end date request – do not enter date);
- Select star (*) (do not know service authorization number).

Submitting Claims:

- The BabyCare provider obtains the BabyCare case management service authorization number and enters the service authorization number on the claim form along with the BabyCare procedure code G9002.
- The BabyCare provider submits the claim including service authorization number and procedure code for reimbursement for covered services.

Authorization Period:

- BabyCare case management service will only be authorized for a period up to the date prior to managed care enrollment, if applicable

Example:
- Case management requested for Mom on October 5,
- However, Mom will transition to managed care on November 1,
- FFS authorization period will end October 31st.

- If a managed care enrollment date is not present in the MMIS system at the time of the request, BabyCare case management will be authorized for a period not to exceed 60 days or until enrollment in a managed care health plan, whichever occurs first.

- If the member is enrolled in an MCO during the requested date of service, the service authorization requests will be returned to the provider because the member is not eligible for FFS BabyCare case management services.

- If the member meets the criteria to be excluded from managed care enrollment, the request will be authorized as follows:

Members must be either pregnant or within 12 months postpartum (up to the last day of the calendar month in which the postpartum year ends.

a. Infants are eligible for BabyCare case management up to their second birthday.

Timely Requests:

DMAS BabyCare service authorization request for case management services must be submitted to DMAS within 30 calendar days from the date the face-to-face assessment was completed and documented on the assessment form as the case management open date (DMAS-50 M or I).

The BabyCare case management service authorization request form should include the provider requested begin date and DMAS will authorize the begin date as requested if eligible.

DMAS will not issue a service authorization number for BabyCare case management if:

a. The face-to-face assessment and service plan is not completed for the pregnant mom or the infant on the DMAS BabyCare service authorization request forms.

b. The case management open date is greater than 30 days from the date the form was submitted to DMAS (except for retrospective reviews).

Incomplete Requests:

- Requests for Service Authorization will be *rejected* by the Service Authorization Contractor, with ARC 4680 as incomplete, if the following criteria are not met:
  - Face-to-face assessment and service plan are not completed for the pregnant woman or infant on the DMAS BabyCare Service Authorization Request form.
  - BabyCare case management service authorization request form is

missing the
- Requested service start date
- The authorized service starts date

- Rejected Service Authorization requests for BabyCare case management will include the message:
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    - Please update the applicable DMAS-50 form to include missing information required to complete the Service Authorization request.

- Requests for Service Authorization will be *denied* with ARC 3010 by the Service Authorization Contractor as incomplete, if the following criteria are not met:
    - Case management open date is *greater than* 30 days from the date the form was submitted to the Service Authorization Contractor.

Change in Eligibility:

For pregnant woman who receive a BabyCare case management service authorization under FFS, then moves to an MCO and returns to FFS in the same prenatal period, the provider shall submit the DMAS–50 Maternal (M) form and check the box for "Re-issue for same prenatal period." DMAS shall, upon verification, reactivate the previous authorization number.

If the member loses Medicaid eligibility, including managed care eligibility, for a period of two (2) months or more, a new face-to-face assessment shall be required prior to submission of a new service authorization request. All timely submission requirements shall apply.

Service Plan

The case manager will develop a Service Plan based on the completed assessment. The case manager may utilize the DMAS 52 or equivalent. The Service Plan must include the following:

- Specific goals and actions to address the medical, psychosocial, educational, and other needs of the eligible individual;
- Include activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identify a course of action to respond to the assessed needs of the eligible individual and a plan for follow-up.

Coordination and Referral

The case manager assists the individual in arranging appropriate services and

ensuring continuity of care. The case manager helps the individual obtain needed services, including those medical, psychosocial, and educational services that address the needs and goals identified in the Service Plan. These services may include, but are not limited to, coordination and referral to the following: primary medical care, Early Intervention Services/Part C, Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Early Periodic Screening Diagnosis and Treatment (EPSDT) services, expanded prenatal services, the State Tobacco Quit Line, DMAS Managed Care Organizations (MCOs) and family planning services.

Note: The case manager should discuss with the pregnant woman or caregiver of the infant the available services through Part C. If the infant appears to not be developing as expected, or has a medical condition that can delay normal development, the case manager should work with the family to initiate a referral for evaluation and assessment through Part C. The case manager may assist the family in contacting the Infant & Toddler Connection for the city or county in which the family resides via the state toll free number: 1-800-234-1448, or through the Infant & Toddler Connection website at www.infantva.org. The case manager may work with the Part C Service Coordinator to help facilitate services as necessary.

Time spent making appointments for an individual is a covered case management activity, however, accompanying or transporting individuals to appointments is not covered under FFS BabyCare Case Management. BabyCare case management referrals and related activities may include scheduling appointments, assisting the individual in completing necessary forms, coordinating services and planning treatment with other agencies and providers, and collateral contacts with significant others to promote implementation of the service plan.

Monitoring and Follow-up

The case manager assesses ongoing progress and ensures services are delivered. The case manager maintains contact with other service providers to ensure the individual keeps appointments and the individual understands and has the ability to comply with the Service Plan and any other requirements of the service providers.

Activities may include contacts with the individual, the individual's caregiver, service providers, and/or family members as often as necessary to ensure that the Service Plan is effectively implemented and to determine if:

- Services are being furnished in accordance with the individual's Service Plan and includes activities and contacts that are necessary to ensure implementation and continued appropriateness of the service care plan;
- The plan and follow-up documented in the Service Plan are adequate to meet the member's identified needs/problems including collateral contacts, site visits and home visits; and
- There have been changes to the needs or status of the member and Service Plan requires updating.

Monitoring includes making necessary adjustments in the Service Plan and service arrangements with providers to ensure that the Service Plan adequately addresses

the needs of the individual. BabyCare case management monitoring and follow-up activities includes at least one annual monitoring to ensure that:

- Services are being furnished in accordance to the service care plan;
- Services in the care plan are adequate;
- Service care plan is updated as needed.

BabyCare case management monitoring and follow-up includes the BabyCare provider monitoring and following up on the individual's needs based on the BabyCare providers professional judgement.

Care Management Support and Education

Support is a covered case management activity when the purpose is to guide the individual and develop a supportive relationship that promotes achieving goals in the Service Plan. Support, in this context, is not psychological counseling, examination, or therapy. Support as part of case management is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community.

Allowed educational activities include discussions describing the benefits of activities listed in the Service Plan to individuals. Educational activities must be individualized. Educational activities do not include group activities that provide general information. For example, group sessions on stress management, the nature of serious mental illness, or family coping skills are not covered BabyCare case management activities.

Service Units and Service Limitations

Code	Description	Unit	Limits
G9001	Case management assessment and development of service plan.	Per assessment and service plan - jointly	2 per provider per year
G9002	Case management	per day	Requires service authorization
S0215	Travel / mileage	per mile	Requires paid case management for same time period

Note: Billing for the service can only begin with the first face-to-face contact and can be submitted only for months in which at least one direct or collateral contact, activity or communication occurs and is documented. (Collateral contact is contact with the individual, primary care provider and/or the individual's significant others to promote implementation of services.) The level of involvement will vary among individuals due to the level of need, identified risks, availability of

providers/services within the area, the support available to the individual and the individual's ability to follow the Service Plan.

There must be at least one documented contact, activity or communication as designated above, and relevant to the Service Plan, during any calendar month for which BabyCare case management services are billed. Written plan development, review, other written work is not considered a billable case management activity.

In the event that the case manager cannot complete a contact during a month after case management services have been authorized, an extension of one additional month will be granted to allow the case manager time to re-connect with the individual to resume services. The case manager must document the reason the contact with the individual did not occur within the given month as well as documentation of any contacts (attempted and/or successful). If the case manager is not able to complete a telephone, collateral or face-to-face contact during the one month extension, the individual's case must be closed. The provider must send a letter stating that the individual's- case is being closed, to the member and the member's primary care provider or referral source.

Initial Contact Requirements for Case Management

Upon referral or indication that a member may benefit from case management, the case manager must initiate contact to the member or member's caregiver to schedule a face-to-face meeting. A telephone call or collateral contact must be made, at a minimum, within 15 calendar days from the date the referral was received. A collateral contact is defined as contact with the member, primary care provider and/or the member's significant others to promote implementation of services. The provider should maintain privacy requirements as set forth by Health Insurance Portability and Accountability Act (HIPAA)

The initial face-to-face contact must occur within 30 calendar days from the date the referral was received. If the case manager cannot make the face-to-face contact within 30 calendar days from the date the referral was received, an extension of 30 calendar days will be granted to allow the case manager to continue efforts to engage member in services. If the case manager is not able to complete the face-to-face contact during the 30 calendar day extension period, the case manager must close the case and notify the referring provider as applicable and the member's primary care provider.

Note: DMAS will only authorize case management at the time the face-to-face assessment and development of service plan is complete and the individual/individual's representative has agreed to be open for BabyCare case management services. If the face-to-face assessment and service plan is not completed, DMAS will not issue a service authorization number to use to bill for BabyCare case management services.

Home Visits

Face-to-face visits may take place in various settings such as the home, an office, and school, place of business, doctor's office or clinic. DMAS requires the case

manager complete a minimum of one home visit to assess the member's home environment. DMAS requires that the case manager conduct a home visit with the member within 30 days from the date of referral to the program in order to complete an initial assessment of the home environment. If the case manager is unable to complete a home visit, there must be clear documentation why the home visit did not occur (i.e. the member or other member of the family refuses to allow the case manager in the home). The BabyCare case management service authorization request is only reimbursable if the DMAS-50 Maternal or Infant high risk assessment form is completed in full.

Closing a Case

An individual is closed to BabyCare case management services if the BabyCare provider is unable to establish a successful contact during a month and an extension of one month was granted. If the BabyCare provider is unable to establish a successful contact after 60 days the BabyCare provider closes the individual's case.

Case management is covered for the maternal member up to the end of the 12th month post-partum and the infant up to their second birthday. If an individual is enrolled in an MCO, BabyCare case management is closed in FFS because the MCOs have high risk pregnant women and their infant programs. The case must be closed if one of the following occurs:

- The member's goals are met and the member is no longer in need of services;
- The maternal member reaches the end of the 12th month postpartum;
- The child member reaches age two;
- The case manager is not able to establish contact with member for 60 consecutive days;
- The maternal member or infant's caregiver request to discontinue services;
- The individual is enrolled in an MCO;
- The individual no longer meets criteria;
- The individual moves out of the service area.

Prior to closing the individual to services, the BabyCare provider case manager needs to ensure a smooth discharge or transition by assisting the individual in locating community services which may be available to the individual and notify the other individual's providers , as appropriate, that services are being discontinued. The Service Plan must be updated and the termination reason must be included in the medical record.

If a member who was closed to case management services becomes eligible again, the provider must follow the guidelines for new enrollments. Note: DMAS no longer requires the BabyCare provider to send notification of the closure/transfer from FFS to an MCO.

Transfers to Managed Care Organizations (MCOs)

Members will often transfer between Fee-for-Service (FFS) and an MCO. Note: DMAS does not require the provider to send notification of the transfer from FFS to an MCO. Providers should contact the appropriate MCO about the requirements of the specific MCO's high risk maternity and infant program and request for continuation of service authorization.

It is the responsibility of the BabyCare provider to verify the individual's eligibility for BabyCare case management service authorization services to ensure they have the appropriate authorizations, approvals, and meet contract requirements in order to bill for services (either FFS or the MCO).

Expanded Prenatal Services

The BabyCare program offers the following expanded prenatal services consistent with 12VAC30-50-510:

- Individual Patient Education Classes
- Nutrition Services
- Blood Glucose Meters
- Homemaker Services
- Substance Use Disorder Services

Referrals for expanded prenatal services may occur at any time during the pregnancy. In most instances, a pregnant woman who requires expanded prenatal services will also have been referred for BabyCare case management, however, case management is not a requirement for receipt of Expanded Prenatal Services. In cases where there is more than one provider able to provide expanded prenatal services to the individual, the individual must be given a choice of providers and this choice must be documented in the individual's record.

BabyCare providers of expanded prenatal services must be enrolled as a provider with DMAS and meet provider requirements as detailed in Chapter II of this manual to receive reimbursement for these services.

Patient Education (S9442 and S9446)

Individual Patient Education includes Childbirth Education (S9442) and Parenting Education (S9946) for pregnant women in a planned, organized teaching environment including but not limited to topics such as pregnancy and childbirth, breastfeeding, signs and symptoms of preterm labor, alcohol/tobacco/substance use and cessation, infant safety, and parenting. There is a reimbursement limit of six classes under Childbirth Education (S9442) and six classes under Parenting Education (S9446) per member.

The patient educator is responsible for offering group classes to the individual and documenting the individual's attendance and completion of the classes. In addition, the patient educator must notify the primary care provider and/or case manager of the dates on which the individual attended classes and any final recommendations for follow-up or additional services needed.

DMAS approved education providers include individuals employed by the Virginia Department of Health, Federally Qualified Health Centers (FQHCs) or Rural Health Clinics who are approved to provide health education in the clinic setting. BabyCare providers should maintain a copy of the employee's approved certification/training in the personnel file at the agency.

Individuals who have certification from programs other than the provider types listed above may forward their course content, a copy of the certificate and the BabyCare provider enrollment application to DMAS at the following address to be reviewed for approval:

DMAS
Attention: BabyCare, Request for Member Education Certification Approval
Division of Health Care Services
600 East Broad Street
Richmond, Virginia 23219

The BabyCare education instructor must complete a formalized course given by a recognized accredited health care organization or education related agency which may be community or hospital based. The BabyCare individual education instructor training must be a formal course of study based on an established written curriculum. The individual education instructor training must include principles of teaching, adult learning and group education as well as content specific to the type of certification (e.g., preparation for childbirth, preparation for parenting, tobacco dependence education), and mechanisms for practice teaching and/or observed teaching practicum should be included.

Nutrition Services

Nutrition Services include assessment of dietary habits, development of a nutrition care plan, nutrition counseling and counseling follow-up. This information is provided in addition to the expected basic nutrition information pregnant women receive from their medical care providers or thehttp://www.vdh.virginia.gov/livewell/programs/wic/ through the Virginia Department of Health. The information must be provided by a Registered Dietitian (R. D.) or a person with a master's degree in nutrition, maternal and child health, or clinical dietetics with experience in public health, maternal and child nutrition, or clinical dietetics.

Program criteria for referral to nutrition prenatal care services includes, but is not limited to, the following: pre-pregnancy underweight/overweight, inadequate or excessive weight gain, a teenager 18 years of age or younger, poor diet, pica, an

obstetrical or medical condition requiring diet modification such as multiple gestation, delayed uterine growth, diabetes, hypertension and anemia.

The nutrition services provider must complete an assessment within 30 days of the referral from the primary care provider or case manager and offer any follow-up nutrition counseling indicated. DMAS will reimburse a provider for the initial nutrition assessment and up to two (2) follow-up visits.

The initial orientation and periodic follow-up should include education concerning basic nutrition during pregnancy, appropriate weight gain during pregnancy and dietary intake. Nutrition assessment, development of a nutrition care plan, provision of nutrition counseling is provided, including appropriate referrals and linkage with WIC.

The provider must forward a copy of the nutrition assessment to the primary care provider. Upon completion of the nutrition counseling, the provider must provide the primary care provider with a report of the progress of the individual and final recommendations.

Please refer to the DMAS Durable Medical Equipment (DME) provider manual for requirements regarding nutritional counseling related to women who receive glucose monitors.

Glucose Monitors

Women with diabetes need to regularly check and control their blood glucose levels. If a woman has medical conditions caused by her diabetes, pregnancy can make these conditions worse. Miscarriage and stillbirth are more common in pregnant women with diabetes. The risks for problems of mother and baby are decreased if the woman maintains her blood glucose levels in the normal range before and during pregnancy.

DMAS will reimburse for blood glucose monitors and test strips for pregnant women suffering from diabetes for which the practitioner determines nutritional counseling alone will not be sufficient to assure a positive pregnancy outcome. Please refer to the DMAS DME Provider Manual, Chapter IV – Covered Services, regarding additional requirements. The DMAS DME Provider manual is available online at https://www.dmas.virginia.gov/

Women who receive a blood glucose meter covered by DMAS, must also be referred for nutrition counseling. Blood glucose meters shall be provided by Medicaid enrolled durable medical equipment providers.

Homemaker Services

Homemaker Services include those services necessary to maintain household routine for pregnant women, primarily in the third trimester, who need bed rest. Services include, but are not limited to, light housekeeping, childcare, laundry, shopping, and meal preparation.

To qualify for homemaker services, the member must be referred by her primary care provider who has determined that it is medically necessary for the member to be on bed rest. The homemaker services must be rendered by Medicaid certified

providers.

Duties may be performed by a companion, homemaker, nursing assistant or home health aide. A RN or Social Worker must provide supervision to the care providers.

The RN or Social Work supervisor must make an initial home assessment visit prior to the start of care and develop a written Service Plan with the member for the homemaker to follow. The supervisor is also responsible for introducing the assigned homemaker to the member and reviewing with the homemaker and the member the duties the homemaker will be performing. The homemaker may perform any household duties which follows the Service Plan and enables complete bed rest as ordered by the individual's primary care provider. The supervisor shall make supervisory visits as often as needed to ensure both the quality and appropriateness of services.

The homemaker may not transport the individual in the homemaker's personal car or perform any skilled nursing care procedures.

The homemaker agency and the member may decide the number of hours of care that are needed per day. There is a limit of 124 hours per 31 days.

If services are medically necessary beyond 31 days, the member's primary care provider or Baby Care case manager may request an extension through Acentra Health. The member's primary care provider must write a letter of medical necessity that includes the following information: the member's name and current Medicaid/FAMIS/FAMIS Plus/FAMIS MOMS ID#; a brief justification for the continued need for bed rest (e.g., placenta previa, preterm labor); and, the expected amount of time the member will need bed rest. The estimated date of delivery should be included if bed rest is required through delivery.

To obtain approval for additional hours, the primary care physician or care manager must complete the request and upload the letter of medical necessity to Acentra Health using their ANG portal.

If the member is authorized by DMAS to receive more than 31 days of homemaker services, the homemaker supervisor must make additional supervisory visits at a minimum frequency of every 30 days. The homemaker must be present during the supervisor's visit at least every other month. Flow sheets must be used by the homemaker/supervisor for documentation purposes. Each date of service must be documented and signed by the homemaker and the individual.

Substance Use Disorder Services

Please refer to the DMAS Community Mental Health Rehabilitative Services Manual for service definitions and requirements. A copy of this manual is available on the DMAS website at https://www.dmas.virginia.gov/

RELATED PROGRAMS FOR PREGNANT WOMEN AND CHILDREN

The following information describes selected covered services that the case

manager may consider for referral of eligible individuals enrolled with Medicaid, FAMIS, FAMIS Plus and FAMIS Moms in order to address needs as identified through the case management process.

Home Health Services

Home health services are available when ordered by a physician for pregnant women whose medical complications require short-term, intermittent nursing care. Such services are provided by DMAS-enrolled home health agencies according to a written plan of care.

For more information, refer to the DMAS Home Health Manual. A copy of this manual is available on the DMAS website at https://www.dmas.virginia.gov/

Family Planning Services

Family planning services are covered by the Virginia Medical Assistance Program when provided or ordered by DMAS-enrolled providers. These are services that delay or prevent pregnancy including diagnosis, treatment, drugs, supplies, devices and certain elective sterilization procedures (for men and women). Coverage of such services does not include services to treat infertility or services to promote fertility.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) benefit covers comprehensive and preventive child health care for individuals eligible for Medicaid who are under the age of 21. The benefit covers periodic screenings, vision, dental and hearing services and medically necessary health care services needed to correct or ameliorate physical and mental conditions. Through the EPSDT benefit eligible children have access to services not necessarily available to adults. For example, hearing aids, assistive technology, personal care services, private duty nursing and medical formula and medically-indicated nutrition supplements:

For more information on EPSDT, refer to the DMAS EPSDT Manuals available on the DMAS website at https://vamedicaid.dmas.virginia.gov/pdf_chapter/epsdt-supplements#gsc.tab=0

Dental Services

Dental treatment for children and adults, including pregnant women enrolled in Medicaid and FAMIS MOMS, is covered through Virginia's dental program, CardinalCare Smiles.

Additional information about the CardinalCare Smiles program is available at https://www.dmas.virginia.gov/for-providers/dental/

Early Intervention

Part C of the Individuals with Disabilities Education Act (IDEA) is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, ages birth through age 2 years, and their families. In Virginia, Part C services are provided through the Infant & Toddler Connection of Virginia. Infant & Toddler Connection of Virginia provides early intervention supports and services to infants and toddlers from birth through age two who are not developing as expected or who have a medical condition that can delay normal development. Early intervention supports and services focus on increasing the child's participation in family and community activities that are important to the family. In addition, supports and services focus on assisting parents and other caregivers to find ways to help the child learn during everyday activities. These supports and services are available for all eligible children and their families regardless of the family's ability to pay.

Additional information on early intervention services in Virginia can be found on the Infant & Toddler Connection of Virginia website at https://www.itcva.online/ or by contacting the Virginia Department of Behavioral Health and Developmental Services (DBHDS).

CLAIM INQUIRIES & RECONSIDERATION

Inquiries concerning covered benefits, specific billing procedures or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers
1-804-786-6273 Richmond Area and out-of-state long distance
1-800-552-8627 In-state long distance (toll-free)

ATTACHMENTS

Fee-for-Service BabyCare Case Management Service Authorization (SA) Request Business Rules

Topic	Information
BabyCare Case Management	Case management is a service to improve coordination of care, reduce barriers, and link members with appropriate services to ensure comprehensive, continuous health care.
Regulation	12VAC30-50-410 Case Management Services for High Risk Pregnant Women and Children http://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section410/
BabyCare Provider Manual	Provider Requirements, Covered Services, and Documentation Requirements https://vamedicaid.dmas.virginia.gov/pdf_chapter/baby-care#gsc.tab=0
Eligibility Criteria	➢ Members must be either pregnant or within 12 months postpartum (up to the last day of the calendar month in which the postpartum year ends. ➢ Infants from birth up to the age of 2 years To be eligible for BabyCare services, pregnant women and infants up to age two must be at risk for poor birth/health outcomes.
SA Request Forms	BabyCare Service Authorization Requests DMAS 50-I: Infant High Risk Case Management DMAS 50-M: Maternal High Risk Case Management https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library#gsc.tab=0&gsc.q=DMAS%2050&gsc.sort=
Eligibility Verification and FFS Service Authorization Numbers	Medicall: 800-884-9730 or 800-772-9996 Automated Response System (ARS) Web Portal www.virginiamedicaid.dmas.virginia.gov
Acentra Contact Information	Please contact Acentra Health for your service authorization questions. You can access information at https://dmas.kepro.com, or by phone at 888.827.2884.
MCO Contact Information for Managed Care Members	Managed Care High Risk Maternity and Infant programs information: http://dmasva.dmas.virginia.gov/Content_atchs/mc/mc-guide_p2.pdf. Aetna Better Health: ➢ Baby Matters (1-800-279-1878) Anthem HealthKeepers Plus: ➢ New Baby New Life (1-800-901-0020) Molina Healthcare: ➢ Mae Health e (1-00-424-4518) United Healthcare: ➢ Healthy First Steps (1-866-599-5985) Sentara: ➢ Partners in Pregnancy (1-866-239-0618) ➢
More Information	More information about BabyCare may be found at https://www.dmas.virginia.gov/for-providers/maternal-and-child-health/baby-care/t

BabyCare Case Management Service Authorization (SA) Requests
Business Rules Process for Virginia Medicaid Fee-for-Service (FFS) Members

1. Enrolled Providers

BabyCare services are available for high-risk pregnant women enrolled in Fee-for-Service (FFS) Virginia Medicaid, Family Access to Medical Insurance Security (FAMIS), FAMIS Plus or FAMIS MOMS programs. Expanded prenatal services are available to pregnant women in FFS, FAMIS, FAMIS Plus or FAMIS MOMS programs. To be eligible for BabyCare services, pregnant women and/or infants up to age two must be identified as at-risk for poor birth/health outcomes.

BabyCare Case Management services may be provided by a:

- Registered Nurse (RN) who has an unrestricted license by the Virginia Department of Health Professions, Virginia Board of Nursing with a minimum of one year of experience in community health nursing and experience in working with pregnant women; or
- Social Worker who has either a master's or bachelor's degree in social work from a school of social work accredited or approved by the Council on Social Work Education with a minimum of one year of experience in health and human services and experience in working with pregnant women and their families. • Behavioral health screenings by an MD/DO, PA or NP, to identify and assist pregnant/post-partum women who may be at risk for mental health, substance use or intimate partner violence. Screenings are also performed to identify infants who may be at risk for developmental issues secondary to their family situation and/or the post-partum women's risks.
- • Case management for high-risk pregnant women, post-partum women and their infants up to two years of age, completed by a case manager licensed registered nurse (RN) or qualified social worker (MSW/BSW).
- • Expanded prenatal services for pregnant women including individual education classes (tobacco dependence, childbirth/parenting), glucometers, nutrition, homemaker and/or substance use disorder (SUD) services by a DMAS approved provider.

Refer to Chapter II of the BabyCare Provider Manual for provider qualification requirements.

2. Eligibility

Members must be either pregnant or within 12 months postpartum (up to the last day of the calendar month in which the postpartum year ends. (The 12-month postpartum continuous coverage applies to pregnant full benefit Medicaid (Aid Category 091) and FAMIS MOMS (Aid Category 005) members. It is not limited to pregnancy coverage groups). FAMIS Prenatal Coverage (Aid Category 110 and 111) members are eligible up to the end of the month following their sixtieth day post-partum.

Infant members are eligible for BabyCare case management up to their second birthday BabyCare case management program is for FFS members only. The Virginia Medicaid/FAMIS managed care organization have high-risk maternity and infant case management programs.

Determining member eligibility:

1. A verification vendor, the Automated Response System (ARS) Web Portal www.virginiamedicaid.dmas.virginia.gov
OR
2. Medicall at 800-884- 9730 or 800-772-9996. The eligibility verification process will provide information on which program the recipient is participating (Medallion 4.0, Medicaid Fee-For-Service, or FAMIS).

Most individuals are covered for BabyCare under a Virginia Medicaid/FAMIS contracted managed care organization (MCO). If the member is enrolled in an MCO, the BabyCare case management service authorization request will be denied and the provider must contact the right MCO about the requirements of the specific MCO's maternity and infant program, to request continuation of service authorization. Providers must be contracted with the MCO to bill for services.
The pregnant woman, or caregiver/parent of the infant, must agree to case management and sign the Letter of Agreement (DMAS-55 or equivalent) that becomes part of the medical record. The Letter of Agreement does not need to be sent to DMAS to process the service authorization request. Refer to Chapter III of the BabyCare Provider Manual for more information on eligibility.

Refer to Chapter IV of the BabyCare Provider Manual for information on eligibility.

3. Case Management Assessment

DMAS requires that the BabyCare case manager complete the initial assessment and submit a copy of the completed relevant form DMAS-50(M) or DMAS-50(I) to the Service Authorization contractor's online portal, ANG.

4. Timely Submissions of Service Authorization Requests

A service authorization must be obtained for FFS Medicaid/FAMIS members that are eligible for BabyCare case management services. The DMAS BabyCare Service Authorization request for case management services must be submitted to the Service Authorization Contractor within 30 calendar days from the date the face-to-face assessment was completed and documented on the DMAS-50(M) or DMAS-50(I), also known as the case management open date, unless the exception for retroactive eligibility is met. Providers may submit BabyCare case management service authorization requests only after:
1. Completion of the face-to-face assessment
2. Development of a service plan
3. The member/member representative has agreed to receive BabyCare case management services.

5. Exceptions to Timely Submission Requirements

Retrospective Reviews:

Performed when a provider is notified of a member's retroactive eligibility for Virginia Medicaid coverage. There is an exception to the above timeliness requirement as noted above in Receipt of Service Authorization section.

6. Incomplete Service Authorization Requests

Approved Service Authorization Requests will result in a system-generated letter sent to the requesting BabyCare Provider to include the approval determination, dates of service for the service authorization, and procedure codes requested.

A) Requests for Service Authorization will be rejected by the Service Authorization Contractor, with ARC 4680 as incomplete, if the following criteria are not met:
1. Face-to-face assessment and service plan are not completed for the pregnant woman or infant on the DMAS BabyCare Service Authorization Request form.
2. BabyCare case management service authorization request form is missing the
a) Requested service start date
b) The authorized service starts date

B) Rejected Service Authorization requests for BabyCare case management will include the message:

Please update the applicable DMAS-50 form to include missing
information required to complete the Service Authorization request.

C) Requests for Service Authorization will be denied with ARC 3010 by the Service Authorization Contractor as incomplete, if the following criteria are not met:
1. Case management open date is greater than 30 days from the date the form was submitted to the Service Authorization Contractor, or
2. The SA is submitted within 30 days of the member becoming retroactively enrolled in Medicaid FFS, and the Open date for the services up to three months prior to the effective date of the member's retroactive FFS eligibility date?

Case management service authorization requests must be submitted to DMAS on the DMAS-50(M)maternal or DMAS-50(I)infant form with all required identifiable and legible information. This includes:
- Identification of the member on each entry by full name and Medicaid/FAMIS ID number
- Member date of birth or Expected Delivery Date (EDD)
- Date of assessment completion
- Date prenatal care begins (# of weeks gestation) *
- Provider case management begin date
- Agency (Health Department) name
- National Provider Identifier (NPI #) for the Health Department
- Signature and credentials** of case manager completing assessment

7. Incorrect Signature Protocol

Signatures and complete dates are required for all documentation and must include, at a minimum, the first initial and last name and credentials of the provider.

The service authorization request will be pended and returned to the provider if the signature protocol is not followed.
*(Only applies to completion of the DMAS-50(M)maternal form)
(Signatures and complete dates are required for all documentation and must include the first initial, last name and credentials (RN/MSW/BSW) of the provider.)
**(Signatures and complete dates are required for all documentation and must include the first initial, last name and credentials (RN/MSW/BSW) of the provider.)

8. Authorization Period

It is the responsibility of the provider to **verify the member's eligibility prior to submitting case management service authorization requests** as members often transfer between fee-for-service and managed care. Service authorizations requests will be rejected and returned to the provider if the member is enrolled in an MCO during the requested date of service.

Spanned Service Dates for Authorization:
- Service Authorization requests are approved initially for 60 days from the start of the case management.
- For continued case management services beyond the 60 period approved, the provider would need to submit another request to reissue within the same prenatal period. As long as eligibility criteria are met, the SA would be reissued for another 60 days. A new assessment is not required.
- Days approved are transmitted in units with specific dates noted as the "from" and "through" dates. Note: One unit = 1 day.

If the member meets the criteria to be excluded from managed care enrollment, the request will be authorized as follows:

a. Members must be either pregnant or within 12 months postpartum (up to the last day of the calendar month in which the postpartum year ends.; or
b. Infants are eligible for case management up to their second birthday.

Receipt of Service Authorization:
- All requests for Service Authorization must be received within 30 days of completion of case management open date. Requests received after 30 days of the case management open date, will be denied untimely with Action Reason Code (ARC 3010). See below for exception.
- The provider must contact the contractor prior to the Service Authorization end date if services are to extend beyond the initial authorization period. The request will be denied untimely up to the date the request is received
- Exception to the above 30 day rule: Retrospective review will be performed when a provider is notified of a member's retroactive eligibility for Virginia Medicaid coverage.
  - o Has the provider requested the SA within 30 days of the member becoming retroactively enrolled in Medicaid FFS?
  - o If yes, is the Open date for the services up to three months prior to the effective date of the member's retroactive FFS eligibility date?

9. Service Authorization Numbers

Providers should not contact DMAS BabyCare staff requesting the authorization number or to generate a duplicate authorization number. It is the responsibility of the provider to obtain the authorization number via the DMAS

web portal or call MediCall at 1-800-884-9730 or 800-772-9996. The provider will need the BabyCare case management open date to obtain the service authorization number. The case management open date is the first begin date for BabyCare case management services.

How to use Medicall:
1. Once dialed in, enter National Provider Identifier
2. Select #4 for Service Authorization status
3. Enter Member ID (12 digits)
4. Enter the BabyCare case management open date
5. Select pound # (skip end date request – do not enter date)
6. Select star * (do not know service authorization number)

The Virginia Medicaid Web Portal will not have authorization numbers for those recipients enrolled in managed care.

Virginia Medicaid Management and Information System (MMIS) generates service authorization notifications and mails those within one (1) business day of authorization of services. If the service authorization is rejected, the notification letter will include the reason for the rejection. Requests that are approved include a service authorization number. This service authorization number must be included in Locator 23 of the CMS -1500 claim form. Claims submitted without a service authorization number will be denied.

Transfers to Managed Care Organizations (MCOs) Providers should contact the member's MCO about the requirements of the specific MCOs maternity and infant programs, and request continuation of service authorization. It is the responsibility of the provider to verify the member's eligibility each time services are rendered to ensure they have the appropriate authorizations, approvals, and contract requirements to bill for services (either FFS or the MCO).

For members that transition into a health plan, the plan will honor the Service Authorization Contractor's authorization for a period of not more than 30 days or until the Service Authorization ends, whichever is sooner, for providers that are in and out of network. When a member enrolls in Cardinal Care, the provider should contact the Cardinal Care Health Plan to obtain an authorization and information regarding billing for services if they have not been contacted by the Cardinal Care Health Plan.

11. Changes in Eligibility

If the member loses Medicaid eligibility, including managed care eligibility, for a period of two (2) months or more, a new face-to-face assessment shall be required prior to submission of a new service authorization requests. All timely submission requirements as outlined in Section 4 of this document shall apply

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MATERNAL HIGH RISK CASE MANAGEMENT

BABYCARE SERVICE AUTHORIZATION REQUEST

Client Information:

Last Name: _____ First Name: _____ MI: ____

Medicaid/FAMIS ID # _____ Prenatal care began: _____

Gravida: ____ Para: ____ AB Elect: ____ AB Spont: ____ EDD: ____ / ____ / _____ (weeks gestation)

Case management open date: ____ / ____ / _____ Agency Name: _____

May only begin after face-to-face assessment is completed.
Time spent to initiate contact is not included in case management.

National Provider Identifier:

Risk Section: Check risks that pertain to maternal client.

Psychosocial	☒		☒		☒
Hx of or current abuse or IPV	☐	Unemployed / lack of financial resources	☐	Needs due to disability	☐
Lack of positive support system	☐	Communication barriers	☐	Maternal/paternal absence	☐
Unplanned pregnancy	☐	Did not complete high school	☐	Protective services involvement	☐
Barriers to care present	☐	Requires increased knowledge re: pregnancy/parenting	☐	Poor emotional bonding / Unwanted pregnancy	☐
Unstable shelter/housing 37. Poor emotional bonding ___ ___ affecting pregnancy ___ ___	☐	Multiple medical providers	☐	Behavioral health dx or symptoms (e.g., PPD)	☐
Medical	☒		☒		☒
Interval from previous pregnancy < 12 months	☐	Uterine anomaly (except fibroids)	☐	Current infection of genital or urinary tract	☐
Multiple gestation	☐	Genetic condition	☐	Substance Use (prescription or illicit)	☐
Previous preterm birth	☐	Previous fetal/infant death	☐	Tobacco Use	☐
Maternal age >35	☐	Previous pregnancy complication	☐	Alcohol Use	☐

Maternal age ≤ 18	☐	Significant medical condition (e.g. DM, PIH, EBLL)	☐	Re-issue for same prenatal period	☐
Nutritional	☒		☒		☒
Prepregnancy overweight	☐	Nutritional education needs	☐	Anemia	☐
Prepregnancy underweight	☐	Special diet/formula prescribed	☐	Anorexia/Bulimia/Pica	☐
Hyperemesis 56. Medical Condition affects diet 61. Breast feeding problems	☐	Diet modification need	☐	Obesity (BMI ≥ 30)	☐
☐	Other risks:				

Case Manager's Signature and Title: _____ **Date:** ____/____/____

DMAS Use Only		
Approve ☐	Pend and return to provider due to missing information ☐ __ Member information __ NPI # __ Correct signature Date Returned_____	Reject ☐ __ Member enrolled in managed care __ Case management begin date >30days Date Returned_____

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

INFANT HIGH RISK CASE MANAGEMENT

BABYCARE SERVICE AUTHORIZATION REQUEST

Client Information *(Infants up to age 2 only)**:***

Last Name: _____ First Name: _____ MI: _____

Medicaid/FAMIS ID #: _____ Date of birth: ____ / ____ / _____

Case management open date: ____ / ____ / _____ Agency Name: _____

May only begin after face-to-face assessment is completed. Time spent to initiate contact is not included in case management.

National Provider Identifier:

Risk Section: *Check risks that pertain to infant up to age 2.*

Psychosocial	☒		☒		☒
Hx of or current abuse in home	☐	Caregiver unemployed / lack of financial resources	☐	Needs due to disability	☐
Lack of positive support system	☐	Caregiver communication barriers	☐	Maternal/paternal absence	☐
Unplanned pregnancy	☐	Caregiver did not complete high school	☐	Protective services involvement	☐
Barriers to care present	☐	Caregiver requires parenting education	☐	Poor emotional bonding	☐
Unstable shelter/housing 37. Poor emotional bonding ___ ___ affecting pregnancy ___ ___	☐	Multiple medical providers requiring coordination	☐	Caregiver behavioral health dx or symptoms (e.g., PPD)	☐
First time parent/caregiver	☐	Maternal age ≤ 18	☐	Other:	☐
Medical	☒		☒		☒
Developmental delay concern or diagnosis	☐	Genetic Condition	☐	Caregiver substance use (prescription or illicit)	☐
Fetal alcohol syndrome / substance exposed newborn	☐	Infant chronic illness	☐	Caregiver alcohol abuse	☐
Birth weight ≤ 2500 grams	☐	Significant medical condition (e.g. EBLL)	☐	Caregiver tobacco use	☐

Needs education/support re: following AAP recommended periodicity schedule	☐	Failure to thrive or flattening of growth curve	☐	Other:	☐
Nutritional	☒		☒		☒
Nutritional education needs	☐	Breast feeding problems	☐	Anemia	☐
Special diet/formula prescribed	☐	Poor use of special formula	☐	Other:	☐
Inadequate sucking	☐	Diet modification need	☐		

☐	Other risks:	

Case Manager's Signature and Title: _____ **Date:** ____ / ____ / _____

DMAS Use Only		
Approve ☐	Pend and return to provider due to missing information ☐ __ Member information __ NPI # __ Correct signature Date Returned_____	Reject ☐ __ Member enrolled in managed care __ Case management begin date >30days Date Returned_____

BabyCare Case Management Service Authorization
Request for More Information

Client Information:

Last Name: _____ First Name: _____

Medicaid/FAMIS ID # _____

Agency Name: _____

National Provider Identifier: _____

Point of Contact: _____

FAX #: _____

Action needed:

- ☐ Medicaid/FAMIS ID required
- ☐ Member does not have Medicaid/FAMIS
- ☐ Provider NPI required
- ☐ Most recent DMAS 50 (M) or (I) required
- ☐ Member covered under managed care - must use the MCO system of care
- ☐ Duplicate request for same time period
- ☐ Specific fee-for-service dates for request needed
- ☐ Overlapping dates of service with the same and/or multiple providers

Notification of Service Authorization Status:

- ☐ Pend
- ☐ Reject

Date Request Received by DMAS:
Date Request Reviewed by DMAS:
Date Request Returned to Provider by DMAS:
Providers will have three (3) business days from the DMAS return date to submit a completed form.