

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES



# **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

Medicaid Targeted Case Management (MTCM) is a means for achieving beneficiary wellness through communication, education and service(s) identification and referral. MTCM is a time-limited process that provides an organized structured process for moving beneficiaries through the process of change and toward the goal of self-sufficiency. The MTCM process is a shared partnership between the beneficiary and/or responsible party and the Case Manager.

MTCM ensures available resources are efficiently accessed and being used in a timely and cost effective manner.

Beneficiaries and/or responsible parties are actively involved in all phases of the process – assessment, planning, problem-solving and identification of resources.

## FREEDOM OF CHOICE

Each MTCM provider must assure that the provision of MTCM services will not restrict the beneficiary's free choice of providers in violation of section 1902(a) (23) of the Social Security Act.

Eligible beneficiaries will have free choice of any qualified MTCM provider within the specified geographic area identified in the plan.

Eligible beneficiaries will have free choice of any qualified Medicaid provider of other medical care under the Medicaid State Plan.

## 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 Targeted Case Management (TCM);
- 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 beneficiary does not meet the above criteria, they must be discharged from MTCM services.**

## COVERAGE

MTCM activities ensure that the changing needs of the Medicaid beneficiary are addressed on an ongoing basis and that appropriate choices are provided from the 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 identifying and ensuring beneficiaries receive needed services.

### **Home- and Community-Based Services (HCBS) Waiver Programs**

MTCM services provided to beneficiaries enrolled in 1915(c) waiver programs must be provided in accordance with MTCM policy.

MTCM services can be used to monitor and coordinate HCBS waiver programs as long as the waiver program does not include case management as a service. These services may be the primary method of providing assurance to the Centers for Medicaid and Medicare Services (CMS) that a beneficiary's health and safety are adequately monitored. HCBS waiver programs have specific requirements for waiver participants, and these requirements are identified in the respective waiver policy and procedures manuals.

### **Concurrent MTCM**

Concurrent case management will be allowed when the beneficiary qualifies for more than one target group and the selected case management entity does not have the experience and resources to meet all the beneficiary's needs. SCDHHS must have prior notification in writing with documentation that the two entities will not duplicate services. The case management entity of choice will be responsible for coordinating care with the concurrent case management entity.

**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

#### **Case Management Target Population**

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

- Individuals with Intellectual and Related Disabilities
- At-Risk Children
- Adults with Serious and Persistent Mental Illness
- At-risk pregnant Women and Infants
- Individuals with Psychoactive Substance 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**

South Carolina Medicaid-eligible individuals who have a suspected diagnosis of intellectual disability. Intellectual disability is defined as significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior or a related disability. Related disability is defined as a severe, chronic condition found to be closely related to intellectual disability and meet the six following conditions:

1. It is manifested before 22 years of age for intellectual disability and related disabilities.
2. It is likely to continue indefinitely.
3. It results in substantial functional limitation in three or more of the following areas of major life activities: self-care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.
4. The person's needs require supervision due to impaired judgment, limited capabilities, behavior problems, abusive or assaultive behavior, or because of drug effects/medical monitoring.

5. The person 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.
6. 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
  - 
  - Absence of a community support system to assist in appropriate follow-up care at home
- Offending or victimization.
- A victim of abuse, neglect or violence.
- Medical complexity that requires frequent care planning.
- 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 diagnosis and/or diagnostic criterion that meets the coding and definition criteria specified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Medical necessity based on Z-codes is allowed but is considered temporary and may not be used for longer than six-month duration. Z-codes do not replace a psychiatric diagnosis from the current edition of the DSM or ICD. After six months, medical necessity must be established by a psychiatric diagnosis if continuation of services is needed. Z-codes may not be used for ages 7 and up for longer than six-month duration. The use of Z-codes is not time-limited for children ages 0 to 6 of age. Clinical documentation justifying the need for continued RBHS 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**

- Medicaid-eligible adults with serious and persistent mental illness must meet the following criteria:
  - Medicaid-eligible individuals age 21 and older who have a major mental disorder included in the current edition of the DSM classification under schizophrenia disorders, major affective disorders, severe personality disorders, psychotic disorders, and delusional (paranoid) disorders or a diagnosis of a mental disorder and at least one hospitalization within the past 12 months for treatment of a mental disorder.
  - 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 Disorders**

Medicaid-eligible individuals who are at risk of substance abuse, dependency or addiction or diagnosed with a substance disorder, psychoactive substance dependency, or induced organic mental disorders, as defined in the current edition of the DSM or Medicaid-eligible individuals who received treatment in an intensive alcohol and drug abuse treatment program or chemical dependence 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 Abuse, Dependency or Addiction**

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

### **Alcohol and Other Drug (AOD) Risk Factors**

- Individual early (pre-adolescent) and adult with persistent problem behaviors:
  - 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 abuse (strong predictor of adolescent substance abuse; 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 AOD.
- Availability of AOD.
- Misperceptions about extent and acceptability of drug abusing behavior.
- Beliefs that drug abuse 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 in order 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.

### **Beneficiary 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/> 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 eligibility criteria for one of the target populations outlined in the South Carolina State Plan, and
- The member demonstrates motivation for receiving support in accessing services and is capable of benefiting from this support, and
- Be able to participate in the planning process, or if applicable, a responsible party participating on behalf of the beneficiary, and
- A well-defined clinical rationale is documented that explains why the member requires assistance in accessing supportive services due to their specific needs, and
- If the beneficiary is between 0–21, the Parent/Guardian/Caregiver must sign the Agreement to Participate in MTCM Services form. Beneficiaries receiving MTCM prior to November 15, 2015, must have this form completed and signed, and in the record by January 1, 2016, or by the date of request for additional units for the calendar quarter of October–December 2015, whichever comes first. New beneficiaries of MTCM services starting on or after November 15, 2015, must have this form completed, signed and in the record prior to receiving MTCM services.

# 3 ELIGIBLE PROVIDERS

## PROVIDER QUALIFICATIONS

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

The provider agency or entity must have:

- An established system to coordinate services for Medicaid beneficiaries who may be covered under another program which offers components of case management or coordination similar to MTCM (i.e., Managed Care, Child Welfare Services, State Waiver Programs).
- Demonstrated programmatic and administrative experience in providing comprehensive case management services and the capability to differentiate MTCM services to be provided to the target population.
- A minimum of four staff with case management qualifications.

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

- 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.
- 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 providers 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.
  - Appropriate and well-supervised staff.
  - Comprehensive management information system.
  - Efficient State or central office billing system.
  - Effective communication process.
  - Quality service delivery system.
- Conducting training sessions for case management staff regarding programmatic changes and/or updates as needed. Lists of all staff who attended the sessions shall be retained for a period of five years.
- Maintaining staff credentials and making the credentials available to the SCDHHS upon request.
- Providing professional staff for the supervision and implementation of the activities listed in this section.

## STAFF QUALIFICATIONS

### **MTCM Case Manager Supervisor**

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

- Possess a bachelor's degree from an accredited college or university, or licensure from the South Carolina Department of Labor, Licensing and Regulation Board as a Registered Nurse, and have two years of case management experience. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
- 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.

### **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 an accredited college or university, or licensure from the South Carolina Department of Labor, Licensing and Regulation Board as a Registered Nurse, and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
- 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 curriculums 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 Licensure as a South Carolina Registered Nurse
- TB Test Results

Proof of these screenings must be maintained and made available for audits.

## **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, mental health counselors who are school-district employees, and entities acting on behalf of a state agency, including child-placing agencies and Developmental Evaluation Centers, 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/ProviderRequirements>).

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/ProviderRequirements>.

## 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 beneficiary and administrative records will be stored.
- The responsible party must retain administrative and beneficiary 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 beneficiary 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 beneficiary and administrative records in the event of a post-payment review.

## 4 COVERED SERVICES AND DEFINITIONS

MTCM activities assist eligible beneficiaries in gaining access to needed medical, social, educational and other services through the following four components:

- Assessment
- CMP
- Referral and Linkage
- Monitoring and Follow-up

### DEFINITION OF MTCM COMPONENTS

The definition of services as cited in the Code of Federal Regulations 42 CFR 440.169 are as follows:

#### **Assessment**

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

- Taking individual history.
- Identifying the needs of the individual and completing related documentation.
- Gathering information from other sources such as family members, medical providers, social workers and educators, if necessary, to form a complete assessment of the eligible individual.

#### **Case Management Plan (CMP)**

Development and periodic revision of a specific CMP 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.

## Referral and Linkage

Referral and related activities (such as scheduling appointments) help the eligible individual obtain needed services. This includes activities that help link the individual with medical, social and educational providers or other programs and services that are capable of providing services that address identified needs and assist with achieving goals specified in the CMP.

For each objective on the CMP, the Case Manager will either make an initial referral for services or confirm with an existing provider that services are still needed. The beneficiary or his or her representative must be given the opportunity to select the service provider.

## Emergency and After Hours Referrals

When a beneficiary presents with an emergency after hours or during a holiday, services may be delivered as deemed appropriate by the provider.

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

## Monitoring and Follow-up

Monitoring and follow-up includes activities and contacts that are necessary to ensure that the CMP is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring and follow-up may be with the individual, family members, service providers or other entities. 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:

- Services are being furnished in accordance with the individual's CMP.
- Services in the CMP are adequate to meet the needs of the individual.
- Identification of changes in the needs or status of the eligible individual. If changes in the needs or status of the individual are identified, monitoring and follow-up activities include making necessary adjustments in the CMP and service arrangements with providers.

Case management includes:

- Contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care.
- Helping the eligible individual access services.
- Identifying needs and supports to assist the eligible individual in obtaining services.
- Providing Case Managers with useful feedback.
- Alerting Case Managers to changes in the eligible individual's needs.

[Refer to Federal Regulation 42 CFR 440.169(e).]

## **Timeframes**

### **Assessment**

A new MTCM beneficiary is defined as a beneficiary that has never received MTCM services, is new to the target population or has had a break in MTCM services. The initial assessment is completed within 45 calendar days after the referral is received for MTCM services.

Addendums or updates to the initial assessment should occur as needed. An update must occur by the 180<sup>th</sup> day for services to continue. If services are still needed after the update period, a complete reassessment and new CMP must be done annually by day 365.

### **Case Management Plan (CMP)**

The initial CMP is completed within 45 calendar days after the referral is received for MTCM services and following the assessment.

Addendums or updates to the CMP should occur as needed. An update must occur by the 180<sup>th</sup> day for services to continue. If services are still needed after the update period, a complete reassessment and new CMP must be done annually by day 365.

### **Monitoring and Follow-up**

For each objective or service listed on the CMP, the Case Manager will monitor an initial referral at a minimum of once every 60 calendar days or more frequently if needed for services, or to confirm with an existing provider that services are still needed.

Please refer to the Utilization Management section of this manual to identify mandatory frequency/timeframes requirements for MTCM contacts.

### **MTCM Billable Activities**

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

- Assessing needs, access to services or client functioning.
- Assessing a beneficiary's medical and/or mental health needs through review of evaluations completed by other providers of services.
- Assessing physical needs, such as food and clothing.
- Assessing social and/or emotional status.
- Assessing housing, financial and/or physical environmental 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 beneficiary in developing goals and actions to address the assessed needs and specified goals documented in the CMP.
- Working with the beneficiary and others to develop goals that address the assessed needs and specified goals documented in the CMP.
- Identifying a course of action with the individual to respond to the assessed needs and specified goals documented in the CMP.
- 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 CMP is implemented effectively and is adequately addressing the needs of the individual.
- Contacting the beneficiary, family members, outside service providers or other entities to ensure services are being furnished in accordance with beneficiary's CMP.
- Ensuring the adequacy of the services in the CMP, particularly as changes occur in the needs or status of beneficiaries.
- Monitoring beneficiary 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 actual treatment must not be included.
- Arranging and monitoring the beneficiary's access to primary healthcare providers. This may include written correspondence to a primary health care provider which gives a synopsis of the treatment the individual is receiving.
- Coordinating and monitoring other health care needs by arranging appointments for medical services with follow-up and documentation.
- Contact with the beneficiary 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 CMP.

- Preparing a written report that details a psychiatric and/or functional status, history, treatment, or progress (other than for legal or consultative purposes) for physicians, other service providers, or agencies.

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

# 5 UTILIZATION MANAGEMENT

## MTCM CONTACT

Providers must meet MTCM contact requirements.

An MTCM contact is defined as any of the following:

- A contact with the beneficiary 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 beneficiary, parent, guardian or provider.

**Note:** Electronic visual encounters (e.g., Skype, teleconferencing or other media) with the beneficiary 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 beneficiary 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 beneficiary must be determined based on their individual needs.

MTCM mandatory contacts include:

- Face-to-face at least once every 180 days.
- At least one annual face-to-face visit in the beneficiary's residential setting or in the beneficiary's natural environment under the following circumstances:
  - Homelessness
  - Beneficiary 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 CMP should address safety issues or housing concerns for the beneficiary.
- Face-to-face, email or telephone contact with the beneficiary, 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

### **Service Limit Exception Process (Excludes State Agencies)**

SCDHHS will reimburse for no more than 24 units per calendar quarter per beneficiary unless additional units are requested and approved by SCDHHS. 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, this process must be followed:

- Providers must submit a MTCM prior authorization document set to MTCM via fax at +1 803 255 8204.
- The document set will consist of the following:
  - Most recent Case Management Assessment (no more than 180 days old).
  - Referrals made on behalf of beneficiary and reports and updates from service providers.
  - Most recent CMP.
  - Most recent review of the CMP.
  - All CSNs for all MTCM services rendered to beneficiary during the previous 30 days.
  - Parent/Guardian/Caregiver Agreement to Participate in MTCM Services form.
  - Fax cover sheet for MTCM Prior Authorization Form.
  - MTCM Prior Authorization Form.
- SCDHHS staff will check the document set to ensure all required documents are present and thoroughly completed.
  - If the document set is complete, SCDHHS will evaluate the documentation and approve or disapprove the prior authorization request.



- If the document set is incomplete, SCDHHS staff will email the “Incomplete Request Letter” to the provider. The provider has five business days from the date of the letter to submit additional information to SCDHHS staff.
  - › SCDHHS staff will evaluate the additional unit request and make determination within five business days of receipt of the request.

## COORDINATION OF CARE

Care coordination must exist between the MTCM Case Manager and the providers of direct services. The direct service providers must utilize the appropriate procedure codes from the array of services they render to beneficiaries.

## 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 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 Section 7 for additional information on activities that are not Medicaid reimbursable as components of MTCM.

## Transitioning to a Community Setting

MTCM includes only services to beneficiaries who are residing in a community setting. MTCM allows transition to a community setting following an institutional stay (nursing homes, in-patient

psychiatric hospitals, Intermediate Care Facilities [ICFs]/Intellectual and Developmental Disabilities [I/DDs] or Psychiatric Residential Treatment Facilities [PRTFs] are considered institutions). Providers may only provide case management services to facilitate the transition of beneficiaries from institutions to the community. A beneficiary is considered to be transitioning to the community during the last 90 consecutive days of a covered institutional stay.

Providers will only receive Medicaid reimbursement for MTCM activities provided to facilitate the transition of beneficiaries from institutions to the community. Transitional case management must not continue once the goal changes or the decision is made that leaving the institution is not an option. MTCM activities provided to beneficiaries residing in an institutional setting for any other purpose and/or beyond the specified time frame are not billable to Medicaid.

# 6 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 beneficiary.
- The dates of the case management services.
- The name of the provider agency (if relevant) and the person providing the case management service.
- The nature, content, units of the case management services received and whether goals specified in the CMP have been achieved.
- If the beneficiary has declined services in the CMP.
- 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 activity notes.
- 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:

- 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 beneficiary, his or her family, guardian, or legal representative, involved agencies, professionals and/or significant others must be conducted prior to completing or updating the MTCM assessment. Contacts shall be documented in the Activity Notes.

Medical aspects of the beneficiary's needs are to be determined and the Case Manager shall assist the beneficiary, his or her family, or other responsible person in locating or arranging appropriate medical services as well as coordinating needed medical transportation. The beneficiary and/or their family members, or other responsible person(s) are to be encouraged to secure a primary health care provider for the beneficiary if he or she currently does not have one. 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.

### **Case Management Plan (CMP)**

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

The CMP must document and include all of the following:

- Beneficiary's name, date of birth and Medicaid number.
- Identification of the beneficiary's service needs. The CMP must address the beneficiary including the family's preferences and choices.
- The identified strengths and weaknesses of the beneficiary (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 should be addressed, if applicable. A projected completion date should be included.

Efforts to obtain services that are recommended in the CMP, but are unavailable to a beneficiary, must be included in the Activity Note documentation. The beneficiary and/or his or her parent, guardian, or legal representative must sign the CMP during the planning meeting and receive a copy. If the beneficiary, or his or her parent, guardian, or legal representative is unavailable, the

Case Manager must document why the signature could not be obtained, and must have them sign during the next face-to-face contact.

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

The CMP 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 Activity Note must reference the CMP. 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 CMP 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 beneficiary's progress toward achieving the objectives identified in the CMP to determine whether the current services should be continued, modified or discontinued.

Case management services rendered to a beneficiary whose CMP was not reviewed/updated by the 180<sup>th</sup> day are not reimbursable by Medicaid from the 181<sup>st</sup> day until the date a new CMP is completed.

### Activity Note

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

Activity 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 beneficiary.
- 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 beneficiary’s record within seven calendar days of delivery of the activity.

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

Each beneficiary or involved party referenced in the Activity Note documentation or electronic mail messages must be identified by his or her full name at least once on each page of documentation. A separate list located in the record with the title or relationship to the beneficiary must also be included (e.g., Mary Smith, mother; or Ms. Ida Jones, teacher) if not fully documented in the activity note.

All MTCM activities, including written correspondence, assessment and/or CMP updates, and completion of reports must be referenced in the Activity Note. The documentation must clearly identify where the information can be located in the beneficiary’s record.

### **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 activity note. A brief explanation causing the misplaced or late entry.
- The activity 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.

### **Beneficiary 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 beneficiary died.
- The beneficiary 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 beneficiary has been admitted to an institution where he or she is ineligible for further services (such as an inmate of a public institution).
- The beneficiary's whereabouts are unknown and mail addressed to him or her is returned indicating no forwarding address.
- The agency verifies that the beneficiary has established residency in another state.
- The beneficiary no longer meets level of care.



# 7 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. 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 NO N-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 beneficiary 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 beneficiary while incarcerated, in an evaluation center (formerly known as reception and evaluation centers), in a local jail and/or prison or a detention center.
- Documenting activity notes.
- Completing MIS reports and monthly statistical reports, etc.
- Performing administrative duties such as copying, filing, mailing of reports, etc.
- Rendering activities 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 beneficiary after death.
- DJJ required probation contacts and/or activities.

- Rendering MTCM services for adjudicated juveniles who have not been placed on formal probation, parole or under a diversion contract.
- Rendering services as MTCM components that are mandated functions required by another payer source (i.e., an assessment that has been completed as a program intake requirement). A treatment plan that covers court mandated services only should not be the basis for MTCM services.
- Rendering services 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.
  - Diagnostic testing and assessments.
- Rendering services which go beyond assisting individuals in gaining access to needed services:
  - Paying bills and/or balancing the beneficiary's checkbook.

- Completing application forms, paperwork, evaluations and reports including applying for Medicaid.
  - Escorting or transporting beneficiaries to scheduled medical appointments.
  - Providing childcare so the beneficiary can access services.
  - Shopping or running errands for the beneficiary.
  - Delivering groceries, medications and gifts.
  - Reading the mail for the beneficiary.
  - Setting up the beneficiary's medication.
- Providing transportation to and from appointments for the beneficiary.
  - Using MTCM codes for billing when the beneficiary does not meet the criteria for one of the nine target populations.
  - Beneficiary 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 CMP in place.
  - Rendering MTCM services and 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 beneficiary's assessed needs and specific goals documented in the Care Management 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 beneficiary contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations will be highlighted for review.

UNITS	TIME
1	Equal to 8 minutes but less than 23 minutes
2	Greater than/equal to 23 minutes, but less than 38 minutes
3	Greater than/equal to 38 minutes, but less than 53 minutes
4	Greater than/equal to 53 minutes, but less than 68 minutes
5	Greater than/equal to 68 minutes, but less than 83 minutes
6	Greater than/equal to 83 minutes, but less than 98 minutes
7	Greater than/equal to 98 minutes, but less than 113 minutes
8	Greater than/equal to 113 minutes, but less than 128 minutes
9	Greater than/equal to 128 minutes, but less than 143 minutes
10	Greater than/equal to 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 beneficiary 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.