MEDICAID TARGETED CASE MANAGEMENT PROVIDER TRAINING

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Training Objective

The following topics regarding the July 1, 2024, updated Medicaid Targeted Case Management (MTCM) Services Provider Manual will be reviewed:

- Updated manual language
- Overview of medical necessity
- Format of manual
- Introduction of new forms
- Overview of prior authorization requirement
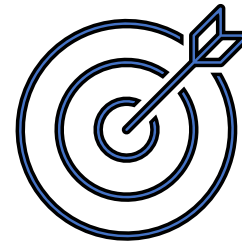
Service Definition

MTCM services are those functions and activities of care coordination which assist eligible members with access to needed medical, social, psychosocial, educational, financial and other services for health-related social needs required to support the member's maximum, independent functioning in the community.

Service Definition Continued

MTCM is time-limited, organized and structured with the ultimate goal of empowering the member to maintain and sustain their most optimal level of functioning independently upon completion of MTCM services.

Service Definition Continued

The MTCM process is a shared partnership between the member and the case manager who actively involves the member and those involved in their care (such as identified family or other caregivers) in all phases of the process – assessment, planning, problem solving and identification of and connection to needed resources.

Eligible Populations*

The following populations, as defined in chapter two of the manual, are eligible for MTCM services:

- Individuals with Intellectual and Related Disabilities (ID/RD)
- At-risk Children
- Adults with Serious and Persistent Mental Illness
- At-risk Pregnant Women and Infants
- Individuals with Psychoactive Substance Disorders

- Individuals at risk for Genetic Disorders
- Individuals with Head and Spinal Cord Injuries (HASCI) and Similar Disorders
- Individuals with Sensory Impairments
- Adults with Functional Impairments

No changes except updated language aligned with statutory definitions for ID/RD and HASCI populations.

Eligible Populations *continued*

Please note:

- MTCM provider organizations are *strongly encouraged* to focus on *one primary population.* However, in some circumstances, certain entities may appropriately cover more than one population.

- The same criteria regarding level of training, knowledge of services and resources and continuing education applies to providers of each target population, whether they do or do not operate within the same provider organization.
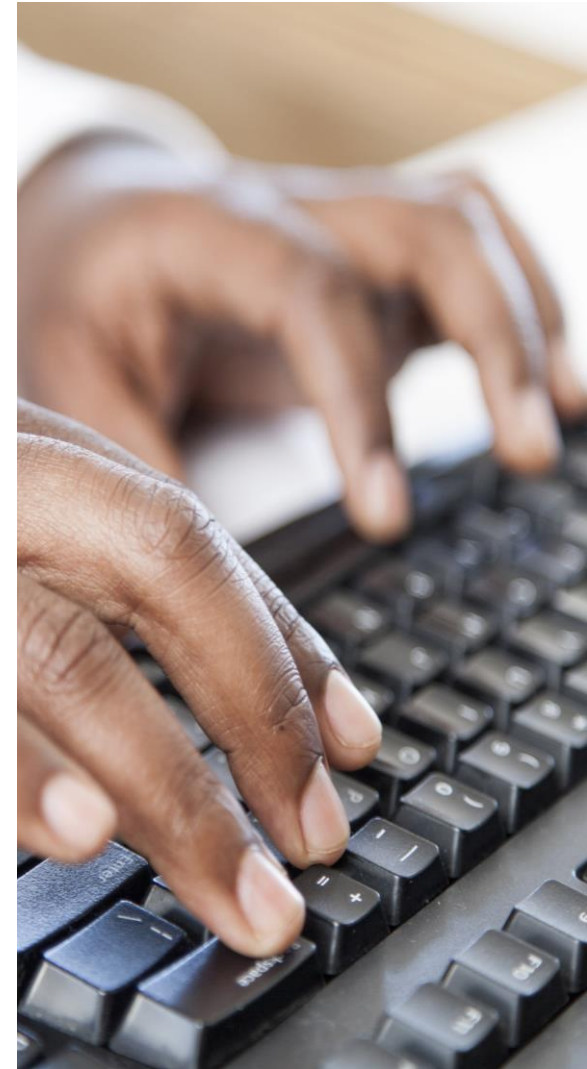
Overview of Medical Necessity

- Medical necessity for MTCM for a specific individual may vary based on diagnosis or other factors.

- Documentation from the referring provider (i.e., a physician or licensed practitioner of the healing arts [LPHA]) must be submitted to the MTCM provider to be maintained in the member's MTCM file.

- Medical necessity documentation and other issues identified in the referral will create the framework for the work of MTCM, including identification of the goals and the objectives necessary to meet those goals.

- MTCM providers must continue to be aware of and ensure that any services provided meet medical necessity as identified by the referring provider or other updated information (such as a facility discharge summary).

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Overview of Medical Necessity *continued*

- Medical necessity must be documented in the Targeted Case Management Referral Form*(found in the forms section of the MTCM Services Provider Manual) **OR** within the referral. This information must be kept in the member's MTCM file.

- MTCM providers shall not begin services without verification of medical necessity.

- Note: If the provider does not use the referenced Targeted Case Management Referral Form, it is the responsibility of the MTCM provider to *ensure that all necessary items on the form are covered within the referral information and identifiable in the member's MTCM file.*

*New form

Overview of Medical Necessity *continued*

To demonstrate **ongoing medical necessity**, documentation in the provider's service notes must reflect one or both of the following two aspects (shown on this and the next slide) related to the member's specific needs:

1. Because of difficulty processing and comprehending information, the member is unable to utilize processes regarding benefit eligibility, medication management, budgeting or is otherwise unable to perform activities required to live in a community-based setting without support.

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Overview of Medical Necessity *continued*

To demonstrate **ongoing medical necessity**, documentation in the provider's service notes must reflect one or both of the following aspects (shown on this and the prior slide) related to the member's specific needs:

2. Because of difficulty communicating and other interpersonal issues as a result of psychiatric or behavioral symptomatology, the member is unable to achieve goals and obtain services necessary for community living without support.

Concurrent MTCM

- Allowable **_only_** when the member qualifies for more than one target population and the selected case management entity does not have the experience and resources to meet all the member's needs.

- Any additional case managers beyond the primary MTCM provider **must also have prior authorization** as outlined in chapter six of the manual before beginning services.

- Provider documentation must clearly identify the specific goals and/or objectives they are working on with the member and reflect no duplication or overlap in provision of services.

Scope of MTCM Services

New format for manual:

- **Intake and Screening**
  - *New form, Targeted Case Management Referral*
  - *New form, Targeted Case Management Brief Screening*
- **Assessment and Reassessment**
- **Care Planning and Coordination**
  - *New term, Care Plan*
- **Referral and Linkage**
- **Monitoring and Follow-up**

New MTCM Forms

- **Targeted Case Management Referral**
    - This form is for physicians/other LPHAs when referring a member to an MTCM provider.
        - ➢ Although it is not required that referring providers use this form, it is the responsibility of the MTCM provider to ensure all applicable information is identifiable in the referral sent for documenting medical necessity.

- **Targeted Case Management Brief Screening**
    - This form is used to complete the telephonic or in-person intake on a newly-referred member.

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New Form: Targeted Case Management Referral

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Targeted Case Management Referral

Beneficiary Information

Beneficiary Name: _____ _____ _____
                          Last   First   M.I.

Beneficiary Date of Birth: _____ Medicaid ID: _____ Date of Referral: _____

Beneficiary Phone Number: _____ Beneficiary Email: _____

Parent/Guardian Name (If Applicable): Last _____ First _____

Diagnosis Code/s: _____

Referral Instructions

(1) Complete sections 1, 2, and 3 of the form.
(2) The Referral Form is only valid for 90 days. If a member requires services beyond 90 days,
    submit a new Referral Form prior to the referral end date.

1. Referral Source Information:

Provider/agency name: _____

Address: _____

Phone number: _____

TIN: _____ NPI: _____

Name of person completing form: _____

Contact information: _____ _____
                              Phone   E-mail

2. **Referral Indicators:**

Note which areas require attention (Choose as many as applicable).

☐ Medical ☐ Social ☐ Psychosocial ☐ Educational ☐ Vocational

☐ Financial ☐ Housing ☐ Transportation ☐ Food Insecurity ☐ Other

Briefly describe the reason for referral for each indicator chosen above:

3. **Referrer Signature:**

I attest that the information on this form is true and accurate to the best of my knowledge.

Printed name   Signature   Date

New Form:
Targeted Case Management Brief Screening

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Targeted Case Management Brief Screening

Beneficiary Information

Beneficiary Name:

Last	First	M.I.

Beneficiary Date of Birth: Medicaid ID: Date of Screening:

Beneficiary Phone Number: Beneficiary Email:

Parent/Guardian Name (If Applicable): *Last*   *First*

Diagnosis Code:

Presenting Concerns(s)/Immediate Needs

Provide a brief description of the Beneficiary's strengths, needs, and preferences in each of the following areas. If there is presenting problem or goal in an area, note as non-applicable.

Medical:

Social:

Psychosocial:

Educational:

New Form:
Targeted Case Management Brief Screening *continued*

Vocational:

Financial:

Housing:

Transportation:

Food Insecurity:

Other:

Other Providers or Agencies

List all other providers or agencies currently being utilized by the Beneficiary. Include the purpose of utilization and phone number, if known.

1.

2.

3.

4.

5.

Supports and Services

Note any family or friends that are a source of support:

List other sources of support in the community, such as church or other organization involvement:

If the Beneficiary is not connected to peer supports, do they want to be referred?

Disposition

Case management recommended? ☐ Yes ☐ No *(Inform client access to CM is available if future need arises)*

Case Management accepted? ☐ Accepted ☐ Declined

X

Beneficiary Signature: _____ **Date:**

OTHER IMMEDIATE REFERRALS MADE: (include contact name)

Hospital/Clinic: _____ Reason:

Agency: _____ Reason:

Agency: _____ Reason:

Internal: _____ Reason:

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Overview of Prior Authorization Requirement

MTCM services must be authorized *prior* to service delivery.
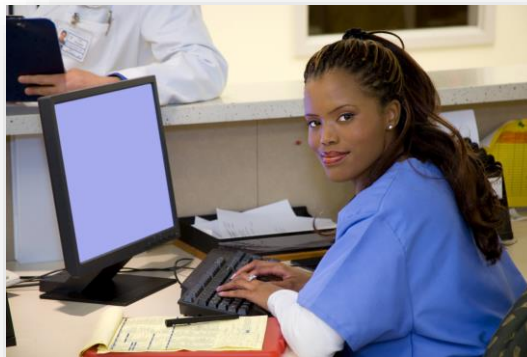
1. Initial authorization:
   - For *newly-referred* Medicaid members prior to beginning MTCM services, **all** of the following must be submitted to the quality improvement organization (QIO), Acentra Health:
     - ➢ Targeted Case Management Referral form (and/or other additional referral information that describes the medical necessity);
     - ➢ Targeted Case Management Brief Screening form; and,
     - ➢ Freedom of Choice form (completed during in-person intake only).
   - Acentra will authorize MTCM units necessary to complete the assessment and care plan within 45 days.

2. First full authorization:

- After completing the MTCM assessment and care plan, the provider will submit to Acentra for review.

- Acentra will authorize MTCM services as per medical necessity.

- Prior to reaching the **180-day mark** for the required updates to the assessment and care plan, the provider will prepare to submit another authorization request.

3. Continuing care:

- For members receiving ongoing MTCM services and who continue to require care beyond 180 days, the following must be submitted to Acentra Health:
  - ➢ Prior to reaching the 180-day mark of MTCM services, the provider will submit the current assessment, care plan and all service notes from the previous 30 days.
  - ➢ Any additional information substantiating medical necessity, such as a recent hospital discharge or psychological report, etc. shall also be submitted to support continued services.

Please do not submit your documentation for authorization to SCDHHS.

- All documentation and inquiries related to prior authorization should be addressed to Acentra Health *(those with MCO coverage would receive authorization through the respective MCO).*

Website:

https://scdhhs.acentra.com/

SCproviderissues@kepro.com

Phone: (855) 326-5219

Fax: (855) 300-0082

Overview of Prior Authorization Requirement
continued

- Please check Acentra Health's website regularly for new information.

- **Upcoming training provided by Acentra Health on the prior authorization process for MTCM will be held on July 24 and July 25.**
  - Check the Acentra Health website (https://scdhhs.acentra.com) for further details; recorded webinars and PowerPoint presentations will be available for review after the training dates for those unable to attend.

QUESTIONS?

Contact us at:

behavioralhealth004@scdhhs.gov