SECTION 2 POLICIES AND PROCEDURES

SERVICE DESCRIPTION

Medicaid Targeted Case Management refers to activities which will assist eligible beneficiaries in gaining access to needed medical, social, educational, and other services through the following **four** components:

- Assessment
- Case Management Plan
- Referral and Linkage
- Monitoring and Follow-up

MTCM DEFINITION

The definition of services as cited in The Code of Federal Regulations42 CFR 440.169 are as follows:

Assessment

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

- Taking individual history
- Identifying the needs of the individual and completing related documentation
- Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual

Case Management Plan (CMP)

Development and periodic revision of a specific CMP based on the information collected through the assessment, and includes the following:

- Specific goals and actions to address the medical, social, educational, and other services needed by the eligible individual
- Activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals
- Identifies a course of action to respond to the assessed needs of the eligible individual

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Referral and Linkage

Referral and related activities (such as scheduling appointments) help the eligible individual obtain needed services. This includes activities that help link the individual with medical, social and educational providers or other programs and services that are capable of providing services that address identified needs and assist with achieving goals specified in the CMP.

Monitoring and Follow-up

Monitoring and follow-up includes activities and contacts that are necessary to ensure that the CMP is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring and follow-up may be with the individual, family members, service providers, or other entities. These activities may be conducted as frequently as necessary, but must be monitored at least every 60 days to help determine whether the following conditions are met:

- Services are being furnished in accordance with the individual's CMP
- Services in the CMP are adequate to meet the needs of the individual
- Identification of changes in the needs or status of the eligible individual. If changes in the needs or status of the individual are identified, monitoring and follow-up activities include making necessary adjustments in the CMP and service arrangements with providers.

Case management includes:

- Contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care;
- Helping the eligible individual access services;
- Identifying needs and supports to assist the eligible individual in obtaining services;
- Providing case managers with useful feedback;
- Alerting case managers to changes in the eligible individual's needs

[Refer to Federal Regulation 42 CFR 440.169(e).]

SECTION 2 POLICIES AND PROCEDURES

SERVICE DESCRIPTION

Timeframes

Assessment

A new MTCM beneficiary is defined as a beneficiary that has never received MTCM services, is new to the target population, or has had a break in MTCM services. The initial assessment is completed within 45 calendar days after the referral is received for MTCM services.

Addendums or updates to the initial assessment should occur as needed. An update must occur by the 180th day for services to continue. If services are still needed after the update period, a complete reassessment and new CMP must be done annually by day 365.

Case Management Plan (CMP)

The initial CMP is completed within 45 calendar days after the referral is received for MTCM services and following the assessment.

Addendums or updates to the CMP should occur as needed. An update must occur by the 180th day for services to continue. If services are still needed after the update period, a complete reassessment and new CMP must be done annually by day 365.

Referral and Linkage

For each objective on the CMP, the case manager will either make an initial referral for services or confirm with an existing provider that services are still needed. The beneficiary or his or her representative must be given the opportunity to select the service provider.

Monitoring and Follow-up

For each objective or service listed on the CMP, the case manager will monitor an initial referral at a minimum once every 60 calendar days or more frequently if needed for services or confirm with an existing provider that services are still needed.

MTCM CONTACT

An MTCM contact is defined as any of the following:

- A contact with the beneficiary to render one or more MTCM components. A face-to-face contact is defined as a planned, in-person contact requiring travel away from the office to meet with the MTCM beneficiary, parent, guardian, or provider.

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MTCM CONTACT (CONT'D.)

Note: Electronic visual encounters (*e.g.,* Skype, teleconferencing, or other media) with the beneficiary are **NOT** considered face-to-face contacts and will be reimbursed at the standard MTCM encounter rate. Only in-person contacts will be reimbursed at the face-to-face MTCM encounter rate.

- A telephone contact in lieu of a face-to-face contact when environmental considerations preclude a face-to-face encounter, for the purpose of rendering one or more MTCM components. Documentation must include details precluding face-to-face encounter.
- A relevant e-mail contact via secured transmittal, on behalf of the beneficiary for the purpose of rendering one or more MTCM components

For Medicaid purposes, a face-to-face contact is preferable with phone and/or e-mail contact being acceptable if necessary.

Note: All contacts must comply with the Health Insurance Portability and Accountability Act (HIPAA) and confidentiality laws.

FREQUENCY OF MTCM CONTACTS

The frequency of contact with each beneficiary must be determined based on their individual needs.

MTCM mandatory contacts include:

- Face-to-face at least once every 180 days
- At least one annual face-to-face visit in the beneficiary's residential setting or in the beneficiary's natural environment under the following circumstances:
    - Homelessness
    - Beneficiary or homeowner's refusal to allow access to the home
    - Documented criminal or violent behavior or isolation that places the case manager in danger
    - When these circumstances exist, the assessment and CMP should address safety issues or housing concerns for the beneficiary.

SECTION 2 POLICIES AND PROCEDURES

SERVICE DESCRIPTION

FREQUENCY OF MTCM CONTACTS (CONT'D.)

- Face-to-face, e-mail or telephone contact with the beneficiary, his or her family, authorized representative, legal guardian or provider at least once every 60 calendar days or more frequently based on client need

Providers are required to meet the minimum frequency requirements as stated above and all contact must be compliant with HIPAA.

EMERGENCY AND AFTER HOURS REFERRALS

When a beneficiary presents with an emergency after hours or during a holiday, services may be delivered as deemed appropriate by the provider.

If activities are included as a part of a direct service, providers must bill using the appropriate procedure code.

LIMITATIONS

MTCM cannot be billed for services that directly address medical, educational, social, or other needs.

MTCM does not include case management activities that are an integral and inseparable component of another covered Medicaid service.

MTCM cannot be billed for mandated functions required by another payor source.

Providers of MTCM services do not have the authority to authorize or deny the provision of other services under the plan.

Medicaid may not be billed for services provided by a family member. Family is defined as a parent, legal guardian, spouse, sibling, aunt, uncle, niece, nephew, child, grandparent or first cousin to include in-laws and step relationships. The case manager must inform the employing entity of any potential conflicts of interest or other ethical dilemma.

Any claims (including those related to case management services) must not duplicate payments to the following entities:

- Public agencies or private entities under the State Plan
- Other services or program authorities
- Administrative expenditures