SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Medicaid Targeted Case Management Comprehensive Assessment

Division of Behavioral Health

Quality Assurance Team

2021

Disclaimer

- Materials presented today are not comprehensive. This training does not take the place of reading the provider policy and procedure manual. Prior to treatment, all beneficiaries must meet the criteria for medical necessity for that service. All information in this presentation pertains to South Carolina Department of Health and Human Services Healthy Connections (SCDHHS) Medicaid beneficiaries.

Purpose of the Orientation

- To act as a guide for Medicaid Targeted Case Management (MTCM) providers who are learning about South Carolina Medicaid policy and procedures prior to rendering MTCM.
  - While this presentation is designed to enhance understanding of the Medicaid standards regarding the MTCM Policy Manual, all aspects and policy are not covered in this presentation. Please review the MTCM Manual and the Administrative and Billing Manual.
- To help providers avoid potential Medicaid recoupment.

Overview of the Assessment

- Assessments must be completed on new beneficiaries. 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 assessment and periodic reassessment of an individual is completed in order to determine service needs, including activities that focus on determining the need for any medical, educational, social or other services.
- The assessment should identify and address risk factors throughout the assessment.
- The assessment determines service needs and program eligibility.
- Such assessment activities include the following:
  - Taking the history of the beneficiary to include the individual and family's 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.

Timeframe of Assessments

- The initial assessment must be completed within 45 calendar days after the referral is received for MTCM services.
- Addendums or updates to the initial assessment should occur as needed.
- Medical necessity must be confirmed by the 180th calendar day of the previous assessment by completing a new assessment.
- If services are still needed after the update period, a complete reassessment and new case management plan (CMP) must be done annually by day 365.

Components of the Assessment

- The MTCM assessment must be completed within 45 calendar days of provider acceptance of referral and must include the following components, as appropriate:
  - Level of functioning (e.g., how does the beneficiary function in personal, interpersonal, and community areas);
  - Medical status;
  - Emotional status;
  - Family dynamics;
  - Individual/family support system;
  - Current living environment, social as well as physical (e.g., who is the beneficiary residing with, where is the beneficiary current living, etc.);
  - Financial status (e.g., is the beneficiary currently employed, does the beneficiary receive SSI or other financial assistance, etc.);
  - Educational or vocational placement;

Components of the Assessment (Cont.)

- The MTCM assessment must be completed within 45 calendar days of provider acceptance of referral and must include the following components, as appropriate:
  - Community involvement (e.g., church, civic groups, volunteering, etc.);
  - Socialization and relationships with others;
  - Services received or needed from others and recommendations for treatment; and/or,
  - A qualified Medicaid Targeted Case Manager's name, title, signature, and signature date to confirm medical necessity.
- 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 MTCM assessment. Contacts shall be documented in the Activity Notes.

Need for Continued Services

- In addition to meeting the medical necessity requirements of a target population outlined in the "Covered Services and Definitions" section of the MTCM manual, the following must be met in order to continue receiving MTCM services:
  - Documentation of member's participation and engagement in Medicaid Targeted Case Management (MTCM);
  - 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;
  - The member has been re-assessed, treatment needs have been re-evaluated and medically necessary referrals have been completed if progress is not being 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.
- When a beneficiary no longer meets the medical necessity, criteria listed above (meaning they no longer need MTCM) they must be discharged from MTCM services.

Additional Guidance

- To receive MTCM, a beneficiary must have a diagnosis made by a qualified clinical professional and a copy of the report must be in the MTCM file.
- Medical necessity must be clearly documented, and evaluations or medical records must validate the client meets target group criteria.
- The assessment must identify unmet needs and current services the beneficiary has received and is currently receiving.


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