MEDICAID 1915 (B) (3)

SERVICE NAME/AUTHORIZATION LEVEL:
Targeted Case Management/Level I Service

SERVICE DESCRIPTION: Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered or family-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

STANDARD PROCEDURE CODE: T1017

UNIT OF MEASURE: 15 minute increment (face-to-face contacts)

ELIGIBILITY CRITERIA AND SERVICE PRIORITIES:

1. Beneficiary is experiencing a severe emotional disturbance, severe mental illness, a developmental disability, or a co-occurring substance use disorder and meets eligibility requirements for specialty services, as defined in the Population Specific Practice Guidelines/Eligibility Chapter of this manual.

2. The service has been determined to meet Medical Necessity Criteria (see section on "Medical Necessity" for specific criteria, located in the Thumb Alliance Guiding Principles Chapter of this manual).

3. Of those populations identified above, persons **must** be experiencing multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP **and/or** are unable to independently access and sustain involvement with needed services.

4. Other potential indicators for service eligibility:

    a. Impairment in social adaptations: evidenced by difficulties maintaining adequate housing, sustaining adequate self-care and daily living skills in need of outreach services
    b. Children/adolescents exhibiting residual impairments and ongoing service coordination needs after discharge from another service may be suitable for this level of care (targeted case management)
    c. With Children/adolescents, the level of distress and/or disordered behavior can be managed only by the Coordination of mental health and community resources to **stabilize**

the family's functioning and provide for the safety and well-being of the child/adolescent and their family

d. Mild to minimal risk of harm to self or others and/or family/community support systems can be coordinated to stabilize risk factors and provide for the essentials of care
e. There **is no less restrictive alternative treatment in the community which meets the needs of the beneficiary**
f. The **family requires coordinated case management services** and supports to meet the child/adolescent's emotional, social, medical, and/or educational needs.

5. The determination of need for case management **must occur at the completion of the intake process** and through the person-centered planning process for beneficiaries receiving services and supports.

    a. Justification as to whether case management is needed or not must be clearly documented in the beneficiary's record.

PROVIDER QUALIFICATIONS:

1. Beneficiaries must be provided choice of **Available,** Qualified case management staff upon initial assignment and on an ongoing basis.

2. **Providers must demonstrate the capacity** to provide **all** core requirements specified below:

    a. assuring that the person-centered planning process takes place and that it results in the individual plan of service
    b. assuring that the plan of service identifies **what** services and supports will be provided, **who** will provide them, and **how** the case manager will monitor (ie: amount of face-to-face contacts) the services and supports identified under **each goal and objective.**
    c. Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence, promoting recovery, and **assisting in the development and maintenance of natural supports.**
    d. Assuring the participation of the beneficiary on an ongoing basis in discussions of their plans, goals, and status
    e. Identifying and addressing gaps in service provision
    f. Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary
    g. Assisting the **beneficiary to access programs** that provide financial, medical, and other assistance such as Home Help and Transportation services
    h. **Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care.**
    i. Coordinating and assisting the beneficiary in crisis intervention and discharge planning, **including community supports after hospitalization**
    j. **Facilitating the transition (**ie: from inpatient to community services, school to work, or dependent to independent living) process, including arrangements for follow-up services.
    k. Assisting beneficiaries with crisis planning
    l. Identifying the process for after-hours contact

3. A primary case manager must be a QMHP or QMRP **OR** if the case manager has only a bachelor's degree, but without the specialized training or experience, they must be **supervised** by a QMHP or QMRP.

4. **Services to a child/adolescent with serious emotional disturbance** must be provided by a QMHP who is Also a Child Mental Health Professional.

5. **Services to children/adolescents 7-17 with a serious emotional disturbance** must be provided by a child mental health professional Trained in the implementation of the CAFAS.

6. **Services to children/adolescents with a developmental disability** must be provided by a QMRP.

TYPICAL SERVICE UTILIZATION PATTERN:

1. Assessment:

    a. Provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, risks, strengths, supports to address barriers, and health/welfare issues
    b. Assessments must be updated when there is **significant** change in the condition or circumstances of the beneficiary
    c. **The individual plan of service must also reflect any updates/changes in the condition or circumstances of the beneficiary**

2. Documentation:

    a. The beneficiary's record must contain sufficient information to document the provision of case management, including:
        * The Nature of each contact
        * The Date of contact
        * The Location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face---

            *****According to the **beneficiary's preference and clinical appropriateness, the majority of services are provided in the beneficiary's home or other community locations rather than an typical office setting**

            the frequency of face-to-face contacts **must be dependent on the intensity of the beneficiary's needs and should be documented with clear clinical rationale

    b. Case manager must review services at intervals defined in the individual plan of service and modify when indicated

    c. A beneficiary OR their guardian/authorized representative may request AND review the plan at any time

d. A formal review of the plan shall NOT occur less often than Annually to review progress toward goals and objectives and to assess beneficiary satisfaction

3. Monitoring:

   a. The case manager must determine, on an Ongoing basis, if the services and supports have been delivered, **AND** if they are adequate to meet the needs/wants of the beneficiary
   b. Frequency and Scope (both face-to-face and telephone):
      * Activities must reflect the intensity of the beneficiary's health and welfare needs Identified in the individual plan of service, with a **minimum of ONE face-to-face contact per month and up to multiple contacts per week** dependent on assessed need
   c. **NOTE:** **Targeted Case Management may **NOT** include direct delivery of ongoing day to day supports and/or training, or provision of other Medicaid services.**
   d. **NOTE**: **Utilization of this service code (T1017) MUST include ALL of the above mentioned elements of service provision, indicated in the individual plan of service and being delivered to the beneficiary during the span of the plan of service, which include: assessment, planning, linkage, advocacy, coordination, and monitoring
   e. Coordination:
      * The element of coordination may include facilitating the transition and follow-up from a more intensive to less intensive level of care, as well as from less intensive to more intensive, depending on the individual circumstances

ASSOCIATED OUTCOMES:

* Increased Recovery
* Reduction in the usage of psychiatric hospitalizations/shortened length of stays of psychiatric hospitalizations
* Reduction in maladaptive behaviors
* Increased ability to function adaptively in interpersonal and social relationships, within a safe and healthy environment.
* Increased attendance/academic status at school
* Increased Psychological/Natural Supports to assist beneficiaries in assessing/obtaining needed services/supports
* Decreased criminal justice/legal involvement
* Decreased symptomatology of severe disorder/illness
* Increased independence in accessing needed services/supports within the community
* Abstinence from drug and/or alcohol use
* Obtain and/or sustain employment
* Increased healthy family functioning
* Increased capacity/demonstration of family system to effectively/safely access needed resources/services/supports for child/adolescent in the community

NOTE: The above outcomes indicate potential results, based on individual needs. Some of these potential outcomes may not be applicable to particular beneficiaries of Targeted Case Management

TRANSFER/DISCHARGE CRITERIA:

1. Transfer:

    a. Less restrictive service:
        * When beneficiary has reached some of their treatment goals, applicable outcomes, and their functional status has demonstrated improvement
        * Supports in the environment have increased
        * Risk or co-morbidity factors have decreased
    b. More restrictive service:
        * Outcomes/treatment goals have not been met after one continuous year of targeted case management
        * Beneficiary's functional status has remained the same or worsened after one year of service
        * Beneficiary's risk to self or others has increased
        * Symtomatology of beneficiary's serious disorder has increased with no alleviation for a marked period of time
        * Co-morbidity factors have significantly increased
    c. **NOTE:** admission/eligibility criteria for the specific service or component has to be met for any transfer to take place

2. Discharge/Termination:

    a. Beneficiaries will be terminated from this service, without transfer to less/more restrictive service, when Any **One** of the following conditions have been met:
        * Beneficiary has reached their treatment goals/objectives, satisfied applicable outcomes, AND can independently **(or with assistance of natural supports) access needed services in the Community.**
        * Beneficiary has withdrawn from services, as evidenced by:
        * Not attending for more than three consecutive sessions, despite active outreach by case manager/provider (would not be applicable for any emergency/crisis related circumstance)
        * Beneficiary has moved out of the service area
        * Beneficiary directly communicates an intent to withdraw (either by phone, letter or in person)

          ****__NOTE__: Outreach defined: provider should utilize all forms of communication (telephone, mail, and in-person contact) before making any decision to pursue termination of service for any beneficiary. All attempts at outreach should be clearly documented in the beneficiary's case record.

        * Death of Beneficiary