

## SECTION 2

### POLICIES AND PROCEDURES

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## SECTION 2 POLICIES AND PROCEDURES

### OVERVIEW

Medicaid Targeted Case Management (MTCM) is a means for achieving beneficiary wellness through communication, education and services identification and referral. MTCM is a time-limited process that provides an organized structured process for moving beneficiaries through the process of change and toward the goal of self-sufficiency.

- The MTCM process is a shared partnership between the beneficiary and/or responsible party and the case manager.
- Beneficiaries and/or responsible parties are actively involved in all phases of the process – assessment, planning, problem solving and identification of resources.
- MTCM ensures available resources are efficiently accessed and being used in a timely and cost effective manner.

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## **SECTION 2 POLICIES AND PROCEDURES**

### **OVERVIEW**

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## SECTION 2 POLICIES AND PROCEDURES

### COVERAGE

MTCM activities ensure that the changing needs of the Medicaid beneficiary are addressed on an ongoing basis and that appropriate choices are provided from the broadest array of options to meet those needs.

SCDHHS limits the provision of MTCM to particular target populations to make certain that qualified providers are capable of identifying and ensuring beneficiaries receive needed services.

#### CASE MANAGEMENT TARGET POPULATION

SCDHHS allows provision of MTCM services to the following target population(s):

- Individuals with Intellectual and Related Disabilities
- At Risk Children
- Adults with Serious and Persistent Mental Illness
- At Risk Pregnant Women and Infants
- Individuals with Psychoactive Substance Disorder
- Individuals at Risk for Genetic Disorders
- Individuals with Head and Spinal Cord Injuries and Related Disabilities
- Individuals with Sensory Impairments
- Adults with Functional Impairments

#### Individuals with Intellectual and Related Disabilities

Medicaid eligible individuals with a suspected diagnosis of Intellectual Disability defined as significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental phase prior to age 22 years, or a related disability defined as a severe, chronic condition found to be closely related to Intellectual Disability and meet the six (6) following conditions:

1. It is manifested before 22 years of age for Intellectual Disability and related disabilities.
2. It is likely to continue indefinitely;
3. It results in substantial functional limitation in 3 or more of the following areas of major life

## SECTION 2 POLICIES AND PROCEDURES

### COVERAGE

#### Individuals with Intellectual and Related Disabilities (Cont'd.)

activities: self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living;

4. The person's needs require supervision due to impaired judgment, limited capabilities, behavior problems, abusive or assaultive behavior, or because of drug effects/medical monitoring; and
5. The person is in need of services directed toward acquiring skills to function as independently as possible or to prevent regression or loss of current optimal functional status.
6. Specific symptoms or disturbances make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

#### At-Risk Children

South Carolina Medicaid eligible children under the age of 21 years old that meet specific needs based criteria and are "at risk" due to one of the following:

- At high risk for medical compromise due to one of the following conditions:
  - Failure to take advantage of necessary health care services
  - Noncompliance with prescribed medical regime
  - Inability to coordinate multiple medical, social, and other services due to an unstable medical condition in need of stabilization
  - Inability to understand medical directions because of comprehension barriers;
- Absence of a community support system to assist in appropriate follow-up care at home;
- Offending or victimization;
- A victim of abuse, neglect, or violence;
- Medical complexity that requires frequent care planning;
- Diagnosis of or suspected diagnosis of a

**SECTION 2 POLICIES AND PROCEDURES****COVERAGE****At-Risk Children (Cont'd.)**

developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay and/or intellectual disability and are less than age 6;

- Children who at any time during the past year have had a diagnosable mental, behavioral or diagnostic criterion that meets the coding and definition criteria specified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Specific symptoms or disturbances make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

**Adults with Serious and Persistent Mental Illness**

Medicaid-eligible adults with serious and persistent mental illness must meet the following criteria:

- Medicaid eligible individuals age 21 and older who have a major mental disorder included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders classification under schizophrenia disorders, major affective disorders, severe personality disorders, psychotic disorders, and delusional (paranoid) disorders or a diagnosis of a mental disorder and at least one hospitalization within the past 12 months for treatment of a mental disorder.
- Specific symptoms or disturbances make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

**At-Risk Pregnant Women and Infants**

Medicaid eligible pregnant women who are at risk for medical compromise due to one of the following:

- Failure to take advantage of necessary prenatal care or services
- Noncompliance with prescribed medical regime
- Inability to coordinate multiple medical, social or other services due to an unstable medical condition in need of stabilization

## SECTION 2 POLICIES AND PROCEDURES

### COVERAGE

#### At-Risk Pregnant Women and Infants (Cont'd.)

- An inability to understand medical directions because of comprehension barriers and:
  - Is expecting her first live birth and has never parented a child, or
  - Has previously been pregnant, but experienced a stillbirth, miscarriage, or had an abortion, or
  - Has previously parented her child but her parental rights were terminated, or
  - Has delivered a child, but the child died within the first 24 months of life, or
  - Has parented a child but there is an age gap of 15 or more years since the last delivery.
- The At-Risk Infant is eligible for case management under this population to the second birthday.
- Specific symptoms or disturbances make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

#### Individuals with Psychoactive Substance Disorder

Medicaid eligible individuals who are at risk of substance abuse, dependency or addiction or diagnosed with a substance disorder, psychoactive substance dependency, or induced organic mental disorders as defined in the current edition of the Diagnostic and Statistical Manual or Medicaid eligible individuals who received treatment in an intensive alcohol and drug abuse treatment program or chemical dependence hospital.

Specific symptoms or disturbances make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

#### **“At Risk” of substance abuse, dependency or addition:**

In order to meet criteria for this target population, the individual should have identified at least two (2) risk factors, one of which involves active substance use in any of the three (3) domains. Risk factors should be identified and addressed throughout the assessment. Severity on the American Society of Addiction Medicine (ASAM) dimensions should be reflected in documentation. The Case Management Plan (CMP) should be directly linked the



## SECTION 2 POLICIES AND PROCEDURES

### COVERAGE

#### Individuals with Psychoactive Substance Disorder (Cont'd.)

assessment findings and the risk factors should be addressed in the goals/objectives.

#### **Alcohol and Other Drug (AOD) Risk Factors by domains:**

- Individual Early (pre-adolescent) and adult with persistent problem behaviors:
- Risk taking, high sensation seeking behaviors (in adolescents, consider developmental stages)
- Antisocial behavior
- AOD use that does not meet diagnostic criteria (in adolescents, includes experimental use; in adults, increased use when stressed or self-medicating due to other symptoms/problems)

#### Family:

- Low perception of harm (increases likelihood of initiating use)
- Perception of parental/sibling acceptance/approval of substance abuse (strong predictor of adolescent substance abuse; linked to alcohol initiation during family gatherings)
- Lack of mutual attachment & nurturing by parents/caregivers with a family history of alcoholism
- Chaotic home environment with substance use in home

#### Peers/School/Community:

- Associating with substance using peers
- Drinking in social settings or having peers who do
- Accessibility to AOD
- Availability of AOD
- Misperceptions about extent and acceptability of drug abusing behavior
- Beliefs that drug abuse is generally tolerated

#### Individuals at Risk for Genetic Disorders

Medicaid eligible individuals who have been diagnosed with a genetic disorder, have preliminary laboratory tests showing evidence of a disorder or individuals who have a

## SECTION 2 POLICIES AND PROCEDURES

### COVERAGE

#### Individuals at Risk for Genetic Disorders (Cont'd.)

family member with an illness which is associated with a genetic disorder. The individual must be referred by the doctor of the individual who has been diagnosed with an illness caused by a genetic disorder.

Specific symptoms or disturbances make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

#### Individuals with Head and Spinal Cord Injuries and Similar Disorders

Medicaid eligible individuals who are suspected of having a traumatic brain injury, spinal cord injury or both or a similar disability not associated with the process of a progressive, degenerative illness, dementia, or a neurological disorder related to aging, regardless of the age of onset. The individual has substantial functional limitations and:

- Has urgent circumstances affecting his or her health or functional status; and
- Is dependent on others to provide or assist with critical health needs, basic activities of daily living or requires daily monitoring or supervision in order to avoid institutionalization.
- Specific symptoms or disturbances make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

#### Individuals with Sensory Impairments

Medicaid eligible non-institutionalized individuals between the ages 0 to 64 years diagnosed as legally blind, visually impaired, deaf, hard of hearing or multi-handicapped by a qualified specialist in the area of vision or hearing.

Specific symptoms or disturbances make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

#### Adults with Functional Impairments

Coverage is limited to Medicaid eligible individuals in need of services and who meet all the following criteria:

- Individuals who are 18 years of age or older
- Individuals who lack formal or informal resources to address their mental and physical needs

## SECTION 2 POLICIES AND PROCEDURES

### COVERAGE

#### Adults with Functional Impairments (Cont'd.)

- Individuals who have at least two functional dependencies or one functional dependency and a cognitive impairment
- Individuals who require MTCM assistance to obtain needed services
- Individuals who are at risk for institutionalization
- Specific symptoms or disturbances make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

#### BENEFICIARY ELIGIBILITY

MTCM includes only services to beneficiaries who are residing in a community setting or transitioning to a community setting following an institutional stay. Referrals will be accepted from the beneficiary, a family member, Medicaid enrolled providers, non-profits, religious organizations, private agencies, neighbors, professionals, volunteers and other organizations.

To be eligible for MTCM, an individual must be enrolled in Medicaid and:

- Meet eligibility criteria for one of the target populations outlined in the South Carolina State Plan; **AND**
- The member demonstrates motivation for receiving support in accessing services and is capable of benefiting from this support; **AND**
- Be able to participate in the planning process, or if applicable, a responsible party participating on behalf of the beneficiary; **AND**
- A well-defined clinical rationale is documented that explains why the member requires assistance in accessing supportive services due to their specific needs; **AND**
- If the beneficiary is between 0-21, the Parent/Guardian/Caregiver, the Agreement to Participate in MTCM Services form must be signed. Beneficiaries receiving MTCM prior to November 15, 2015, must have this form completed and signed and in the record by January 1, 2016, or by

**SECTION 2 POLICIES AND PROCEDURES****COVERAGE****BENEFICIARY ELIGIBILITY  
(CONT'D.)**

the date of request for additional units for the calendar quarter of October-December 2015, whichever comes first. New beneficiaries of MTCM services starting on or after November 15, 2015, must have this form completed, signed and in the record prior to receiving MTCM services.

## SECTION 2 POLICIES AND PROCEDURES

### FREEDOM OF CHOICE

Each MTCM provider assures that the provision of MTCM services will not restrict the beneficiary's free choice of providers in violation of section 1902(a)(23) of the Social Security Act.

Eligible beneficiaries will have free choice of any qualified Medicaid Targeted Case Management provider within the specified geographic area identified in the plan.

Eligible beneficiaries will have free choice of any qualified Medicaid provider of other medical care under the Medicaid State Plan.

A copy of the signed Freedom of Choice form must be faxed or scanned and emailed to SCDHHS for all MTCM cases and a copy maintained in the beneficiary's case management folder or electronic case file.

## **SECTION 2 POLICIES AND PROCEDURES**

### **FREEDOM OF CHOICE**

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## SECTION 2 POLICIES AND PROCEDURES

### PROVIDER QUALIFICATIONS

Providers must go through South Carolina Medicaid Provider Enrollment to become an MTCM provider. After enrolling, SCDHHS will make referrals to MTCM providers based on beneficiary choice. These referrals will be made electronically and the provider's response will be electronic through the Phoenix system. Newly enrolled providers must complete MTCM enrollment and Phoenix prior to receiving referrals. The provider agency or entity must have:

- An established system to coordinate services for Medicaid beneficiaries who may be covered under another program which offers components of case management or coordination similar to MTCM (*i.e.*, Managed Care, Child Welfare Services, State Waiver programs.)
- Demonstrated programmatic and administrative experience in providing comprehensive case management services and the capability to differentiate MTCM services to be provided to the target population
- A minimum of four staff with case management qualifications

**Note:** For existing providers with less than four staff, an emergency plan or agreement with another case management provider must be on file and beneficiaries must be informed of Freedom of Choice rights to choose another entity.

- Established referral systems, demonstrated linkages, and referral ability with essential social and health service agencies
- A minimum of three years providing comprehensive case management services to the target population
- Administrative capacity to ensure quality services in accordance with state and federal requirements
- Financial management capacity and a system that provides documentation of services and costs in accordance with OMB A-87 principles

## SECTION 2 POLICIES AND PROCEDURES

### PROVIDER QUALIFICATIONS

#### PROVIDER QUALIFICATIONS (CONT'D.)

- Capacity to document and maintain individual case records in accordance with state and federal requirements
- Demonstrated ability to meet state and federal requirements for documentation, billing and audits
- Ability to evaluate the effectiveness, accessibility, and quality of MTCM services provided to the target population in the community served
- Documentation that the provider is in good standing with the local municipality or State of South Carolina as a recognized business or non-profit
- A secure location to store all records in-state or within 25 miles of the South Carolina border



## SECTION 2 POLICIES AND PROCEDURES

### STAFF QUALIFICATIONS

#### MTCM CASE MANAGER SUPERVISOR

The Medicaid Targeted Case Manager Supervisor must, at a minimum:

- Possess a bachelor's degree from an accredited college or university, or licensure from the South Carolina Department of Labor, Licensing and Regulation Board as a Registered Nurse, and have two years of case management experience. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
- Be employed by the MTCM provider and not be on any state or the Office of the Inspector General's Medicaid Exclusion List
- Be familiar with the resources for the service community

#### MTCM CASE MANAGER

The Medicaid Targeted Case Manager must, at a minimum:

- Be employed by the MTCM-enrolled provider and not be on any state or the Office of the Inspector General's Medicaid Exclusion List
- Possess a bachelor's degree from an accredited college or university, or licensure from the South Carolina Department of Labor, Licensing and Regulation Board as a Registered Nurse, and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
- Have access to multi-disciplinary staff when needed
- Have documented experience, skills, or training in crisis intervention, effective communication, and cultural diversity and competency
- Possess knowledge of community resources
- Possess a working knowledge of families and/or systems theory

## SECTION 2 POLICIES AND PROCEDURES

### STAFF QUALIFICATIONS

#### MTCM TRAINING

All MTCM staff must successfully complete SCDHHS-approved curricula for case management services. Approved curriculums must include, but are not limited to, the following subject areas:

- Characteristics of the target population(s) to be served
- Non-billable activities
- Billable activities
- Basic case management skills
- Service planning
- Documentation of case management activities
- The system of care available for the target population

#### MAINTENANCE OF STAFF CREDENTIALS

All MTCM providers must maintain a file substantiating all MTCM staff qualifications and training, which includes the following:

- Completed application form and resume, if applicable
- Official transcripts and/or copies of diplomas from an accredited university or college
- Signature Sheet
- Training files, which include documentation of participation in the required MTCM training program
- Documentation of required experience

Effective on July 1, 2014, existing staff must have the following minimal background checks and screenings:

- Criminal checks
- Child Abuse and Neglect Central Registry Checks
- Medicaid Exclusion list
- Nurse Registry
- Sex Offender Registry

## **SECTION 2 POLICIES AND PROCEDURES**

### **STAFF QUALIFICATIONS**

#### **MAINTENANCE OF STAFF CREDENTIALS (CONT'D.)**

- Proof of current licensure as a SC Registered Nurse
- TB test results

Proof of these screenings must be maintained and made available for audits.

**SECTION 2 POLICIES AND PROCEDURES**  
**STAFF QUALIFICATIONS**

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## SECTION 2 POLICIES AND PROCEDURES

### PROVIDER RESPONSIBILITIES

Each provider shall:

- Attempt to identify during the intake process whether an applicant is already receiving case management services from another Medicaid provider
- Notify any other involved Medicaid case management providers of an applicant's request for service

Additionally, MTCM providers shall be responsible for the following:

- Providing consultation and technical assistance to case management staff
- Confirm, facilitate and/or promote the presence of appropriate management structures to include the following:
  - Uniform case management record or billing system
  - Appropriate and well-supervised staff
  - Comprehensive management information system
  - Efficient state or central office billing system
  - Effective communication process
  - Quality service delivery system
- Conducting training sessions for case management staff regarding programmatic changes and/or updates as needed. Lists of all staff who attended the sessions shall be retained for a period of five years.
- Maintaining staff credentials and making the credentials available to the SCDHHS upon request
- Providing professional staff for the supervision and implementation of the activities listed in this section

**SECTION 2 POLICIES AND PROCEDURES**  
**PROVIDER RESPONSIBILITIES**

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## 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 Regulations 42 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

## SECTION 2 POLICIES AND PROCEDURES

### SERVICE DESCRIPTION

#### 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 180<sup>th</sup> 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 180<sup>th</sup> 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.

## SECTION 2 POLICIES AND PROCEDURES

### SERVICE DESCRIPTION

#### 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

## SECTION 2 POLICIES AND PROCEDURES

### SERVICE DESCRIPTION

#### LIMITATIONS (CONT'D.)

Please see the section titled **MTCM NON-BILLABLE ACTIVITIES** for additional information on activities that are not Medicaid reimbursable as components of MTCM.

#### HOME- AND COMMUNITY-BASED SERVICES (HCBS) WAIVER PROGRAMS

MTCM services provided to beneficiaries enrolled in 1915(c) waiver programs must be provided in accordance with MTCM policy.

MTCM services can be used to monitor and coordinate Home- and Community-based Services (HCBS) waiver programs as long as the waiver program does not include case management as a service. These services may be the primary method of providing assurance to Centers for Medicaid and Medicare Services (CMS) that a beneficiary's health and safety are adequately monitored. However, any services performed for waiver participants that are not one of the four MTCM service components are not reimbursable by Medicaid. HCBS waiver programs have specific requirements for waiver participants, and these requirements are identified in the respective waiver policy and procedures manuals.

#### PRIOR AUTHORIZATION PROCESS (EXCLUDES STATE AGENCIES)

SCDHHS will reimburse for no more than 24 units per calendar quarter per beneficiary unless medical necessity has been demonstrated and approved through the prior authorization process. The 24-unit allowance applies to any combination of face-to-face or telephonic MTCM. The provider must ensure the record contains relevant and sufficient documentation to show the initial and continued need for MTCM services. If 24 units have been utilized within a calendar quarter and the client meets medical necessity for additional MTCM services in order to meet imminent needs, the following process applies:

1. Providers must submit a MTCM prior authorization document set to MTCM via fax at 803-255-8209.
2. The document set will consist of the following:
  - Most recent Case Management Assessment (no more than 180 days old)
  - Referrals made on behalf of beneficiary and reports and updates from service providers
  - Most recent Case Management Plan

## SECTION 2 POLICIES AND PROCEDURES

### SERVICE DESCRIPTION

#### PRIOR AUTHORIZATION PROCESS (EXCLUDES STATE AGENCIES) (CONT'D.)

- Most recent review of the Case Management Plan
  - All CSNs for all MTCM services rendered to beneficiary during the previous 30 days
  - Parent/Guardian/Caregiver Agreement to Participate in MTCM Services form
  - Fax Cover Sheet for MTCM Prior Authorization
  - MTCM Prior Authorization Form
3. SCDHHS staff will check the document set to ensure all required documents are present and thoroughly completed.
    - If the document set is complete, SCDHHS will evaluate the documentation and approve or disapprove the prior authorization request.
    - If the document set is incomplete, SCDHHS staff will email the “Incomplete Request Letter” to the provider. The provider has five (5) business days from the date of the letter to submit additional information to SCDHHS staff.
  4. SCDHHS staff will evaluate the prior authorization request and make determination within five (5) business days of receipt of the request.

#### NEED FOR CONTINUED SERVICES

It is the expectation of SCDHHS that beneficiaries receive MTCM services not to exceed medical necessity. In addition to meeting the medical necessity requirements outlined in “Coverage” section of this manual, in order to continue receiving MTCM services the following must be met:

- Documentation of members participation and engagement in TCM;
- Progress toward accessing needed services is documented at the expected pace given the presence of medical/physical conditions, stressors and level of support, as evidenced by adherence with treatment and support services, improving severity of symptoms and functional impairment, and continued progress is expected;

## SECTION 2 POLICIES AND PROCEDURES

### SERVICE DESCRIPTION

#### NEED FOR CONTINUED SERVICES (CONT'D.)

- If progress is not being made,, the member has been re-assessed and treatment needs have been re-evaluated and medically necessary referrals have been made; **AND**
- The member is allowing coordination of care with other providers and is involving family members where indicated and evidence of this is documented; for children/adolescents, the family is participating in treatment, adhering to recommendations, and demonstrating ability to coordinate services on member's behalf.

If the beneficiary does not meet the above criteria, they must be discharged from MTCM services.

## SECTION 2 POLICIES AND PROCEDURES

### TRANSITIONING TO A COMMUNITY SETTING

MTCM includes only services to beneficiaries who are residing in a community setting. MTCM allows transition to a community setting following an institutional stay (Nursing homes, in-patient psychiatric hospitals, ICF/IIDs or PRTFs are considered institutions). Providers may only provide case management services to facilitate the transition of beneficiaries from institutions to the community. A beneficiary is considered to be transitioning to the community during the last 180 consecutive days of a covered institutional stay.

Providers may only receive Medicaid reimbursement for MTCM activities provided to facilitate the transition of beneficiaries from institutions to the community. Transitional case management must not continue once the goal changes or the decision is made that leaving the institution is not an option. MTCM activities provided to beneficiaries residing in an institutional setting for any other purpose and/or beyond the specified time frame are not billable to Medicaid.

**SECTION 2 POLICIES AND PROCEDURES**  
**TRANSITIONING TO A COMMUNITY SETTING**

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## SECTION 2 POLICIES AND PROCEDURES

### CONCURRENT MTCM

Concurrent case management will be allowed when the beneficiary qualifies for more than one target group and the selected case management entity does not have the experience and resources to meet all the beneficiary's needs. SCDHHS must have prior notification in writing with documentation that the two entities will not duplicate services. The case management entity of choice will be responsible for coordinating care with the concurrent case management entity.

### COORDINATION OF CARE

Care coordination exists between the MTCM case manager and the providers of direct services. The direct service providers must utilize the appropriate procedure codes from the array of services they render to beneficiaries. Only the MTCM case manager from the Freedom of Choice form shall bill for MTCM services. If there is a question between MTCM providers about the selection, both providers must send copies of the forms to SCDHHS at the following address:

SCDHHS  
Attention: MTCM Policy J9  
PO Box 8206  
Columbia, SC 29202-8206

**SECTION 2 POLICIES AND PROCEDURES**  
**CONCURRENT MTCM**

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## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### MTCM RECORDS

##### General Requirements

Providers must maintain MTCM records in accordance with the Code of Federal Regulation 42 CFR 441.18(a)(7),

Providers must document the following for all individuals receiving MTCM services:

- The name of the beneficiary
- The dates of the case management services
- The name of the provider agency (if relevant) and the person providing the case management service
- The nature, content, units of the case management services received and whether goals specified in the CMP have been achieved
- If the beneficiary has declined services in the CMP
- The need for, and occurrences of, coordination with other case managers
- A timeline for obtaining needed services

**Medicaid Targeted Case Managers who also provide direct services must document MTCM services separately from any other service.**

In addition to the requirements listed from the Code of Federal regulations, individual MTCM records must include the following:

- Needs assessments
- Service planning documents
- Case management activity notes
- All correspondence, including electronic mail messages and documentation written by the case manager and claimed for Medicaid reimbursement
- Social history assessments and/or social history updates if applicable
- Medical Information

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### General Requirements (Cont'd.)

- Psychological assessments/Psychiatric reports, if applicable
- Staffing Reports
- Individualized Education Plans (IEPs), and Individual Family Service Plans (IFSPs), as appropriate and/or available
- Information from other service agencies providing services to the individual
- Forms and/or assessments that are contractually required by a specific case management provider
- Service agreements, if applicable

MTCM records shall be arranged in a logical order such that the identification of needs, referrals, follow-ups, plan development and monitoring can be easily and clearly reviewed, copied, and audited. Each case management provider shall maintain an index as to how the case management record is organized for paper and electronic case records.

#### Electronic Records

SCDHHS will accept electronic records and activity notes in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §26-6-10 et seq.) and federal HIPAA electronic health record requirements. Electronic information must be in a reasonably accessible format in order to be accepted by SCDHHS.

In general, electronic records must be maintained to the same standards as paper copies.

#### Paper Records

Case management paper records shall be maintained as follows:

- All required signatures/initials and signature dates (date of signature) must be handwritten. Signature stamps or preprinted signature dates are not acceptable.
- All entries shall be typed or handwritten using only black or dark blue ink. In the event of multiple family members receiving case management services, documentation must be specific to each individual. A photocopy of a single note which references each eligible beneficiary is not acceptable documentation for a case record.

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### Paper Records (Cont'd.)

- All entries must be legible and kept in chronological order.
- All entries must be consistently organized using uniform case management forms within programs.
- All entries must include sufficient documentation to justify Medicaid participation and to permit a case manager not familiar with the beneficiary and/or family to oversee or assume the case.
- All entries must be legibly signed, titled and signature dated. A Signature Sheet must be maintained by the case management provider. The Signature Sheet shall include each way a case manager or case manager assistant has abbreviated his or her name in the case record, as well as professional title.
- Each case management office shall maintain a list of abbreviations and symbols used in the documentation, which leaves no doubt as to the meaning of the documentation. Providers must furnish the list and abbreviation key upon request of SCDHHS and/or its designee.

#### MTCM Assessment

The MTCM assessment must be completed within 45 days of provider acceptance of referral and shall include the following components, as appropriate:

- Level of functioning
- Medical status
- Emotional status
- Family dynamics
- Individual/family support system
- Current living environment
- Financial status
- Educational or vocational placement
- Community involvement
- Socialization and relationships with others
- Services received or needed from others

Contact(s) with the beneficiary, his or her family, guardian, or legal representative, involved agencies, professionals

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### MTCM Assessment (Cont'd.)

and/or significant others must be conducted prior to completing or updating the MTCM assessment. Contacts shall be documented in the Activity Notes.

Medical aspects of the beneficiary's needs are to be determined and the case manager shall assist the beneficiary, his or her family, or other responsible person in locating or arranging appropriate medical services as well as coordinating needed medical transportation. The beneficiary and/or their family members, or other responsible person(s) are to be encouraged to secure a primary health care provider for the beneficiary if he or she currently does not have one. Family planning should be addressed as appropriate and the utilization of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings and services should be encouraged for beneficiaries under the age of 21.

#### Case Management Plan (CMP)

The case management plan (CMP) shall be developed in consultation with the beneficiary, the beneficiary's family or other social support system. The initial CMP must be completed within the initial 45 calendar days of provider acceptance of referral and after the case management assessment. The CMP shall serve as a guide for the case manager to assist the beneficiary, his or her family, guardian, or legal representative in accessing appropriate services on behalf of the beneficiary and to move them through the service delivery system.

The CMP must document and include all of the following:

- Beneficiary's name, date of birth, and Medicaid number
- Identification of the beneficiary's service needs. The CMP must address the beneficiary including the family's preferences and choices.
- The identified strengths and weaknesses of the beneficiary (if appropriate)
- The services and actions required to meet the identified service needs
- The service provider or provider type, community programs, and/or agencies to which the individual will be referred
- The frequency (monthly, weekly, daily, etc.) of activities should be addressed, if applicable. A

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### Case Management Plan (CMP) (Cont'd.)

projected completion date should be included. Efforts to obtain services that are recommended in the CMP, but are unavailable to a beneficiary, must be included in the Activity Note documentation. . The beneficiary and/or his or her parent, guardian, or legal representative must sign the CMP during the planning meeting and receive a copy. If the beneficiary, or his or her parent, guardian, or legal representative is unavailable, the case manager must document why the signature could not be obtained, and must have them sign during the next face-to-face contact.

- Case manager's handwritten signature, title and signature date.

The CMP must be updated when changes are identified in family and individual strengths, needs, risk factors, desires, problems, resources, support network and/or individual goals.

When the care planning component of MTCM is provided, the Activity Note must reference the CMP. However, this entry does not replace the requirement to document each MTCM activity in the note.

#### *Additions or Changes*

Additions to or changes in the CMP must be dated and signed or initialed by the case manager.

#### *Updates/ Reviews*

The Medicaid Targeted Case Manager must periodically monitor and re-evaluate the beneficiary's progress toward achieving the objectives identified in the CMP to determine whether the current services should be continued, modified, or discontinued.

Case management services rendered to a beneficiary whose CMP was not reviewed/updated by the 180<sup>th</sup> day are not reimbursable by Medicaid from the 181<sup>st</sup> day until the date a new CMP is completed.

#### Activity Note

Documentation must be completed for each specific case management activity rendered to a beneficiary. If multiple MTCM components are provided at the same time, activities may be documented in the same note. Each component provided must be listed in the activity note. Entries to the MTCM record should be made at the time the activity is rendered.

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### Activity Note (Cont'd.)

Activity notes must include:

- Type of case management activity and MTCM component being provided
- Type of contact
- Place of contact or activity
- Person with whom the contact occurred and relationship to the beneficiary
- Purpose of the contact or activity
- Description of the MTCM intervention delivered
- Outcome(s) of the contact activity
- Next step(s) for that activity note – follow-up needed (if applicable)
- Signature, title and signature date of the qualified staff person(s) who rendered the case management activity
- Must be filed or entered in the beneficiary's record within seven calendar days of delivery of the activity

Activity notes must correspond to billing in type of activity, length of activity, units of service, and date of delivery. Activity note entries must be individualized and specific to each beneficiary.

Each beneficiary or involved party referenced in the Activity Note documentation or electronic mail messages must be identified by his or her full name at least once on each page of documentation. A separate list located in the record with the title or relationship to the beneficiary must also be included (*e.g.*, Mary Smith, mother; or Ms. Ida Jones, teacher) if not fully documented in the activity note.

All MTCM activities, including written correspondence, assessment and/or CMP updates, and completion of reports must be referenced in the Activity Note. The documentation must clearly identify where the information can be located in the beneficiary's record.



## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### Misplaced/Late Entries and Addendums

Misplaced/Late entries may be necessary at times to handle omissions in the documentation. Expectation is that timeliness guidelines are met and these are rare occurrences. Frequent occurrences will result in review and may result in recoupment.

The late or misplaced entry must be recorded in the following manner:

- Document the date the activity occurred.
- “Misplaced Entry” or “Late Entry” with the actual date of the activity is entered on the first line of the activity note. A brief explanation causing the misplaced or late entry
- The activity note is recorded to document the MTCM activity, behaviors, provision of service, and components of a billable activity when appropriate.

An “addendum” to an activity note is utilized when adding additional data or correcting information in the text entry. Documentation should be labeled as an addendum and follow other requirements for documenting case activity.

#### Error Correction

MTCM records are legal documents and Medicaid targeted case managers must be extremely cautious in altering records. When an error is made, these guidelines shall be followed:

1. If an entry is erroneous, clearly draw one line through the error, write “error” to the side in parentheses, enter the correction and add signature or initials, and date. If an explanation seems appropriate, do not hesitate to clarify the correction. In extreme circumstances, it may be prudent to have a corrected notation witnessed.
2. Errors must not be totally marked through, as the information in error must remain legible.
3. No correction fluid or erasable ink may be used.
4. Typographical errors shall not be corrected with correction tape.

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## **SECTION 2 POLICIES AND PROCEDURES**

### **DOCUMENTATION REQUIREMENTS**

#### **Signature Sheet**

A Signature Sheet must be maintained and made available to SCDHHS. The Signature Sheet must include each way a Medicaid targeted case manager has abbreviated his or her name in the record, as well as their professional title and the user ID for electronic files.

## SECTION 2 POLICIES AND PROCEDURES

### BENEFICIARY ADVANCE NOTICE

Beneficiaries must be given advance written notification prior to reduction of services and closure of the MTCM service. To meet the advance notice requirement, MTCM must mail the Notice of Adverse Action at least ten (10) calendar days before the date of action. The advance notice period may be shortened to five (5) calendar days before the date of action if the agency has facts that indicate probable fraud, and the facts have been verified by secondary sources.

A Notice of Adverse Action may be mailed on the date of the action, if:

- The beneficiary died.
- The beneficiary provides a signed statement that he or she no longer wishes services or that he or she waives his right to a ten (10) day notice.
- The beneficiary has been admitted to an institution where he or she is ineligible for further services (such as an inmate of a public institution).
- The beneficiary's whereabouts are unknown and mail addressed to him or her is returned indicating no forwarding address.
- The agency verifies that the beneficiary has established residency in another state.
- The beneficiary no longer meets level of care.

## **SECTION 2 POLICIES AND PROCEDURES**

### **BENEFICIARY ADVANCED NOTICE**

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## SECTION 2 POLICIES AND PROCEDURES

### SERVICE UNIT CONTACT TIME

All MTCM must be billed in 15-minute unit increments.

SCDHHS has adopted the Medicare 8 Minute Rule for MTCM services. This means a provider may not bill for a service of less than eight minutes if it is the only MTCM service provided that day. The actual minutes billed for any one case manager in a workday may not exceed the work hours of that case manager.

If any MTCM 15-minute service (same procedure code) is performed for seven minutes or less on the same day as another MTCM (same procedure code) service that was also performed for seven minutes or less, and the total time of the two services is eight minutes or greater, then the provider must bill for one unit of service.

The expectation is that a provider's direct beneficiary contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations will be highlighted for review.

Units	Time
1	Equal to 8 minutes but less than 23 minutes
2	Greater than/equal to 23 minutes, but less than 38 minutes
3	Greater than/equal to 38 minutes, but less than 53 minutes
4	Greater than/equal to 53 minutes, but less than 68 minutes
5	Greater than/equal to 68 minutes, but less than 83 minutes
6	Greater than/equal to 83 minutes, but less than 98 minutes
7	Greater than/equal to 98 minutes, but less than 113 minutes
8	Greater than/equal to 113 minutes, but less than 128 minutes
9	Greater than/equal to 128 minutes, but less than 143 minutes
10	Greater than/equal to 143minutes, but less than 158 minutes
11	Greater than/equal to 158minutes, but less than 173 minutes
12	Greater than/equal to 173 minutes, but less than 188 minutes
13	Greater than/equal to 188 minutes, but less than 203 minutes
14	Greater than/equal to 203 minutes, but less than 218 minutes
15	Greater than/equal to 218 minutes, but less than 233 minutes

**SECTION 2 POLICIES AND PROCEDURES****SERVICE UNIT CONTACT TIME**

Units	Time
16	Greater than/equal to 233 minutes, but less than 248 minutes

**SPECIAL RESTRICTIONS**

Reimbursement for MTCM activities involved in trying to locate a beneficiary may be claimed for only the first 30 days.

Additional restrictions may also apply as payment for MTCM services shall not duplicate other federal payments made for the provision of case management services.

## SECTION 2 POLICIES AND PROCEDURES

### MTCM BILLABLE ACTIVITIES

Any of the activities provided from the list below must be documented and directly linked to the beneficiary's assessed needs and specific goals documented in the Care Management Plan (CMP). The activities listed below will not automatically qualify for reimbursement if they are determined to be unrelated to needs and goals on the CMP.

- Assessing needs, access to services or client functioning
- Assessing a beneficiary's medical and/or mental health needs through review of evaluations completed by other providers of services
- Assessing physical needs, such as food and clothing
- Assessing social and/or emotional status
- Assessing housing, financial and/or physical environmental needs
- Assessing familial and/or social support system
- Assessing vocational and/or educational needs
- Assessing independent living skills and/or abilities
- Ensuring the active participation of the beneficiary in developing goals and actions to address the assessed needs and specified goals documented in the CMP
- Working with the beneficiary and others to develop goals that address the assessed needs and specified goals documented in the CMP
- Identifying a course of action with the individual to respond to the assessed needs and specified goals documented in the CMP
- Linking beneficiaries with medical, social, educational, and/or other providers, programs, and services that are capable of providing needed services as specified in the CMP
- Ensuring the CMP is implemented effectively and is adequately addressing the needs of the individual

## SECTION 2 POLICIES AND PROCEDURES

### MTCM BILLABLE ACTIVITIES

#### MTCM BILLABLE ACTIVITIES (CONT'D.)

- Contacting the beneficiary, family members, outside service providers, or other entities to ensure services are being furnished in accordance with beneficiary's CMP
- Ensuring the adequacy of the services in the CMP, particularly as changes occur in the needs or status of beneficiaries
- Monitoring beneficiary progress and performing periodic reviews and reassessment of treatment needs. When an assessment indicates the need for medical treatment, referrals or arrangements for such treatment may be included as MTCM services, but the actual treatment **must not** be included
- Arranging and monitoring the beneficiary's access to primary healthcare providers. This may include written correspondence to a primary health care provider which gives a synopsis of the treatment the individual is receiving
- Coordinating and monitoring other health care needs by arranging appointments for medical services with follow-up and documentation
- Contact with the beneficiary in which the case manager helps to guide or advise in the resolution of service access issues
- Contacting the family, representatives of human service agencies, and other service providers to form a multidisciplinary team to develop a comprehensive and individualized CMP
- Preparing a written report that details a psychiatric and/or functional status, history, treatment, or progress (other than for legal or consultative purposes) for physicians, other service providers, or agencies



## SECTION 2 POLICIES AND PROCEDURES

### MTCM NON-BILLABLE ACTIVITIES

The following is a list of activities that are not Medicaid reimbursable as components of MTCM. This list is intended as a guide and is not intended to list all non-reimbursable activities.

- Attempting but not completing a contact whether in person or by telephone
- Review of case management records within the agency
- Referring and monitoring of one's own activities
- Providing special requested information regarding beneficiaries for the provider, public agencies or other private entities for administrative purposes
- Participating in recreation or socialization activities with a beneficiary or his or her family
- Rendering case management to individuals in institutional placements [*i.e.*, Psychiatric Residential Treatment Facilities (PRTFs) Intermediate Care Facilities (ICFs) or ICF-IIDs (Intellectual Disabilities), nursing homes, hospitals, etc.], except during the last 180 days of the stay for the purpose of transition and/or discharge planning
- Rendering services to a beneficiary while incarcerated, in an evaluation center (formerly known as reception and evaluation centers), in a local jail and/or prison, or a detention center
- Documenting activity notes
- Completing MIS reports and monthly statistical reports, etc.
- Performing administrative duties such as copying, filing, mailing of reports, etc.
- Rendering activities which are convened to address custody, criminal charges, or other judicial matters by the individual or others (SC Family Court, General Sessions or Federal Court)

## SECTION 2 POLICIES AND PROCEDURES

### MTCM NON-BILLABLE ACTIVITIES

#### MTCM NON-BILLABLE ACTIVITIES (CONT'D.)

- Rendering services on behalf of a beneficiary after death
- DJJ required probation contacts and/or activities
- Rendering MTCM services for adjudicated juveniles who have not been placed on formal probation, parole, or under a diversion contract
- Rendering services as MTCM components that are mandated functions required by another payer source (*i.e.*, an assessment that has been completed as a program intake requirement). A treatment plan that covers court mandated services only should not be the basis for MTCM services
- Rendering services provided as administrative case management including Medicaid eligibility determination, intake processing, and preadmission screening for inpatient care
- Performing utilization review and prior authorization for Medicaid
- Rendering services for foster care programs, such as, but not limited to, the following:
  - Research gathering and completion of documentation required by the foster care program
  - Assessing adoption placements; recruiting or interviewing potential foster care parents
  - Serving legal papers; home investigations; providing transportation
  - Administering foster care subsidies
  - Making placement arrangements
- Rendering the actual or direct provision of medical services or treatment:
  - Training in daily living skills
  - Training in work skills and social skills
  - Grooming and other personal services
  - Training in housekeeping, laundry, cooking
  - Individual, group or family therapy services

## SECTION 2 POLICIES AND PROCEDURES

### MTCM NON-BILLABLE ACTIVITIES

#### MTCM NON-BILLABLE ACTIVITIES (CONT'D.)

- Crisis intervention services
- Diagnostic testing and assessments
- Rendering services which go beyond assisting individuals in gaining access to needed services:
  - Paying bills and/or balancing the beneficiary's checkbook
  - Completing application forms, paperwork, evaluations and reports including applying for Medicaid
  - Escorting or transporting beneficiaries to scheduled medical appointments
  - Providing childcare so the beneficiary can access services
  - Shopping or running errands for the beneficiary
  - Delivering groceries, medications, gifts
  - Reading the mail for the beneficiary
  - Setting up the beneficiary's medication
- Providing transportation to and from appointments for the beneficiary
- Using MTCM codes for billing when the beneficiary does not meet the criteria for one of the nine target populations
- Beneficiary Outreach activities in which a state agency or other provider attempts to contact potential beneficiaries of a service do not constitute MTCM services.
- Performing administrative functions for beneficiaries under the Individuals with Disabilities Education Act (IDEA) such as the development of an Individual Education Plan and the implementation and development of an Individual Family Service Plan for Early Intervention Services
- Rendering MTCM services when there is no CMP in place
- Rendering MTCM services and not enrolled as a South Carolina MTCM provider

## **SECTION 2 POLICIES AND PROCEDURES**

### **MTCM Non-Billable Activities**

#### **MTCM NON-BILLABLE ACTIVITIES (CONT'D.)**

- Rendering, ordering, or authorizing MTCM services when excluded from participation in Medicaid, Medicare, CHIP or other federal program
- Rendering MTCM services that are not documented and directly linked to the beneficiary's assessed needs and specific goals documented in the Care Management Plan (CMP)