CHAPTER–523–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TARGETED CASE MANAGEMENT SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 523.1	Targeted Case Management Services	11-21-05	01-01-06
Section 523.2	Member Eligibility	11-21-05	01-01-06
Section 523.2.2	Functional Limitations Requirement: Major Life Areas Defined	11-21-05	01-01-06
Section 523.3.1	BMS Enrollment	11-21-05	12-01-05
Section 523.4	Procedure Code Units, Components, Limits, and Exclusions	11-21-05	12-01-05

NOVEMBER 21, 2005

SECTION 523.1

Introduction: Section 501 – Targeted Case Management Services

Old Policy: Did not contain provisions of services to individuals over age 20 that are in long term care facilities or in need of Supported Living arrangements.

New Policy: Added provision of services to individual over age 20 that are in long term care facility or in need of Supported Living arrangements

Change: Addition of provision

Directions: See addition

SECTION 523.2

Introduction: Section 502 – Member Eligibility

Old Policy: Did not contain language – individuals over age 20 that are in long term care facilities or in need of supported living arrangements.

New Policy: Added language individuals over age 20 that are in Long Term Care facilities or in need of supported living arrangements.

Change: Addition of language individuals over age 20 that are in long term care facilities or need of Supported Living arrangements.

Directions: See addition

SECTION 523.2.2

Introduction: Section 523.2.2 – Functional Limitations Requirement: Major Life Areas Defined

Old Policy: Did not contain information on Supportive Living Arrangements

New Policy: Defines Supported Living Arrangements

Change: Includes Definition for Support Living Arrangement

Directions: See addition

SECTION 523.3.1

Introduction: Section 523.3.1 BMS Enrollment

Old Policy: BMS address given as address in which to submit letter requesting participation.

New Policy: Changed to give Unisys address for submit letter requesting participation

Change: Change of address

Directions: See addition

SECTION 523.4

Introduction: Section 523.4 Procedure Code Units, Components, limits, and Exclusions

Old Policy: BMS address given as address in which to submit letter requesting participation.

New Policy: Changed to give Unisys address for submit letter requesting participation

Change: Change of address

Directions: See addition

CHAPTER 523—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR TARGETED CASE MANAGEMENT SERVICES

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CHAPTER 523–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TARGETED CASE MANAGEMENT SERVICES

INTRODUCTION

The West Virginia Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise, in writing, by the Bureau for Medical Services (BMS).

This chapter sets forth the Bureau for Medical Services' requirements for payment of Targeted Case Management Services for persons with mental illness, developmental disabilities, substance-related disorders, and/or victims of domestic violence; rendered by qualified providers to eligible West Virginia Medicaid members.

The policies and procedures set forth herein are promulgated as regulations governing the provision of Targeted Case Management Services in the Medicaid Program administered by the West Virginia Department of Health and Human Resources under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

523.1 TARGETED CASE MANAGEMENT SERVICES

Targeted Case Management Services are federally defined as "those services which assist Medicaid eligible recipients in the target group to gain access to needed medical, behavioral health, social, educational and other services". Targeted Case Management is not a direct service.

- Targeted populations are:
  - Children with mental illness
  - Adults with mental illness
  - Children with substance-related disorders
  - Adults with substance-related disorders
  - Children with developmental disabilities not enrolled in the Mentally Retarded/ Developmentally Disabled (MR/DD) Waiver Program
  - Adults with developmental disabilities not enrolled in the MR/DD Waiver Program
  - Members temporarily residing in licensed domestic violence centers Adults over the age of 20 who are residents of long term care facilities or who need supported living arrangements.

Providers must only provide Targeted Case Management Services for the specific population(s) for which they are certified. A provider may be certified to serve more than one population.

- The goals of Targeted Case Management are to assure that:

- Eligible members have access to needed services and resources
- Necessary evaluations are conducted
- Individual service plans are developed and implemented
- Reassessment of the services provided and members' needs occur on an on-going basis.

These criteria are consistent with Section 1902(23) of the Social Security Act.

Services must be provided in settings accessible to the member. The member must be given the option of whether or not to utilize Targeted Case Management Services. If the member chooses Targeted Case Management Services, he/she must also be given a choice of providers approved by the Bureau for Medical Services.

523.2 MEMBER ELIGIBILITY

In order to receive Targeted Case Management Services, members must meet the criteria for one of the targeted population groups. A member must be either:

- A child who is identified as eligible for Part C of the Individuals with Disabilities Education Act services through an agency under contract with the Department of Health and Human Resources (DHHR), Office of Maternal and Child Health (OMCH).

OR

- A member temporarily residing in a licensed domestic violence center (Neither the diagnosis requirements nor the functional limitations requirements listed below apply to this group).

OR

- A child or an adult who (1) meets one of the diagnostic categories in the International Classification of Diseases, 9th Edition or Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (ICD-9/DSM-IV-TR) listed in section 523.2.1 or a developmental disability as defined in §49-4A-2 of the West Virginia Code, and (2) exhibits substantial functional limitations as determined by an appropriate standardized assessment instrument in two of the major life areas defined in 523.2.2. **(A child or adult diagnosed as MR/DD must demonstrate functional limitations in <u>three</u> of the major life areas defined in section 523.2.2).**

  A Medicaid-eligible individual over age 20 who has been determined in need of supported living arrangements either in a long term care facility or community placement or an individual who is a resident of said facility and in need of discharge, disposition, placement and after care follow up. These services will not exceed 30 days prior to the estimate date of discharge.

523.2.1 DIAGNOSIS REQUIREMENT: CATEGORIES DEFINED

- For children who are 17 years of age or younger, all ICD-9/DSM-IV-TR diagnoses are eligible.
- For adults who are 18 years of age or older, the eligible diagnostic categories are:

- Substance-Related Disorders (except Caffeine-Related Disorders and Nicotine-Related Disorders)
- Schizophrenia
- Other Psychotic Disorders
- Mood Disorders
- Delusional Disorders
- Borderline Personality Disorder.

523.2.2 FUNCTIONAL LIMITATIONS REQUIREMENT: MAJOR LIFE AREAS DEFINED

- **Vocational**

  Impairment in vocational functioning as manifested by (1) an inability to be consistently employed at a self-sustaining level or (2) an ability to be employed only with extensive supports (except a person who is able to earn sustaining income, but is recurrently unemployed because of acute episodes of mental illness or addictions)

- **Educational**

  Impairment in educational functioning as manifested by an inability to establish and pursue educational goals within a normal time frame or without extensive supports.

- **Homemaker**

  Impairment in homemaker functioning as manifested by an inability to consistently and independently accomplish home management tasks, including household meal preparation, washing clothes, and budgeting.

- **Social or interpersonal**

  Impairment in social or interpersonal functioning as manifested by an inability to independently develop or maintain social relationships, or to independently participate in social or recreational activities. This may be evidenced by:

  - Repeated inappropriate or inadequate social behavior (an ability to behave appropriately or adequately only with extensive or consistent support or coaching; or only in special contexts or situations such as social groups organized by the provider), or
  - Consistent participation in activities only with extensive support or coaching, and when involvement is mostly limited to special activities established for persons with interpersonal impairments.

- **Community**

  Impairment in community functioning as manifested by a pattern of significant community disruption, including family disruption or social unacceptability or inappropriateness, which may not recur often but is of such magnitude that it results in severe consequences (including exclusion from the member's primary social group or incarceration) or in severe impediments to securing basic needs such as housing.

- **Self-care or independent living**

Impairment in self-care or independent living as manifested by an inability to consistently perform the range of practical daily living tasks required for basic functioning in the community, including:

- Grooming, hygiene, and meeting nutritional needs
- Care of personal business affairs
- Transportation and care of residence
- Procurement of medical, legal, and housing services
- Recognition and avoidance of common dangers or hazards to self and possessions

ICD-9/DSM-IV-TR diagnoses must be rendered by a physician or licensed psychologist. Functional limitations must be identified, supported, and documented in assessments using appropriate standardized instruments appropriate to the members being assessed.

Supported Living Arrangements:

Individuals in this target group have limiting physical conditions which impair their ability to independently carry out the essential activities of daily living, and it is these impairments which require that they reside in settings where necessary support services can be made available to them. For individuals who reside in long term care facilities, case management will focus on appropriate discharge, disposition, placement and after-care follow-up services. These services will not exceed a period of 30 days prior to the estimated date of discharge. These services will compliment, not duplicate, case management services provided by the nursing facility. For individuals in the community, services will focus upon linking the individual with medical and social support services in order to maintain them in this setting.

523.3 PROVIDER ENROLLMENT REQUIREMENTS

In order to participate in the West Virginia Medicaid Program and receive payment from BMS, each provider of Targeted Case Management Services must meet all enrollment criteria as described in chapter 300 and:

- Meet and maintain all BMS, enrollment, certification, and service provision requirements as described in this manual
- Have a valid provider agreement on file
- Be licensed under the laws of the State of West Virginia as a Behavioral Health Agency; unless the provider is a domestic violence center. Based on the 1989 Domestic Violence Act, an agency (domestic violence center) must be licensed as a domestic violence center under Chapter 48, Article 2C of the West Virginia Code.

523.3.1 BMS ENROLLMENT

- Providers who wish to participate in Targeted Case Management Services must submit a letter requesting participation to:

Unisys Corporation, Inc.

Provider Enrollment

Post Office Box 625

Charleston, West Virginia 25322

- Providers will receive additional information on enrollment requirements upon receiving an application notice.

523.3.2 ENROLLMENT REQUIREMENTS: AGENCY ADMINISTRATION

- Targeted Case Management agencies must promote effective operation of the various programs and agencies in a manner consistent with applicable State laws, regulations, and procedures. There must be clear policy guidelines for decision making, program operations, and provision for monitoring the same.
- Targeted Case Management providers must have:
  - Provisions for orientation, continuing education, and on-going communication with all applicable governing boards
  - Policies and procedures to protect the rights of members of service
  - A comprehensive set of personnel policies and procedures
  - Job descriptions and qualifications, including licensure, for all staff employed either directly or by contract with the provider or with an agency contracting with the provider or program
  - Provisions for ensuring staff or contractors possess the skills, attitudes, and knowledge needed to perform job functions, and provisions for performing regular staff evaluations. Written definitions and procedures for use of all volunteers must be maintained.
- Targeted Case Management providers must exhibit effective inter-agency coordination that demonstrates a working knowledge of other community agencies. This means the provider and its contracting agencies must be aware of the specific program goals of other human service agencies, and maintain current information regarding the types of services offered and limitations on these services. Similarly, providers must ensure that other human service agencies are provided with accurate, up-to-date information regarding the provider's services, service limitations, and priorities within those services.

523.3.3 ENROLLMENT REQUIREMENTS: STAFF QUALIFICATIONS

- Targeted Case Management providers must assure that all staff who provide Targeted Case Management Services to members possess one of the following qualifications:
  - A psychologist with a Master's or Doctoral degree from an accredited program
  - A licensed social worker
  - A registered nurse
  - A Master's or Bachelor's degree in a human services field (e.g. counseling, special education, psychology, rehabilitation counseling, nursing)
  - Previous certification on the basis of training and experience by the Office of Behavioral Health Services.

Providers must maintain documentation of staff qualifications in staff personnel files. Documented evidence includes, but is not limited to: transcripts, licenses, and certificates.

- Targeted Case Management providers must have a review process to ensure that employees providing Targeted Case Management Services possess the minimum qualifications outlined above. The review process must occur upon hiring of new employees and on an annual basis to assure that credentials remain valid.
- Targeted Case Management providers must plan staff development and continuing education activities for its employees and contractors that broaden their existing knowledge in the field of mental health, substance abuse, and/or developmental disabilities and related areas.
- Targeted Case Management providers must credential their staff by an internal curriculum specific to Targeted Case Management prior to the staff assuming their Targeted Case Management duties.
- Staff development and continuing education activities must be related to program goals and may include supporting staff by attendance at conferences, university courses, visits to other agencies, use of consultants, and educational presentations within the agency.

Documentation of staff continuing education, staff development, and Targeted Case Management Training must be maintained in staff personnel files.

523.3.4 OTHER ADMINISTRATIVE REQUIREMENTS

- The provider must assure implementation of BMS' policies and procedures pertaining to service planning and documentation and case record review. Case records should be arranged so information can be found quickly and easily. Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must contain completed member identifying information. The member's individual plan of service must contain service goals and objectives which are derived from a comprehensive member assessment, and must stipulate the planned service activities and how they will assist in goal attainment. Termination reports should be filed upon case closure. There should be on-going case record reviews to ensure that records contain current, accurate, and complete information. The crisis intervention system must maintain complete information on each member it serves.
- Provider staff must be available to provide Targeted Case Management Services 24 hours a day; seven days a week.

523.3.5 METHOD OF VERIFYING BUREAU FOR MEDICAL SERVICES' REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by BMS and/or its contracted agents. Bureau for Medical Services' contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by BMS. These approved guidelines function as policy. Additional information governing the

surveillance and utilization control program may be found in Chapter 800, General Administration, of the Provider Manual.

523.4 PROCEDURE CODE UNITS, COMPONENTS, LIMITS, AND EXCLUSIONS

PROCEDURE CODE: T1017
SERVICE UNITS: 15 minutes
SERVICE LIMITS: All units must be prior authorized by APS Healthcare, Inc.
PRIOR AUTHORIZATION: Yes; (with the exception of domestic violence centers)

If, between regular service planning sessions, the member requires access to a service not previously mentioned on the case management section of his/her service plan, both the member (or their guardian) and their case manager must agree to attach an addendum addressing the needed service to the plan.

The case manager must have at least one face-to-face contact with the member per month that is a valid Targeted Case Management activity. If no other Targeted Case Management activity has occurred, a service plan evaluation, at a minimum, must transpire.

504.1 COMPONENTS OF TARGETED CASE MANAGEMENT SERVICES

Within Targeted Case Management are a number of activities federally recognized as components of case management. These components are:

- **Assessment:**

  The case manager will ensure an on-going formal and informal process is to collect and interpret information about a member's strengths, needs, resources, and life goals to be used in the development of an individualized service plan. Assessment is a collaborative process between the member, his/her family, and the case manager.

- **Service Planning:**

  The case manager will assure and facilitate the development of a comprehensive, individualized service plan. The service plan records the full range of services, treatment, and/or other support needs necessary to meet the member's goals. The case manager is responsible for regular service planning reviews based on the member's needs and at regularly scheduled intervals. However, when the case manager participates in a treatment team meeting, the services provided are not billable as Targeted Case Management.

- **Linkage/Referral:**

  Case managers assure linkage to all internal and external services and supports identified in the member's service plan.

- **Advocacy:**

  Targeted Case Management advocacy refers to the actions undertaken on behalf of the member in order to ensure continuity of services, system flexibility, integrated

services, proper utilization of facilities, and resources, and accessibility to services. This includes assuring that the member's legal and human rights are protected.

- **Crisis Response Planning:**

  The case manager must assure that adequate and appropriate crisis response procedures are available to the member and identified in the individual service plan. The case manager will assist the member as necessary in accessing crisis support services and interventions.

- **Service Plan Evaluation:**

  The case manager will continually evaluate the appropriateness of the member's service plan and make appropriate modifications, establish new linkages, or engage in other dispositions as necessary.

These components do not constitute separate services and cannot be billed as separate services, but are identified and defined here to assist case managers in understanding their roles and responsibilities.

523.4.2 SERVICE LIMITATIONS

Service limitations governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 300, Provider Participation of the Provider Manual. In addition to the requirements for payment of services described in this chapter, Targeted Case Management Services will not be authorized prior to a member's discharge from an Intermediate Care Facility/Mental Retardation (ICF/MR) or an inpatient psychiatric facility except for those provided within 30 days prior to discharge as part of the discharge process.

523.4.3 SERVICE EXCLUSIONS

- In addition to the exclusions listed in Chapter 100, General Information of the Provider Manual, members who receive case management services under the Home and Community-Based Services Waivers granted under Section 1915 (c) of the Social Security Act are excluded from receiving Targeted Case Management reimbursement through this service option.
- Payment for Targeted Case Management Services must not duplicate payments made to public agencies or private entities under other program authorities for case management/service coordination services.

523.5 MEMBER CHOICE OF SINGLE TARGETED CASE MANAGEMENT PROVIDER

- Each member or their legal guardian must be provided information, by the provider with whom they are seeking services, about the availability of all State-Approved Targeted Case Management providers within reasonable proximity of their residence.
- The member must be given an opportunity to choose only one approved Targeted Case Management provider and must indicate this choice on BMS approved “Medicaid Targeted Case Management Client Enrollment” form. (See Attachment 1).

- A signed copy of the "Medicaid Targeted Case Management Client Enrollment" form must be retained in the member's record and must serve as an enrollment, dis-enrollment, or re-enrollment of the member with the provider.
- The Bureau for Medical Services will reimburse only for Targeted Case Management Services provided by the approved provider chosen by the member.
- A member may choose a new Targeted Case Management provider at any time. The effective date of the change of providers will be the first day of the month following the change.

523.6 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Targeted Case Management providers must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information, Chapter 300, Provider Participation, and Chapter 800, General Administration of the Provider Manual. In addition to the documentation requirements described in this chapter, the following requirements also apply to payment of Targeted Case Management Services:

An agency approved by BMS for provision of Targeted Case Management Services for Medicaid reimbursement must maintain the following information/documentation:

- Each member receiving Targeted Case Management Services must have an individual permanent clinical record.
  - There must be evidence in each clinical record that the member is shown to be in a targeted population as defined in 523.1.
  - Each member must have an individualized service plan detailing the need for Targeted Case Management Services which is updated at 90-day intervals or more frequently if indicated by member need.
- Each clinical record must include documentation specific to services/activities reimbursed as Medicaid Targeted Case Management. This includes a specific note for each individual case management service/activity provided and billed. Each case note must:
  - Be dated and signed by the case manager along with a listing of the case manager's credentials
  - Link back to the service goal/objective in the individual's plan of service with which it is to assist
  - Include the purpose and content of the activity as well as the outcome achieved
  - Include a description of the type of contact provided; (e.g., face-to-face, correspondence, telephone contacts)
  - Include a description of the type of activity provided; (i.e., assessment, service planning, linkage/referral, advocacy, crisis response planning, service plan evaluation)
  - List the place where the activity occurred
  - List the actual time spent providing each activity by listing the start – and - stop time.

- A Targeted Case Management unit of service consists of a 15-minute period of time. Claims must not be processed for less than a full unit of service. Consequently, in filing claims for Medicaid reimbursement, the amount of time documented in minutes must be totaled and divided by 15 to arrive at the number of units billed. After arriving at the number of billable units, the last date of service provision must be billed as the date of service. **The billing period cannot overlap calendar months.**
- The documentation must demonstrate only one staff person's time is billed for any specific activity provided to the member.

523.7 PRIOR AUTHORIZATION (This section is not applicable to domestic violence centers)

Prior authorization requirements governing the provision of Targeted Case Management Services will apply pursuant to the following limitations.

523.7.1 PRIOR AUTHORIZATION PROCEDURES

- BMS requires that providers prior authorize all Targeted Case Management Services with BMS' contracted agent.
- General information on prior authorization requirements for Targeted Case Management Services and contact information for submitting a request may be obtained by contacting BMS' contracted agent.

• 523.7.2 PRIOR AUTHORIZATION REQUIREMENTS

- Prior authorization requests for Targeted Case Management Services must be submitted within the timelines required by BMS' contracted agent.
- Prior authorization requests must be submitted in a manner specified by BMS' contracted agent.

CHAPTER 523
TARGETED CASE MANAGEMENT SERVICES
MAY 1, 2004

ATTACHMENT 1
MEDICAID TARGETED CASE MANAGEMENT
CLIENT ENROLLMENT FORM
PAGE 1 OF 2

PROVIDER AGENCY:

MEDICAID TARGETED CASE MANAGEMENT
CLIENT ENROLLMENT

Client Name: _____ County: _____

Date of Birth: _____ SS#: _____

Effective Date

Medicaid Number: _____ of Enrollment: _____

Previous Agency of Record:

- I (and/or my legal representative) have been informed of my rights to Targeted Case Management Services including the right to appeal my individual service plan.

- I (and/or my legal representative) understand that my use of these services is voluntary and services may be withdrawn or ended at my request.

- I (and/or my legal representative) understand that I may choose to receive Targeted Case Management Services from any available qualified provider, and I have the right to change my case management provider if I feel services are not appropriate or sufficient to meet my needs.

- I (and/or my legal representative) understand that I may not enroll with another provider until at least 30 days have elapsed.

- I (and/or my legal representative) have been informed of the definition of Targeted Case Management Services, and I understand that receiving these services does not guarantee the receipt of other services or treatments, but it is a process to help me get necessary services and/or treatment based on my individual needs.

☐ I (and/or my legal representative) have been informed of other case management providers available in my county.

☐ I choose to receive Targeted Case Management Services.

☐ I choose **NOT** to receive Targeted Case Management Services.

_____ _____

Member/Legal Representative Date

_____ _____

Provider Representative Date

CHAPTER 523
TARGETED CASE MANAGEMENT SERVICES
MAY 1, 2004

ATTACHMENT 2
MEDICAID TARGETED CASE MANAGEMENT PROVIDER AGREEMENT
PAGE 1 OF 2

MEDICAID TARGETED CASE MANAGEMENT

PROVIDER AGREEMENT

_____ hereby agrees to

(Name of Behavioral Health Provider Agency) (License Number)

contract with the West Virginia Department of Health and Human Resources to provide Targeted

Case Management effective _____. Further this agency will provide Targeted Case

(Effective Date)

Management Services specifically as follows:

I. TARGETED POPULATION SERVED: This agency specifies that it will serve the following populations. (Check all that apply.)

Substance Abuse	**Developmental Disabilities**	**Mental Illness**
Children ☐	Children ☐	Children ☐
Adults ☐	Adults ☐	Adults ☐
	Infants and toddlers ☐	
Domestic Abuse	In Part C Programs	
Residents ☐		

II. COUNTIES SERVED: This agency has the capacity to serve the above designated populations in the following counties: (Note: Agencies may only designate counties in which they have an approved Certificate of Need for Targeted Case Management Services.

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(Note: Any counties additional to the 20 spaces above must be listed on a separate attachment.)

III. CREDENTIALING PROCESS: A copy of the agency's credentialing process and the current training plan has been attached with this contract addendum.

IV. MEMBER CHOICE: The provider understands that each eligible member has a choice of available certified Targeted Case Management providers within a reasonable proximity of the member's residence. The provider further recognizes that they may only be reimbursed for services provided to those members for whom they have a signed, dated copy of enrollment form indicating that the provider was chosen by the member for that time period for which the service was rendered. Further, the provider understands that any false or misleading statements, promises, and/or other inappropriate inducements made to members will be cause for de-certification as a Medicaid provider of Targeted Case Management Services.