SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

MEDICAID TARGETED CASE MANAGEMENT (MTCM) PROVIDER MANUAL

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South Carolina Department of Health and Human Services

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1 PROGRAM OVERVIEW

SERVICE DEFINITION:

Medicaid Targeted Case Management (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. memberMTCM 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. 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 care givers) in all phases of the process – assessment, planning, problem solving, and identification of and connection to needed resources.

FREEDOM OF CHOICE:

In accordance with section 1902(a) (23) of the Social Security Act, each MTCM provider must ensure that the provision of MTCM services does not restrict the member's free choice of providers. To demonstrate freedom of choice, the MTCM provider must review the applicable form with the member ("Freedom of Choice," *FORMS* section), obtain the member's signature, and maintain the original in the member's file. A copy shall be provided to the member.

COVERAGE:

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

SCDHHS limits the provision of MTCM to particular target populations to make certain that qualified providers are capable of ensuring beneficiaries receive needed services (see Chap. 2, *Covered Populations*).

ELIGIBILE POPULATIONS

The following populations, as defined in Chap. 2, are eligible for MTCM:

- 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 Disorders

- Individuals at risk for Genetic Disorders
- Individuals with Head and Spinal Cord Injuries and Related Disabilities
- Individuals with Sensory Impairments
- Adults with Functional Impairments

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 or not they operate within the same provider organization. Individual providers shall not be expected to maintain expertise in each population the organization serves (as an example, it is unlikely that each provider has the same level of expertise regarding at-risk youth as they have for individuals with sensory impairments with if that is their area of expertise), but rather the provider organization must hire adequate staff appropriate to cover each population served.

MEDICAL NECESSITY

Medical necessity for MTCM for a specific individual may vary based on diagnosis or other factors, however, documentation from the referring provider (i.e., a physician or licensed practioner of the healing arts [LPHA]) must be submitted to the MTCM provider to maintain in the member's MTCM file. This 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 defined.

Medical necessity must be documented in the **MTCM Referral Form**, found in the *FORMS* section of the MTCM manual, or within the referral and 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 MTCM 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.*

In order to demonstrate ongoing medical necessity, documentation in the provider's service notes must reflect one or both of the following aspects 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;

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.

PRIOR AUTHORIZATION

Prior authorization (PA) is required for MTCM services delivered by private providers.

Initial authorization for newly-referred members beginning services includes:

- The following must be submitted to the QIO for review:
  - MTCM Referral Form (and/or other additional referral information that describes the medical necessity),
  - MTCM Brief Screening form (completed by the provider agency),
  - Freedom of Choice form

Upon approval, the QIO will authorize the number of MTCM units necessary to complete the assessment and care plan within the 45-day period as defined by policy.

After completing the assessment and care plan, prior authorization for additional services will include the following steps:

- The assessment and care plan will be submitted to the QIO for review.

For members receiving ongoing MTCM services who continue to require care, prior authorization will include the following steps:

- Prior to reaching the 180 day mark for the required updates to the assessment and care plan, the provider must submit the current assessment, care plan, and all service notes from the previous 30 days to the QIO for review.
- Any additional information substantiating medical necessity, such as a recent hospital discharge or psychological report, etc., shall be submitted to support continued services.

CONCURRENT MTCM

Concurrent case management will be allowed 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. member Any additional case managers beyond the primary MTCM provider must also have prior authorization as outlined in Chapter 5 before beginning services; documentation submitted for approval must describe the roles of both case managers and verify there will be no service duplication. 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.

Interagency collaboration is crucial to ensuring that a member's needs are adequately met without duplication of services. Thus, it is important for provider agencies to ensure that targeted case managers are communicating with other professionals and involved parties, coordinating care and services and meeting the specific needs of each member and, as appropriate, the needs of families, to avoid duplication of services. Supervision of the MTCM provider and/or case reviews must ensure that concurrent case management requirements as identified above are met.

NOTE: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- Provider Administrative and Billing Manual
- Forms

  Section 4 - Procedure Codes

2 COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Member Eligibility

MTCM includes only services to beneficiaries who are residing in a community setting ***OR*** transitioning to a community setting following an institutional stay. For a list of MTCM providers, visit http://www1.scdhhs.gov/mtcmdirectory/l or call the Healthy Connections Member Contact Center at: +1 888 549 0820.

To be eligible for MTCM, an individual must be enrolled in Medicaid, and meet **all** of the following criteria:

- Meet eligibility criteria for one of the target populations outlined in the South Carolina State Plan;
- Demonstrate motivation for receiving support in accessing services and be capable of benefiting from this support;
- Be able to participate in the planning process, or if applicable, a responsible party must participate on behalf of the member; and
- A well-defined clinical rationale is documented in the initial referral that explains why the member requires assistance in accessing supportive services due to their specific needs.
- Each member must sign the Agreement to Partment in MTCM Services form. If the member is between ages 0–16, the Parent/Guardian/Caregiver must sign the Agreement to Participate in MTCM Services form.

Case Management Target Population

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

- 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 Disorders
- 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

This target population includes individuals who are diagnosed or have a suspected diagnosis of intellectual disability. *Intellectual disability* is defined as significantly sub-average general intellectual functioning (affecting areas of learning, problem-solving, and judgement) which exist concurrently with deficits in adaptive functioning (including activities of daily living such as communication and personal care).

This population also includes those with an identified or suspected related disability. *Related disability* is defined as a severe, chronic condition found to be closely related to intellectual disability that may cause adaptive functioning deficits, activity limitation, and difficulty interacting with others. This category includes those with autism.

Both intellectual and related disabilities must meet each of the following conditions:

- It is manifested before 22 years of age.
- It is expected to be a life-long condition.
- It results in substantial functional limitation in three or more of the following areas of major life activities: self-care, language use and comprehension, learning, mobility, self-direction, and capacity for independent living.
- The individual's needs require supervision due to impaired judgment, limited capabilities, behavior problems to include aggression, or because of drug effects/medical monitoring.
- The individual is in need of services directed toward acquiring skills to function as independently as possible or to prevent regression or loss of current optimal functional status.
- Specific symptoms or disturbances make the member unable to access behavioral health, medical, educational, social, developmental, or other supportive services required.

At-Risk Children

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

- At high risk for medical compromise due to one or more of the following:
  - Failure to take advantage of necessary health care services;
  - Non-compliance with prescribed medical regime;

  - Inability to coordinate multiple medical, social, and other services due to an unstable medical condition in need of stabilization; or
  - Absence of a community support system to assist in appropriate follow-up care at home.

- Behavior that is harmful to others, such as severe aggression.

- A victim of abuse, neglect, or violence.

- Medical complexity that requires frequent care planning.

- Diagnosis of or suspected diagnosis of a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay and/or intellectual disability and are less than age six.

- Children and youth who at any time during the past year have had a mental or behavioral health diagnosis and/or has met diagnostic criteria as specified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

  Z-codes do not replace a psychiatric diagnosis from the current edition of the DSM or ICD. Medical necessity based on Z-codes is allowable, but primarily for children six and under; it is considered temporary in children aged 7 and older and may not be used for longer than a six-month duration. After six months, medical necessity must be established by a psychiatric diagnosis if continuation of services is needed. Clinical documentation justifying the need for continued services must be maintained in the child's clinical record.

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

Adults with Serious and Persistent Mental Illness

Adults with serious and persistent mental illness must meet the following criteria:

- Medicaid-eligible individuals aged 21 and older who have a major mental disorder included in the current edition of the DSM under the schizophrenia spectrum and other psychotic disorders, major affective disorders, severe personality disorders, , or a diagnosis of a mental disorder and at least one psychiatric hospitalization within the past 12 months for treatment of a mental disorder.

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

At-Risk Pregnant Women and Infants

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

- Failure to take advantage of necessary prenatal care or services.

- Non-compliance with prescribed medical regime.

- Inability to coordinate multiple medical, social, or other services due to an unstable medical condition in need of stabilization.

- An inability to understand medical directions because of comprehension barriers and:
    - Is expecting her first live birth and has never parented a child, or
    - Has previously been pregnant, but experienced a stillbirth, miscarriage or had an abortion, or
    - Has previously parented her child but her parental rights were terminated, or
    - Has delivered a child, but the child died within the first 24 months of life, or
    - Has parented a child but there is an age gap of 15 or more years since the last delivery.

- The at-risk infant is eligible for case management under this population to the second birthday.

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

Individuals with Psychoactive Substance Use Disorders

Medicaid-eligible individuals who are at risk of substance use disorders, dependency or addiction, or diagnosed with a substance use disorder, psychoactive substance dependency, or substance-induced organic mental disorders, as defined in the current edition of the DSM or Medicaid-eligible individuals who received treatment in an intensive substance use treatment program or required services in a chemical dependency hospital.

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

"At-Risk" of Substance Use Disorders, Dependency, or Addiction

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

Substance Use Disorder (SUD) Risk Factors

- Persistent problem behaviors (pre-adolescence to adult) including:

- Risk-taking, high sensation-seeking behaviors (in adolescents, consider developmental stages).
- Antisocial behavior.
- AOD use that does not meet diagnostic criteria (in adolescents, includes experimental use; in adults, increased use when stressed or self-medicating due to other symptoms/problems).

Family

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

Peers/School/Community

- Associating with substance-using peers.
- Drinking in social settings or having peers who do.
- Accessibility to alcohol and other drugs.
- Availability of alcohol and other drugs.
- Misperceptions about extent and acceptability of drug-using behavior.
- Beliefs that drug use is generally tolerated.

Individuals At Risk for Genetic Disorders

South Carolina 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 caused by a genetic disorder.

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

Individuals with Head and Spinal Cord Injuries and Similar Disorders

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

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

Individuals with Sensory Impairments

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

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

Adults with Functional Impairments

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

- Individuals who are 18 years of age or older.
- Individuals who lack formal or informal resources to address their mental and physical needs.
- Individuals who have at least two functional dependencies or one functional dependency and a cognitive impairment.
- Individuals who require MTCM assistance to obtain needed services.
- Individuals who are at-risk for institutionalization.

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

3 SCOPE OF MTCM SERVICES

In general, MTCM services consist of the activities listed in this chapter and as specified for the identified target populations.

INTAKE AND SCREENING

During initial screening an attempt is made to engage a member's interest and ascertain his/her willingness and need to participate in case management. These intake and screening activities include:

- The initial contact with a referred member, which should be made as soon as possible subsequent to identification of the member's potential program eligibility.
- Completion of the MTCM Brief Screening form *(see FORMS section for further information).*
- In a manner appropriate to the member's age and individual needs, provide information concerning case management sufficient to enable the member to make an informed choice of whether or not to accept the case management service and MTCM provider. This must include a clear presentation that participation in MTCM does not affect any public assistance currently received by the member (or eligibility for such services) or a member's engagement in other Medicaid services.
- Information also should include a statement that the member may have only one MTCM provider at a time (with the exception of specially approved circumstances [see Concurrent Case Management, page 6]) and that the member may choose any MTCM provider for which the member is eligible as long as the provider is capable of serving the member's needs *(see previous statement on Freedom of Choice).*

Intake and screening is a billable activity only for those Medicaid members within the target population who voluntarily accept services. Providers may bill for intake/screening activities that occur no more than 90 days prior to the date the member accepts service. For members in an acute care hospital or other therapeutic facility whose discharge is imminent (i.e., a discharge date has been identified or is being planned), providers may bill for intake/screening activities for members who accept services. While intake and screening is provided to enrolled Medicaid members who meet the target population characteristics, claims will not be accepted for the following:

- Medicaid members in the target population who refuse or do not voluntarily accept services;
- Institutionalized individuals with no plans for discharge (this provision does **NOT** include members in Community Residential Care Facilities [CRCFs]).

Intake and screening must take place within 15 days of referral to the program. The MTCM Brief Screening (see *FORMS* section for further information) must be completed and filed in the member's chart at the time of intake to address immediate needs, if identified *(if there are no immediate or urgent needs, this form is not required).* A member may be screened and have an

intake completed while living in a long-term care facility as long as discharge is imminent [within 180 days (per ADA, Olmstead v. L.C.)]

PROGRAM-SPECIFIC VARIATIONS FOR INTAKE AND SCREENING

Adults with Serious Mental Illness (SMI)

Medicaid members diagnosed with SMI are potentially eligible for MTCM services, however, the services must be voluntarily accepted. Primary providers involved in the individual's treatment team and other relevant supports to the member should be included in care planning. The member must be made aware at intake of participation of other providers and be given an opportunity to identify relevant family/collateral supports they would also like involved in their care planning.

For members admitted to an acute psychiatric hospital, case management should concentrate on the needs of the member once discharged from the hospital. It should not duplicate the efforts of other care managers that are situation-specific (i.e., hospital social worker or discharge planner), but should concentrate on implementing and monitoring the plan for the member, taking into account any additions that should be made to the MTCM Care Plan based on newly identified recommendations or needs as a result of the hospitalization.

The case manager should contact the appropriate hospital staff (social worker, discharge planner, or other treatment team member) to discuss their recommendations, medical orders, and follow-up care and to advise them of plans for ongoing case management of the member. Case management for those in acute settings may include attendance at a treatment team or other meeting where providers discuss plans for treatment and subsequent discharge.

Individuals with Intellectual and Related Disabilities

All Medicaid members with an intellectual or related disability and those with are eligible for MTCM services on a voluntary basis. Providers who serve this population through coordination with the SC Department of Disabilities and Special Needs (DDSN) will follow the DDSN referral process and will coordinate services in conjunction with the appropriate County Disability and Special Needs (DSN) Board as well as other state agencies, providers, and appropriate family/collateral supports.

Pre-Waiver Enrollment Population

Medicaid members who meet a target population definition who are awaiting enrollment in an SC Medicaid HCBS Waiver are eligible for MTCM services until enrollment is completed. Once enrolled, waiver recipients are no longer eligible for MTCM and receive case management services through the specific waiver.

ASSESSMENT AND REASSESSMENT

A new MTCM member is defined as an individual that has never received MTCM services, is new to the target population or has had a break in MTCM services. During this process, information about the member and the resources available to the member are gathered to develop a plan specific to the member's needs. Assessment activities include the following:

- Taking an individual history;
- Identifying the needs of the individual and potential resources that would be of benefit;

- 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; and
- Completing related documentation.

The case management process is initiated by a written assessment of the member's need for case management in the areas of medical, social, psychosocial, educational, financial, vocational, housing and/or other health-related social needs services. This process should include information from the member and, with the member's permission, from any collateral sources whose information is necessary to make a comprehensive assessment.

Assessment should provide verification of the member's current functioning and continuing need for services. It defines the service priorities and provides an evaluation of the member's ability to benefit from such services.

Upon the member's acceptance of case management services, an initial assessment must be completed by a case manager within 45 days of the member accepting services.

Assessment is a continuous process, which is the result of each encounter with the member and the dialogue between the member and case manager. However, a reassessment of the member's need for case management and other services must be completed by the case manager every six months, or earlier if required by changes in the member's condition or circumstances.

Addendums or updates to the initial assessment should occur as needed. An update must occur by the 180th day for services to continue. If services are still needed after this timeframe, a complete reassessment and new Care Plan must be done annually by day 365.

MTCM CARE PLANNING AND COORDINATION

MTCM care planning and coordination requires the development and periodic revision of a specific MTCM Care Plan (Care Plan) based on the information collected through the assessment, and includes the following:

- Specific goals and actions to address the medical, social, educational and other services needed by the eligible individual.
- Activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals.
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Case managers will facilitate Care Planning for all members they serve. This includes having knowledge about the resources, supports, services, and opportunities available in the state and local area that may benefit the member. Case managers will also be linguistically and culturally competent to meet the needs of the members they serve.

Upon completion of the assessment, the case manager and the member identify the course of action to be followed. The case manager will identify and describe the formal and informal resources available to the member, and the frequency, duration, and amount of service(s) from the resources that will best suit the member's needs**. A written MTCM Care Plan must be completed by the case manager for each member served within 45 days of the member's acceptance of services.**

Care Planning includes, but is not limited to, the following activities:

- Identification of the nature, amount, frequency, and duration of the case management services to a particular member;
- Selection of the services to be provided to the member;
- Identification of the member's informal support network and providers of services;
- Specification of the long-term and short-term objectives to be achieved through the case management process;
- Identification of the member's strengths, preferences, needs, and desired outcomes;
- Identification of specific providers that can address the identified supports and services.

Collaboration with other involved agencies, health care providers, and/or other formal and informal service providers shall be demonstrated in the goals and objectives. This may occur through case conferences or other means and is intended to encourage exchange of clinical information and to ensure:

- Integration of identified needs discerned by other providers are accounted for to eliminate service delivery gaps; corresponding goals and objectives for ALL identified needs shall be developed and listed on the MTCM Care Plan;
- Continuity of care between providers;
- Avoidance of duplication of services (including case management services); and
- Establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational, vocational, housing, financial, and/or other supports needed by the member.

The Care Plan must specify:

- Those activities which the member or the case manager is expected to complete within a given period of time toward the accomplishment of each case management objective;
- The name of the person or agency, including the individual and/or family members, who will perform needed tasks;
- The type of treatment program, service providers, or community resources to which the member will be referred;
- The activities, services, tasks, or supports to be provided by the referred entity to achieve the member's related objectives; and
- The type, amount, frequency, and duration of the services to be delivered or tasks to be performed.

The completed MTCM Care Plan must be signed by the case manager, the member, and where relevant, any other participants involved in the care planning process.

Progress Summaries

The Care Plan must be reviewed and updated by the case manager when there are changes in the member's condition or circumstances, but not less frequently than every 180 days subsequent to the initial plan. These updates shall be in the form of a Progress Summary.

Each time the Care Plan is reviewed and a Progress Summary completed, the objectives established in the initial plan must be identified as ongoing or shall be revised; if new objectives, additional goals, and/or new time frames are established, this must be documented in an updated Care Plan that demonstrates the participation of the member.

The case mger will meet with the member face-to-face on a regular basis—including in the community rather than in the Case Manager's office—and will conduct regular visits to the member's residence, consistent with the member's needs and preferences.

Case management must be provided at times and locations necessary to meet the member's needs including the home, workplace, and community, and be provided with the frequency necessary to meet the needs and goals identified in the member's Care Plan.

IMPLEMENTATION OF THE MTCM CARE PLAN

Implementation means marshalling available resources to translate the plan into action. This includes:

- Becoming knowledgeable about community resources, including the various entitlement programs and the extent to which these programs are capable of meeting member needs;
- Working with various community and human services programs to determine which tasks/functions of the Care Plan will be carried out by the case manager versus the other community and human services agencies. This activity may involve negotiating functions. The case manager is responsible for case coordination;
- Securing the services determined in the Care Plan to be appropriate for a particular member, through referral to those agencies or providers who are capable of implementing the identified services;
- Assisting the member with referral and/or application forms required for the acquisition of services;
- Advocating with all providers of services when necessary to obtain/maintain fulfillment of the member's service needs; and
- Developing alternative services to ensure continuity in the event of service disruption.

REFERRAL AND LINKAGE

Referral and related activities (such as scheduling appointments) help the member obtain needed services. This includes activities that help link the member with medical, social and educational providers or other programs and services, such as those related to employment, housing or other

health-related social needs, that are capable of providing services that address identified needs and assist with achieving goals specified in the Care Plan.

For each objective on the Care Plan, the case manager will either make an initial referral for services or confirm with an existing provider that services are implemented and still needed. *The member and/or their representative must be given the opportunity to select the service provider, and this discussion must be documented in the case manager's service notes.*

Crisis Intervention

A case manager may be required to coordinate case management and other services in the event of a crisis. Crisis intervention includes:

- Assessment of the nature of the member's presenting circumstances;
- Determination of the member's emergency service needs;
- Securing the services to meet the emergency needs; and
- Revision of the Care Plan, including any changes in activities or objectives required to achieve the established goal. Emergency services are defined as those services required to alleviate or eliminate a crisis.

Emergency and After-Hours Referrals

When a member presents with an emergency after hours or during a holiday, services may be delivered as deemed appropriate by the provider. Referrals shall be documented to the appropriate emergency services needed.

If activities are included as a part of a direct service, providers must bill using the appropriate procedure code.

MONITORING AND FOLLOW-UP OF CASE MANAGEMENT SERVICES

Monitoring the acquisition/provision of services and following up with members regularly guarantees continuity of service. Monitoring and follow-up include activities and contacts that are necessary to ensure that the Care Plan is effectively implemented and adequately addresses the needs of the member. Monitoring and follow-up may be with the member, family members, service providers, or other entities relevant to the Care Plan. These activities may be conducted as frequently as necessary, but **must be monitored at least every 60 days** to help determine whether the following conditions are met:

- Quality services, as identified in the Care Plan, are being received by the member and are being delivered by providers in a conscientious manner;
- The member is following the Care Plan, and if not, ascertaining why the member is not following the agreed upon plan, and adjusting or adding/changing goals and objectives as necessary to address the issues identified;
- Ascertaining the member's satisfaction with the services provided;
- Collecting data and documenting in the case record the progress of the member (this includes documenting contacts made to or on behalf of the member);
- Making necessary revisions to the Care Plan;
- Making alternate arrangements when services have been denied or are unavailable to the member; and

- Assisting the member and/or provider in resolving any disagreements, questions, or problems identified during implementation of the Care Plan.

TRANSITION PLANNING

MTCM is often provided in situations where a member is transitioning from a residential setting, such as a CRCF or nursing facility, to the community (generalized aspects of Transition Planning can also be found in each MTCM service component description earlier in this chapter). Aspects of transition planning must be identified in the Care Plan when members are seeking assistance or referred due to a community transition.

Transition planning begins the day a member is admitted to a residential facility,and is based on the philosophy that with adequate services and supports, most individuals can live and work in an integrated community setting. Transition planning will be documented on the MTCM Care Plan and must include the following:

- The individual's strengths, preferences, needs, and desired outcomes related to community living;
- Identification of the most integrated setting appropriate for the member and the specific supports and services needed for success in that setting, regardless of whether these services and supports are currently available;
- A list of specific resources that may provide the necessary supports and services;
- Any identified barriers with goals identified to address such barriers;
- A target date for potential transition to the new setting, as well as identified timeframes for each goal/objective and the identified provider responsible for completing all needed steps for a timely transition.

The concept of "informed choice" is a necessary factor for consideration in any transitional case management process. *Informed choice* refers to a member of a target population having a choice of service setting, based on full and accurate information about community-based alternatives to a facility setting. Ensuring a member has informed choice requires proactive, documented efforts to identify and address any concerns about community living raised by the member. Activities promoting informed choice might include:

- Providing individualized information about the benefits of community living;
- The array of services and supports available to those in supportive and other community-based housing; and
- What assistance is available, financial or otherwise, to support a move to community living.

Within 60 days after a transition from a residential setting, the case manager will ensure that the member has an updated Care Plan. Additionally, the case manager will ensure that the member receives the services and supports identified in their Care Plan related to transition and will track any services and supports that are not initiated in a timely fashion after transition.

NEED FOR CONTINUED SERVICES

It is the expectation of the State of South Carolina (State or South Carolina) Department of Health and Human Services (SCDHHS) that beneficiaries receive MTCM services not to exceed medical necessity. In addition to meeting the medical necessity requirements of a target population outlined

in the “Covered Services and Definitions” section of this manual, in order to continue receiving MTCM services the following must be met:

- Documentation of member’s participation and engagement in 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;

- If progress is not being made, the member has been re-assessed and treatment needs have been re-evaluated and medically necessary referrals have been made; and

- The member is allowing coordination of care with other providers and is involving family members where indicated and evidence of this is documented; for children/adolescents, the family is participating in treatment, adhering to recommendations and demonstrating ability to coordinate services on member's behalf.

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

4 ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

Providers must go through South Carolina Medicaid Provider Enrollment to become an MTCM provider. As part of enrollment, providers must complete MTCM training prior to providing MTCM services (please see *MTCM Provider Enrollment Guidelines* on page 16 for specific criteria).

MTCM provider organizations must exhibit effective interagency coordination that demonstrates a working knowledge of other community agencies. This means that providers and agency staff 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 those services. Similarly, the organization 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.

Note: For existing providers with less than four staff, an emergency plan or agreement with another case management provider must be on file at the provider agency and members must be informed of freedom of choice rights to choose anotherprovider.

The provider agency or entity must have:

- Established referral systems, demonstrated linkages, and referral ability with essential social and health service agencies.
- A minimum of three years providing comprehensive case management services to the target population.
- A minimum of four staff with case management qualifications.
- 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 provided to the target population in the community served.

Documentation that the provider is in good standing with the local municipality or State of South Carolina as a recognized business or non-profit.

- A secure location to store all records in-state or within 25 miles of the South Carolina border.

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 supervisors shall be responsible for the following:

- Providing consultation and technical assistance to case management staff.
- Confirm, facilitate and/or promote the presence of appropriate management structures to include the following:
  - Uniform case management record or billing system.
  - Appropriately trained and well-supervised staff.
  - Comprehensive management information system for the purpose of tracking intakes/referrals, case assignments, and other relevant information.
  - 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.

STAFF QUALIFICATIONS

MTCM Case Manager Supervisor

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

- Possess a bachelor's degree from a college or university that is accredited by a nationally recognized educational accrediting body.

- A SC license as a Registered Nurse, LBSW, LMSW, or LPHA and have two years of case management experience.
- Be employed by the MTCM provider, and not be on any State or the Office of the Inspector General's Medicaid Exclusion List.
- Be familiar with the resources for the service community and evidence-based principles of case management.
- Have at least one year of supervisory experience in case management.

MTCM Case Manager

The Medicaid Targeted Case Manager must, at a minimum:

- Be employed by the MTCM-enrolled provider, and not be on any State or the Office of the Inspector General's Medicaid Exclusion List.

  - Possess a bachelor's degree from a college or university that is accredited by a nationally recognized educational accrediting body.

- Documentation of at least one year of experience working with the target population.
- Have access to multi-disciplinary staff when needed.
- Have documented experience, skills, or training in crisis intervention, effective communication, and cultural diversity and competency.
- Possess knowledge of community resources.
- Possess a working knowledge of families and/or systems theory.

MTCM Training

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

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

Maintenance of Staff Credentials

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

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

Staff must have the following background checks and screenings:

- Criminal Background Checks
- Child Abuse and Neglect Central Registry Checks
- Medicaid Exclusion List
- Nurse Registry
- Sex Offender Registry
- Proof of Current SC Licensure, if applicable
- TB Test Results

Proof of these screenings must be maintained and made available for audits. TB Testing shall be conducted yearly and the central registry check every three years, with documentation of completion in each personnel file (guidelines for criminal background checks as listed below).

PROVIDER MEDICAID ENROLLMENT AND LICENSING

MTCM Provider Enrollment Guidelines

The Centers for Medicare and Medicaid Services (CMS) strengthened requirements for Medicaid provider screening to prevent fraud, waste, and abuse. CMS requires state Medicaid agencies to screen all provider applications based on a categorical risk level of "limited," "moderate" or "high." This categorization helps the agency align with federal requirements and ensures taxpayer funds are appropriately safeguarded.

When a state Medicaid agency designates a provider type as a "high" categorical risk, the agency must require fingerprint-based criminal background checks (FCBC) for providers and any entity with 5% or more direct or indirect ownership interest in the provider. ***MTCM providers are included in the "high risk" category and as such are required to comply with the CMS regulations (42 CFR Part 455 subpart E) associated with this category.*** The FCBC must be completed during the enrollment process. Additionally, it is vital that provider owners and managing employees understand that they can be held criminally liable for the actions of the providers' employees, agents, and representatives.

Requirements for enrollment as a "high risk" provider include the following steps:

- Newly enrolling MTCM providers must undergo level 1 and level 2 fingerprint-based criminal history background checks (FCBC) with both the South Carolina Law Enforcement Division and the Federal Bureau of Investigation;
- Must undergo a pre-enrollment site visit;
- May undergo a post-enrollment site visit to verify that the information submitted to SCDHHS is accurate and to determine compliance with federal and state enrollment requirements. (§ 455.432[(a)]);
- Must provide 100% disclosure of ownership to the grandparent level and attest to the disclosure of ownership during the provider enrollment process in accordance with CFR 42 §455.102.

**** State agency providers and entities acting on behalf of a state agency are not considered high-risk and therefore not subject to the requirements described above.***

Newly enrolling MTCM providers may learn more about fingerprinting requirements, high-risk provider types, and disqualifying criteria by visiting the list of frequently asked questions (FAQ) on the agency's Provider Enrollment page (https://www.scdhhs.gov/providers/become-provider).

Additional resources and complete instructions for the online Medicaid Provider Enrollment application process are also available on the Provider Enrollment webpage at: https://www.scdhhs.gov/providers/become-provider.

BUSINESS CLOSURES

Business Termination Guidelines

In the event the MTCM provider closes his or her practice, the provider will adhere to all of the following applicable State laws, rules and regulations:

- In cases of voluntary termination or closure, the provider shall provide written notification 30 days prior to the closure to SCDHHS and other appropriate agencies.
- Notification shall include the location where member and administrative records will be stored.
- The responsible party must retain administrative and member records for five years.
- Prior to closure, the MTCM provider will notify all beneficiaries and assist them with locating appropriate service providers.
- When a provider closes, the owner is responsible for releasing records to any member who requests a copy of his or her records. The owner is also responsible for the transfer of records to the appropriate State agencies, if applicable.
- Even if a provider closes, the provider may be responsible for repayment of any overpayments that occurred during the time the provider rendered treatment to Medicaid beneficiaries.

If a provider does not have any claim activity (fee-for-service or encounter, paid or denied) over the course of an 18-month period, their provider ID will be terminated. This inactivity alone will not qualify as an adverse termination and the provider may re-apply to the South Carolina Healthy Connections Medicaid program should they meet all current requirements.

If the provider is terminated involuntarily by Medicaid, the provider is responsible for all member and administrative records in the event of a post-payment review.

5 MTCM BILLABLE ACTIVITIES

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

MTCM billable activities may include:

- Assessing needs, access to services, or client functioning.
- Assessing a member's medical and/or mental health needs through review of evaluations completed by other providers of services.
- Assessing physical needs, such as having food available and weather-appropriate clothing.
- Assessing social and/or emotional status.
- Assessing housing, financial, and/or physical environment needs.
- Assessing familial and/or social support system.
- Assessing vocational and/or educational needs.
- Assessing independent living skills and/or abilities.
- Ensuring the active participation of the member in developing goals and actions to address the assessed needs and specified goals documented in the Care Plan.
- Working with the member and others to develop goals that address the assessed needs and specified goals documented in the Care Plan.
- Identifying a course of action with the individual to respond to the assessed needs and specified goals documented in the Care Plan.
- Linking beneficiaries with medical, social, educational, and/or other providers, programs, and services that are capable of providing needed services as specified in the CMP.
- Ensuring the Care Plan is implemented effectively and is adequately addressing the needs of the individual.
- Contacting the member, family members, outside service providers, or other entities to ensure services are being furnished in accordance with member's Care Plan.

- Ensuring the adequacy of the services in the Care Plan, particularly as changes occur in the needs or status of beneficiaries.

- Monitoring member progress and performing periodic reviews and reassessment of treatment needs. When an assessment indicates the need for medical treatment, referrals or arrangements for such treatment may be included as MTCM services, but the MTCM provider shall not provide the actual treatment, even if qualified to do so.

- Arranging and monitoring the member's access to primary healthcare providers. This may include written correspondence to a primary health care provider which gives a synopsis of the services the individual is receiving.

- Coordinating and monitoring other health care needs by arranging appointments for medical services with follow-up and documentation.

- Contact with the member in which the Case Manager helps to guide or advise in the resolution of service access issues.

- Contacting the family, representatives of human service agencies and other service providers to form a multidisciplinary team to develop a comprehensive and individualized Care Plan.

- Preparing a written report that provides a psychiatric and/or functional status history, services currently accessed and being monitored, and/or progress on specified Care Plan goals for physicians, other service providers, or involved agencies. Such reports shall be provided only for the purpose of an overview of the member's needs and status to a current or new provider, not for legal or consultative purposes.

Please refer to Billing Guidance section for a list of non-billable activities (which is not all inclusive).

6 UTILIZATION MANAGEMENT

MTCM CONTACT

Providers must meet MTCM contact requirements.

An MTCM contact is defined as any of the following:

- A contact with the member to render one or more MTCM components. Face-to-face contact is defined as a planned, in-person contact requiring travel away from the office to meet with the MTCM member, parent, guardian, or provider.

Note: Electronic visual encounters (e.g., Skype, teleconferencing or other media) with the member are ***not*** considered a face-to-face contact and will be reimbursed at the T1016 MTCM encounter rate.

- A telephone contact is in lieu of a face-to-face contact when environmental considerations preclude a face-to-face encounter, for the purpose of rendering one or more MTCM components. Documentation must include details precluding a face-to-face encounter.

- A relevant email contact via secured transmittal, on behalf of the member for the purpose of rendering one or more MTCM components.

For Medicaid purposes, face-to-face contact is preferable, with phone and/or email contact being acceptable if necessary.

Note: All contacts must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and confidentiality laws.

Frequency of MTCM Contacts

The frequency of contact with each member must be determined based on their individual needs. While guidelines outline the minimal accepted level of contact for provision of MTCM, each individual member requires a frequency of contact that benefits their specific needs and what is required to establish appropriate rapport and effective engagement. Frequency of contacts shall be discussed between the provider and the member during the Care Planning process and documented in initial service notes.

- MTCM mandatory contacts include: Face-to-face at least once every 180 days; more face-to-face contacts may be required for those reentering the community from hospital, out-of-home placement, or institutional/carceral settings. The frequency of those contacts is determined by individual need and documented in the file.

- At least one annual face-to-face visit in the member's residential setting or in the member's natural environment. In rare circumstances, a face-to-face visit may not be possible in the residential setting or natural environment. Every effort should be made to attempt this visit and documentation must demonstrate the efforts. Alternative environments shall be offered when the home visit is not possible. Such circumstances may include:
  - Homelessness
  - Member or homeowner's refusal to allow access to the home.
  - Documented criminal or violent behavior or isolation that places the Case Manager in danger.
  - When these circumstances exist, the assessment and Care Plan should address safety issues or housing concerns for the member.
- Face-to-face, email or telephone contact with the member, his or her family, authorized representative, legal guardian or provider at least once every 60 calendar days or more frequently based on client need.

PRIOR AUTHORIZATION (Excludes State Agencies)

All MTCM services delivered by private provider organizations are required to be authorized prior to service delivery.

- Providers must submit a MTCM prior authorization document set to the authorized QIO.
- The document set will consist of the following:
  - For initial case management authorization request, if all of the below documents are not yet available, submission will include the referral form, the completed Intake form, and if utilized, the Brief Assessment form; all other documentation as noted below shall be submitted as available.
  - Most recent Case Management Assessment (no more than 180 days old).
  - Referrals made on behalf of member and reports and updates from service providers.
  - Most recent Care Plan.
  - Most recent progress summary for the Care Plan.
  - All service notes for all MTCM services rendered to member during the previous 30 days.
  - Fax cover sheet
  - QIO Prior Authorization Form.

Service Limit Exception Process (Excludes State Agencies)

SCDHHS will reimburse for no more than 24 units per calendar quarter per member unless additional units are requested and approved by the QIO. The 24-unit allowance applies to any combination of face-to-face and telephonic MTCM. The provider must ensure the record contains relevant and sufficient documentation to show the initial and continued need for MTCM services. If 24 units have been utilized within a calendar quarter and the client meets medical necessity for additional MTCM services in order to meet imminent needs, the process outlined above must be followed.

COORDINATION OF CARE

Care coordination must exist between the MTCM Case Manager and the providers of direct services. Documentation in MTCM service notes shall indicate care coordination and collaboration throughout the period for which services are delivered.

OTHER SERVICE/PRODUCT LIMITATIONS

Limitations

MTCM cannot be billed for services that directly address medical, educational, social or other needs.

MTCM does not include case management activities that are an integral and inseparable component of another covered Medicaid service; MTCM shall not be provided to members engaged in Multisystemic Therapy (MST), Homebuilders, or Assertive Community Treatment (ACT).

MTCM cannot be billed for mandated functions required by another payor source.

Providers of MTCM services do not have the authority to authorize or deny the provision of other services under the plan.

Medicaid must not be billed for services provided by a family member. Family is defined as a parent, legal guardian, spouse, sibling, aunt, uncle, niece, nephew, child, grandparent or first cousin to include in-laws and step-relationships. The Case Manager must inform the employing entity of any potential conflicts of interest or other ethical dilemma.

Any claims (including those related to case management services) must not duplicate payments to the following entities:

- Public agencies or private entities under the State Plan.
- Other services or program authorities.
- Administrative expenditures.

Please see the section titled MTCM Non-Billable Activities in Chapter 7 for additional information on activities that are not Medicaid reimbursable as components of MTCM.member.

7 REPORTING/DOCUMENTATION

DOCUMENTATION REQUIREMENTS

MTCM Records

General Requirements

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

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

- The name of the member.
- 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.
- If the member has declined services in the Care Plan.
- The need for, and occurrences of, coordination with other Case Managers.
- A timeline for obtaining needed services.

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

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

- Needs assessments.
- Service planning documents.
- Case management service notes.
- Progress Summaries for each 90 day period from date of admission to services.
- All correspondence, including electronic mail messages and documentation written by the Case Manager and claimed for Medicaid reimbursement.
- Social history assessments and/or social history updates, if applicable.

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

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

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

- Reason for referral
- 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
- Printed name, title, signatures, and signature dates on the assessment to validate the need or lack of need for MTCM services

Contact(s) with the member, 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 service notes.

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

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

The Care Plan must document and include all of the following:

- Member's name, date of birth, and Medicaid number.
- Identification of the member's service needs. The Care Plan must address the member's desires and include the family's preferences and choices, where relevant.
- The identified strengths and weaknesses of the member (if appropriate).
- The services and actions required to meet the identified service needs.
- The service provider or provider type, community programs, and/or agencies to which the individual will be referred.
- The frequency (monthly, weekly, daily, etc.) of activities shall be addressed, if applicable. A projected completion date must be included.

Efforts to obtain services that are recommended in theCare Plan, but are unavailable to a member, must be included in the service note documentation. The member and/or his or her parent, guardian, or legal representative must sign the Care Plan during the planning meeting and receive a

copy. If the member, or his or her parent, guardian, or legal representative is unavailable, the Case Manager must document why the signature could not be obtained, and must have them sign during the next face-to-face contact.

- Case Manager's handwritten signature or e-signature, title and signature date.

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

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

Additions or Changes

Additions to or changes in the Care Plan must be dated and signed or initialed by the Case Manager.

Updates/Reviews

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

Case management services rendered to a member whose Care Plan was not reviewed/updated by the 180th day are not reimbursable by Medicaid from the 181st day until the date a new Care Plan is completed.

Service Note

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

Service notes must include:

- Type of case management activity and MTCM component being provided.
- Type of contact.
- Place of contact or activity.
- Person with whom the contact occurred and relationship to the member.
- Purpose of the contact or activity.
- Description of the MTCM intervention delivered.

- Outcome(s) of the contact activity.
- Next step(s) for that activity note – follow-up needed (if applicable).
- Signature, title, and signature date of the qualified staff person(s) who rendered the case management activity.
- Must be filed or entered in the member's record within seven calendar days of delivery of the activity.

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

Each member or involved party referenced in the service 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 member must also be included (e.g., Mary Smith, mother; or Ms. Ida Jones, teacher) if not fully documented in the service note.

All MTCM activities, including written correspondence, assessment, and/or Care Plan updates, and completion of reports must be referenced in the service note. The documentation must clearly identify where the information can be located in the member's record.

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

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

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

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

Member Advance Notice

Beneficiaries must be given advance written notification prior to reduction of services and closure of the MTCM service. To meet the advance notice requirement, MTCM must mail the Notice of Adverse Action at least 10 calendar days before the date of action. The advance notice period may

be shortened to five calendar days before the date of action if the agency has facts that indicate probable fraud and the facts have been verified by secondary sources.

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

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

8 BILLING GUIDANCE

USE OF Z -CODES

The use of Z-codes is allowed but this is considered a temporary diagnosis for ages 7 and older. Confirmatory diagnoses must be given within 6 months of the initial use of Z-codes. The use of Z-codes is not time-limited for children ages 0 to 6 of age. Z-codes can be used in any diagnosis field on the claim form.

MTCM NON-BILLABLE ACTIVITIES

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

- Attempting but not completing a contact whether in person or by telephone.
- Review of case management records within the agency.
- Referring and monitoring of one's own activities.
- Providing special requested information regarding beneficiaries for the provider, public agencies or other private entities for administrative purposes.
- Participating in recreation or socialization activities with a member or his or her family.
- Rendering case management to individuals in institutional placements (i.e., PRTFs, ICFs or ICF-I/DDs, nursing homes, hospitals, etc.), except during the last 90 days of the stay for the purpose of transition and/or discharge planning.
- Rendering services to a member while incarcerated or detained.
- Documenting service notes.
- Completing MIS reports and monthly statistical reports, etc.
- Performing administrative duties such as copying, filing, mailing of reports, etc.
- Rendering activities which are convened to address custody, criminal charges, or other judicial matters by the individual or others (South Carolina Family Court, General Sessions or Federal Court).
- Rendering services on behalf of a member after death.

- 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).
- Rendering services provided as administrative case management including Medicaid eligibility determination, intake processing, and preadmission screening for inpatient care.
- Performing utilization review and prior authorization for Medicaid.
- Rendering services for foster care programs, such as, but not limited to, the following:
  - Research gathering and completion of documentation required by the foster care program.
  - Assessing adoption placements; recruiting or interviewing potential foster care parents.
  - Serving legal papers; home investigations; providing transportation.
  - Administering foster care subsidies.
  - Making placement arrangements.
- Rendering the actual or direct provision of medical services or treatment:
  - Training in daily living skills.
  - Training in work skills and social skills.
  - Grooming and other personal services.
  - Training in housekeeping, laundry, and cooking.
  - Individual, group, or family therapy services.
  - Crisis intervention services beyond coordinating care for someone in crisis.
  - Diagnostic testing and assessments.
- Rendering services which go beyond assisting individuals in gaining access to needed services:
  - Paying bills and/or balancing the member'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 member can access services.

  - Shopping or running errands for the member.
  - Delivering groceries, medications, and gifts.
  - Reading the mail for the member.
  - Setting up the member's medication.
- Providing transportation to and from appointments for the member.
- Using MTCM codes for billing when the member does not meet the criteria for one of the nine target populations.
- Member outreach activities in which a State agency or other provider attempts to contact potential beneficiaries of a service do not constitute MTCM services.
- Performing administrative functions for beneficiaries under the Individuals with Disabilities Education Act such as the development of an IEP and the implementation and development of an IFSP for Early Intervention Services.
- Rendering MTCM services when there is no Care Plan in place.
- Rendering MTCM services when not enrolled as a South Carolina MTCM provider.
- Rendering, ordering, or authorizing MTCM services when excluded from participation in Medicaid, Medicare, Children's Health Insurance Program (CHIP) or other federal program.
- Rendering MTCM services that are not documented and directly linked to the member's assessed needs and specific goals identified in the Care Plan.

SERVICE UNIT CONTACT TIME

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

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

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

The expectation is that a provider's direct member 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 143 minutes, but less than 158 minutes
11	Greater than/equal to 158 minutes, but less than 173 minutes
12	Greater than/equal to 173 minutes, but less than 188 minutes
13	Greater than/equal to 188 minutes, but less than 203 minutes
14	Greater than/equal to 203 minutes, but less than 218 minutes
15	Greater than/equal to 218 minutes, but less than 233 minutes
16	Greater than/equal to 233 minutes, but less than 248 minutes

SPECIAL RESTRICTIONS

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

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