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SECTION 2 POLICIES AND PROCEDURES

PHILOSOPHY

The relationship of the targeted case manager with a beneficiary and his or her family is one of a partnership. Beneficiaries, parents, and families are active participants in care planning throughout the case management process. This is for the beneficiary's needs and/or preferences to be considered and addressed holistically (including individual needs, as well as needs that families have in common), rather than independently. Accordingly, organized strategies that empower beneficiaries, parents, and families to assume and carry out their responsibilities must be included in this mutual planning process.

It is important that the MTCM case manager is aware of and sensitive to the values, attitudes, and beliefs that are unique to each family. Values concerning approaches and styles of parenting and/or family life vary. The effectiveness of Medicaid Targeted Case Management (MTCM) is positively impacted by a demonstrated respect for cultural variations among families. MTCM effectiveness is further enhanced when integrated with other services and resources considering all active participants in the individual's life (including the individual's parents, family, significant others, and any involved service providers).

SECTION 2 POLICIES AND PROCEDURES

PHILOSOPHY

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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 widest array of options for meeting those needs.

SCDHHS limits the provision of MTCM to 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 confirmed 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 as defined as a severe, chronic condition found to be closely related to Intellectual Disability and meet the five following conditions:

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

SECTION 2 POLICIES AND PROCEDURES

COVERAGE

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

Self Care, Understanding and use of language, learning, mobility, self-direction, and capacity for independent living;

- The person's needs are such that supervision is necessary due to impaired judgment, limited capabilities, behavior problems, abusiveness, assaultive behavior or because drug effects/medical monitorship; and
- The person is in need of services directed toward acquiring skills to function as independently as possible or the prevention or regression or loss of current optimal functional status.

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 their prescribed medical regime;
  - An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization;
  - An inability to understand medical directions because of comprehension barriers;
- A lack 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;
- Children who have been or are suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay and/or intellectual disabilities and who are less than age 6;

SECTION 2 POLICIES AND PROCEDURES

COVERAGE

At-Risk Children (Cont'd.)

- Children who at anytime during the past year have a diagnosable mental, behavioral or diagnostic criterion that meets the coding and definition criteria specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Adults with Serious and Persistent Mental Illness

- 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.

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, or
- Noncompliance with their prescribed medical regime, or
- An inability to coordinate multiple medical, social or other services due to the existence of an unstable medical condition in need of stabilization
- An inability to understand medical directions because of comprehension barriers and

  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.

SECTION 2 POLICIES AND PROCEDURES

COVERAGE

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

- The At Risk Infant is eligible for case management under this population to the second birthday.

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 individuals who received treatment in an intensive alcohol and drug abuse treatment program or chemical dependence hospital.

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 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 which is caused by a genetic disorder.

Individuals with Head and Spinal Cord Injuries and Similar Disorders

Medicaid eligible individuals determined to have an 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. Where the individual has substantial functional limitations and:

- Has urgent circumstances affecting his/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.

Individuals with Sensory Impairments

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

SECTION 2 POLICIES AND PROCEDURES

COVERAGE

Adults with Functional Impairments

Coverage is limited to 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.
- 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.

BENEFICIARY ELIGIBILITY

TCM includes only services to beneficiaries who are residing in a community setting or transitioning to a community setting following an institutional stay.

To be eligible for MTCM, an individual must:

- Meet eligibility criteria for one of the target populations outlined in the South Carolina State Plan, and
- Be able to participate in the planning process, or if applicable, a responsible party participating on behalf of the beneficiary, and
- Be able to benefit from MTCM services, and
- Be a voluntary participant.

SECTION 2 POLICIES AND PROCEDURES

COVERAGE

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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
- Care Plan
- Referral and Linkage
- Monitoring and Follow-up

MTCM DEFINITION

The definition of services as cited in Federal Regulation 42 CFR 440.169 are as follows:

Assessment

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

- Taking individual history
- Identifying the needs of the beneficiary 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

Care Plan

Development(and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:

- Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual;
- Includes 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;

SECTION 2 POLICIES AND PROCEDURES

SERVICE DESCRIPTION

Care Plan (Cont'd.)

- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and Linkage

Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social and education providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

Monitoring and Follow-up

Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan 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 or individuals. These activities may be conducted as frequently as necessary, and including at least one annual monitoring to help determine whether the following conditions are met:

- Services are being furnished in accordance with the individual's care plan
- Services in the care plan are adequate to meet the needs of the individual
- There are changes in the needs or status of the eligible individual. If there are changes in the needs or status of the individual, monitoring and follow-up activities include making necessary adjustments in the care plan 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, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and 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

MTCM Billable Activities

Allowable MTCM activities are those that include:

- Assessing needs, access to services or client functioning
- Assessing the medical and/or mental needs through review of evaluations completed by other providers of services.
- Assessing of physical needs, such as food and clothing
- Assessing of social and/or emotional status
- Assessing for housing, financial and/or physical environmental needs
- Assessing for familial and/or social support system
- Assessing for vocational and/or educational needs
- Assessing for independent living skills and/or abilities
- Ensuring the active participation of the beneficiary
- Working with the beneficiary and others to develop goals
- Identifying a course of action to respond to the assessed needs of the beneficiary
- Linking beneficiaries with medical, social, educational, and/or other providers, programs, and services that are capable of providing the assessed needed services
- Ensuring the CMP is implemented effectively and is adequately addressing the needs of the individual
- Contacting the individual, family members, outside service providers, or other entities to ensure services are being furnished in accordance with individual's CMP
- Ensuring the adequacy of the services in the CMP, and changes in the needs or status of beneficiaries
- Assisting in obtaining required educational, treatment, residential, medical, social, or other support services by accessing available services or advocating for service provision
- Contacting social, health, and rehabilitation service

SECTION 2 POLICIES AND PROCEDURES

SERVICE DESCRIPTION

MTCM Billable Activities (Cont'd.)

providers, either via telephone or face-to-face, in order to promote access to and appropriate use of services. Additionally, services by multiple providers may be coordinated.

- Monitoring the progress through the services 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 including written correspondence sent 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
- Staffings related to receiving consultation and supervision on a specific case to facilitate optimal case management. This includes recommending and facilitating movement from one program to another or from one agency to another.
- Contacting the beneficiary to deal with specific and identifiable problems of service access and requiring the case manager to guide or advise his or her in the resolution of the problem
- Contacting the family, representatives of human service agencies, and other service providers to form a multidisciplinary team to develop a comprehensive and individualized service plan. The individualized service plan describes the problems, corresponding needs, and details services to be accessed or procured to meet the beneficiary's needs.
- 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

SERVICE DESCRIPTION

MTCM CONTACT

A MTCM contact is defined as any of the following:

- A face-to-face encounter for the purpose of rendering one or more MTCM components
- 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
- A relevant e-mail contact 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.

FREQUENCY OF MTCM CONTACTS

The frequency of contact with each beneficiary must be determined based on their individual needs. A case manager must make contact with the beneficiary, parent, legal guardian, or representative, at least once every 180 calendar days or more frequently as specified in the beneficiary's case management plan. At least one face-to-face contact must be made in the beneficiary's residential setting but within the first six months (180 days) of service. Face-to-face or telephone contact with the eligible individual, family member, authorized representative, or provider at least every 60 days to ensure appropriateness, utilization and continued need for services. The case manager must be available to meet with the beneficiary at their request more frequently.

Providers are required to meet the minimum frequency requirements as stated above.

LIMITATIONS

MTCM does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible beneficiary has been referred, including, with respect to the direct delivery of Foster Care services, services such as (but not limited to) the following as described in Federal regulation 42 CFR 441.18(c):

- Research gathering and completion of documentation required by the Foster Care program
- Assessing adoption placements

SECTION 2 POLICIES AND PROCEDURES

SERVICE DESCRIPTION

LIMITATIONS (CONT'D.)

- Recruiting or interviewing potential foster care parents
- Serving legal papers
- Home investigations
- Providing transportation
- Administering foster care subsidies
- Making placement arrangements

Medicaid Targeted Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service.

Persons with family relationships to the beneficiary **may not** provide MTCM services to that beneficiary.

MTCM components that are billed shall not be mandated functions required by another payor source. (*i.e.*, MTCM 3 not be billed for an assessment that has been completed as a program intake requirement.)

Providers of MTCM services do not exercise the agency's authority to authorize or deny the provision of other services under the plan. For example, if a child has been referred to a State foster care program, activities performed by the foster care case worker that relate directly to the provision of foster care services cannot be covered as MTCM. Since these activities are a component of the overall foster care service to which the child has been referred, the activities do not qualify as case management.

FFP only is available for MTCM services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act (§§1902(a)(25) and 1905(c)).

SECTION 2 POLICIES AND PROCEDURES

SERVICE DESCRIPTION

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 s Home- and Community-based Services (HCBS) waiver programs. These services may be the primary method of providing assurance to 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. The provider should seek reimbursement under another funding source. HCBS waiver programs have specific requirements for waiver participants, and these requirements are identified in the respective waiver policy and procedures manuals.

SECTION 2 POLICIES AND PROCEDURES

SERVICE DESCRIPTION

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SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

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, as well as State waiver programs.)
- Demonstrated programmatic and administrative experience in providing comprehensive case management services and the ability and capability to differentiate MTCM services to be provided to the target group
- A minimum of four Staff with case management qualifications
- Establish 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 group
- 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
- 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 on a community-wide basis

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

PROVIDER QUALIFICATIONS (CONT'D.)

- Documented 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

The Medicaid targeted case manager supervisor must:

- Possess a bachelor's degree in health or human services from an accredited college or university and have two years of supervisory experience and two years of case management experience
- Be employed by the MTCM provider and not be on any State's or the Office of the Inspector General's Medicaid Exclusion List
- Be familiar with the resources for the service community

The Medicaid targeted case manager must at a minimum:

- Be employed by the MTCM enrolled provider and not be on any State's or the Office of the Inspector General's Medicaid Exclusion List
- Possess baccalaureate or graduate degree from an accredited college or university in a health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the individual being served 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. A Registered Nurse (RN) licensed by the state of South Carolina may also render these services.
- Have the ability to access 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

MTCM qualified case managers who also provide direct services must ensure that MTCM is documented separately from any other services.

SECTION 2 POLICIES AND PROCEDURES

STAFF QUALIFICATIONS

STAFF QUALIFICATIONS (CONT'D.)

All MTCM staff must complete a SCDHHS-approved training curriculum.

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
- Basic case management skills
- Service planning
- Documentation of case management activities
- The system of care available for the target population

MAINTENANCE OF STAFF CREDENTIALS

CASE MANAGER

A credentials folder shall be maintained for each qualified case manager, which includes the following:

- Completed application form and resumes, 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

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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 following for all individual 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 care plan have been achieved
- Whether the beneficiary has declined services in the care plan
- The need for, and occurrences of, coordination with other case managers
- A timeline for obtaining needed services
- A timeline for re-evaluation of the plan

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

MTCM records shall be arranged in a logical order such that the identification of needs, referrals, follow-ups, plan development and monitorship 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.

In addition to the requirements listed from the Code of Federal regulations, individual MTCM records must include, but are not limited to, the following:

- Needs assessments
- Service planning documents

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

General Requirements (Cont'd.)

- Case management activity notes
- All correspondences including electronic mail (email) 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
- 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 must be in the record
- Service agreements, if applicable

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.). 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 and adhere to the following guidelines below:

- When correcting or making a change to an electronic entry a mechanism must exist to retain and easily access copies of the original, if data is incorrect.
- The original entry must be viewable, including the date and time of the entry, the person making the entry, and the reason for the change/note alteration.
- The hard copy must also be corrected in situations where there is a hard copy printed from the

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Electronic Records (Cont'd.)

electronic record (see "Paper Records").

- The process must permit the author of the error to identify, time/date stamp the change and document whether the original was an error.
- The process must offer the ability to suppress viewing of the actual error, but ensure that a flag exists to notify other users of the newly corrected information.
- The location of the error must also point to a correction. The correction may be in a different location from the error if there is narrative data entered, but there must be a mechanism to reflect the correction.

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. Other forms, such as signature sheets that reference signatures do not meet signature requirements for case management records.
- 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.
- 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

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Paper Records (Cont'd.)

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.

- Only approved abbreviations and symbols may be used. Each case management office shall maintain a list of any abbreviations and symbols used in the records. This list must be clear as to the meaning of each abbreviation and symbol.

RECORD RETENTION

MTCM records shall be retained for a period of five (5) years (after last payment made under each service contract, including any amendments and/or extensions to the contract). If any litigation claims, or other actions involving the records have been initiated prior to the five-year expiration period, the records shall be retained until completion of the actions and resolution of all issues that arise from the claim or until the end of the five-year period, whichever is later.

Closed MTCM records shall be maintained in a neat, orderly manner. Records should remain in chronological order, be bound or clipped, and maintained according to the MTCM program's indexing requirements. Closed MTCM records must be made available upon request.

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.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

CASE MANAGEMENT PLAN (CMP)

Requirements

The Medicaid targeted case manager shall develop a written, comprehensive individualized case management plan (CMP), based upon a documented assessment for each individual beneficiary.

Prior to completion of the CMP, an assessment of each beneficiary's case must be completed to identify strengths, weaknesses, resources, problems, and service or medical needs. The assessment must include, as appropriate, an evaluation of the beneficiary's functional level, emotional status, general health, medication needs, family and/or home situation, employment status and/or capabilities, training needs, financial status, self-care potential available and/or needed support network, etc. This assessment shall not duplicate or replace any other assessments that are required for other state or federal program requirements and does not include a clinical assessment.

The CMP shall be developed in consultation with the beneficiary, the beneficiary's family or other social support system. 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 and to move them through the service delivery system.

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 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 needs of the family and/or beneficiary including the family's preferences and choices.
- The identified strengths and weaknesses of the beneficiary
- The services and actions required to meet the identified service needs

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Requirements (Cont'd.)

- The service provider, community programs, and/or agencies able to provide those services and to which the individual will be referred
- The frequency of activities should be addressed, if applicable. (Efforts to obtain services which are recommended in the CMP, but are unavailable to a beneficiary, must be included in the Activity Note documentation.)
- Involvement of the beneficiary. The beneficiary and/or his or her parent, guardian, or legal representative must sign the CMP 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, but must have them sign during the next face-to-face contact.
- Case manager's handwritten signature, title and signature date. Other forms that reference signature sheets do not meet the signature requirements for the CMP.

Signatures on the CMP are certification that the statements on the plan, and the services provided to that beneficiary are true and correct and appropriate for federal reimbursement. Each page of the CMP must be signed or initialed, titled and signature dated by the case manager. Other forms that reference signature sheets do not meet the signature requirements for the CMP. For CMPs maintained in electronic formats, signatures must meet all policy and electronic format requirements.

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

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Time Frame

The initial CMP for each beneficiary must be developed based on the needs that were determined in the assessment process. The CMP must be developed within 14 working days of the MTCM assessment. MTCM requires the CMP to be developed based on identified needs from the assessment. The CMP must be developed prior to billing for MTCM services and must be reviewed and updated as needed. At a minimum, the CMP must be reformulated every 180 calendar days thereafter.

Contents

The CMP shall address, as appropriate, the following needs relative to the beneficiary's:

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

The case manager shall assist the beneficiary, his or her family, or other responsible person as needed in locating or arranging appropriate medical services as well as coordinating needed medical transportation. 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.

Medical aspects of the beneficiary's needs are to be determined and each beneficiary is to have access to

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Contents (Cont'd.)

appropriate medical services. 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.

Additions or Changes

Additions to or changes in the Medicaid targeted case management plan must be dated and signed or initialed by the case manager.

Reformulation

The CMP must be reformulated at a minimum of 180 calendar days after the development of the initial CMP.

Case management services rendered to a beneficiary whose CMP was not reformulated by the 180th days is not reimbursable by Medicaid from the 181st day until the date of the completion of a new CMP.

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 Medicaid targeted case management record should be made at the time the activity is rendered.

Activity notations must:

- Each case management activity must be documented
- Specify the case management component being provided
- Reflect delivery of a billable and/or reimbursable activity. The documentation of activities must correspond to billing in type of activity, length of activity, units of service, and date of delivery.
- Be authored, signed, titled and signature dated by the qualified staff person(s) who rendered the case management activity
- Be filed or entered in the beneficiary's record within seven calendar days of delivery of the activity

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Activity Note (Cont'd.)

Each Activity Note must provide a pertinent description of the nature of the services rendered and shall address, as appropriate, the following:

- Justification of the need for MTCM and the activity provided
- The process of assessing and/or identifying needs, planning, referring, arranging or referring and linking to services
- Providing ongoing follow-up to ensure that the referred services continue to be necessary and appropriate

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.

Signature Sheet

A Signature Sheet must be maintained and made available to the 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.

PERIODIC REVIEW AND PROGRESS SUMMARY

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.

The review shall be:

- Completed at least every six months (180 days)
- Conducted by the case manager in consultation

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

PERIODIC REVIEW AND PROGRESS SUMMARY (CONT'D.)

with the beneficiary

- Documented in the beneficiary's case record
- Signed, titled and signature dated by the case manager

SECTION 2 POLICIES AND PROCEDURES

SPECIAL RESTRICTIONS

Reimbursement for Medicaid targeted case management activities involved in trying to locate a beneficiary may be claimed for only the first 30 days.

Federal Financial Participation (FFP) only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

Providers shall allocate the costs of any part of such services, which are reimbursable under another federally funded program, in a cost allocation plan to be approved by SCDHHS.

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

SPECIAL RESTRICTIONS

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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
- Reviewing case management record (of own agency files)
- Referring and monitoring of one's own activities
- Completing special requested information regarding beneficiaries for the provider, public agencies or other private entities for administration 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.*, Intermediate Care Facilities (ICFs) or ICF-IIDs (Intellectual Disabilities), nursing homes, etc.], except during the last 90days of the stay for the purpose of transition and/or discharge planning
- Rendering services to juveniles while incarcerated in a DJJ institution, an evaluation center (formerly known as reception and evaluation centers), 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 (SC Family Court, General Sessions or Federal Court), which are convened to address custody, criminal charges, or other judicial matter by the individual or others**.**

SECTION 2 POLICIES AND PROCEDURES

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 provide 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

SECTION 2 POLICIES AND PROCEDURES

NON-BILLABLE ACTIVITIES

MTCM NON-BILLABLE ACTIVITIES (CONT'D.)

- Individual, group or family therapy services
- 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
- Traveling to and from appointments on behalf of the beneficiary
- Using MTCM codes for billing when the beneficiary does not meet the criteria for one of the nine target groups
- Performing Beneficiary Outreach – 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 (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

SECTION 2 POLICIES AND PROCEDURES

NON-BILLABLE ACTIVITIES

MTCM NON-BILLABLE ACTIVITIES (CONT'D.)

- Rendering MTCM services when there is no CMP in place
- Rendering MTCM services and not enrolled as a South Carolina Medicaid MTCM provider
- Rendering, ordering, or authorizing MTCM services when excluded from participation in Medicaid, Medicare, CHIP or other federal program

SECTION 2 POLICIES AND PROCEDURES

TRANSITIONAL CASE MANAGEMENT

MTCM includes only services to beneficiaries who are residing in a community setting or transitioning to a community setting following an institutional stay. Providers may only provide case management services to facilitate the transitioning of beneficiaries from institutions to the community. A beneficiary is considered to be transitioning to the community during the last 90 consecutive days of a covered, institutional stay.

Providers may only receive Medicaid reimbursement for Medicaid targeted case management activities provided to facilitate the transition of beneficiaries from institutions to the community. Medicaid targeted case management activities provided to beneficiaries residing in an institutional setting for any other purposes and/or beyond the specified times frame are not billable to Medicaid.

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 J 7th
PO Box 8206
Columbia, SC 29202-8206

SECTION 2 POLICIES AND PROCEDURES

TRANSITIONAL CASE MANAGEMENT

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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.

SECTION 2 POLICIES AND PROCEDURES

FREEDOM OF CHOICE

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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 another case management provider to 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
- Conducting Quality Assurance (QA) audits of the agency's MTCM program, at least annually. The

SECTION 2 POLICIES AND PROCEDURES

PROVIDER RESPONSIBILITIES

PROVIDER RESPONSIBILITIES (CONT'D.)

results of each QA audit shall be summarized and forwarded to the SCDHHS which includes the office's compliance with MTCM policy and standards, deficiencies in documentation, and recommendations regarding any necessary corrections within 60 days of the end of the fiscal year.

MTCM providers should refer to the contractual agreements with the SCDHHS for specific stipulations regarding guidelines for record reviews.

SECTION 2 POLICIES AND PROCEDURES

SCDHHS RESPONSIBILITIES

SCDHHS shall provide Medicaid compliance monitoring and utilization control through the Program Management staff. The role of SCDHHS program staff is to review, define and educate the provider as to Medicaid policy.

SCDHHS program staff will monitor and/or assess effectiveness of the provider's annual service review process and, as warranted, the quality of the case management programs to verify that:

- Services reimbursed by Medicaid were actually rendered to beneficiaries
- Services were rendered in accordance with each beneficiary's needs
- Services substantiate a continued need for case management
- Services meet Medicaid standards
- Program practices do not result in unnecessary costs to the Medicaid program

SCDHHS program staff will monitor and evaluate activities concerning utilization control to:

- Safeguard against unnecessary or inappropriate use of Medicaid services
- Assess the quality of services
- Assess the timeliness of services
- Identify exceptions so that SCDHHS may correct inappropriate utilization practices of services and providers.

SCDHHS may initiate contact with the provider's local offices and/or conduct an on-site visit as contractually required or when ongoing, uncorrected deficiencies are identified in the provider's annual service reviews. Unless an unannounced visit is warranted, on-site visits shall be coordinated through the provider's State or Central Office.

SCDHHS shall provide the agency head a written report following each review. The report shall address the quality

SECTION 2 POLICIES AND PROCEDURES

SCDHHS RESPONSIBILITIES

SCDHHS RESPONSIBILITIES (CONT'D.)

of the current service delivery, the program's compliance with Medicaid standards, and whether further action is warranted.

A Corrective Action Plan may be requested by SCDHHS when severe and/or multiple infractions of Medicaid policies are identified. Infractions shall reflect issues, which may be subject to recoupment in a Medicaid Program Integrity Post Payment Review. The Corrective Action Plan shall include a step-by-step method for dealing with each recoupable issue and identify the individual(s) responsible for ensuring each deficiency or infraction is corrected.

SECTION 2 POLICIES AND PROCEDURES

BILLING FREQUENCY

All MTCM must be billed in unit increments of 15 minutes for a maximum of 16 units per day.

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 is performed for seven minutes or less on the same day as another MTCM 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

SECTION 2 POLICIES AND PROCEDURES

BILLING FREQUENCY

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