NEW YORK STATE
MEDICAID PROGRAM

COMPREHENSIVE MEDICAID
CASE MANAGEMENT

POLICY GUIDELINES

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Section I - Comprehensive Medicaid Case Management Services

Comprehensive Medicaid Case Management (CMCM) services are those functions/activities of case management which will assist persons eligible for Medicaid to access needed medical, social, psychosocial, educational, financial and other services required to encourage the client's maximum, independent functioning in the community.

Case management provides access to services but does not include the actual provision of the needed services.

CMCM has the following unique characteristics among Medicaid services:

- It is targeted to specific populations who will benefit from a focused effort to improve access to a wide range of medical and social services;

- A separate State Medicaid Plan Amendment is prepared by the Department of Health (DOH) for each targeted population. In accordance with NYS/DSS Administrative Directive 89-29, this amendment is developed from common target groups in approved proposals submitted by either the Local Department of Social Services (LDSS) or a statewide supervising authority;

- Each CMCM program and State plan amendment may (within the parameters of 18 NYCRR 505.16) be tailored to the needs of the target population;

- Provider entities, with the exception of early intervention service coordination providers, are enrolled as Medicaid providers of CMCM for the targeted population on the basis of the approved proposal and designation by either the LDSS or the statewide supervising authority, whichever entity submitted the proposal. *Providers may serve only the population for whom they are designated*; and

- Monthly contact requirements, case manager qualifications, service standards, reimbursement methodology and resulting billing rules may be specific to the approved State Plan Amendment (i.e. target population). When applicable to claiming, these variations are noted below under Program Specific Variations.

Scope of Services

In general, case management services consist of the activities listed below. Programs with a rate methodology resulting in quarter hour units of service should refer to the following descriptions of case management activities to determine what constitutes billable services.

For the New York State Office of Mental Health Intensive Case Management Program (OMH-ICM), claiming is based on an all-inclusive monthly rate and only face-to-face contacts (including acute care in hospital) with the client may be counted toward the minimum of four contacts per month required for billing.

Intake and Screening

During initial screening an attempt is made to engage an eligible client'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 client; this should be made as soon as possible subsequent to identification of a client's potential program eligibility.
- Providing information concerning case management sufficient to enable the client to make an informed choice of whether or not to accept the case management service and CMCM provider. ***This should include a clear presentation that participation in CMCM does not affect Public Assistance/Medical Assistance (PA/MA) eligibility or receipt of other Medicaid services.*** It also should include a statement that the client may have only one CMCM provider at a time and that the client may choose any CMCM provider for which the client is eligible as long as the provider is capable of serving the client's needs.
- Identifying potential payors for services such as third party coverage for case management services.

Intake and screening is a billable activity only for those Medicaid eligibles within the target population who voluntarily accept services. The provider must give assurance of the client's appropriateness for and voluntary acceptance of CMCM to the LDSS at the time of registration/authorization in Welfare Management System (WMS).

Providers may bill for intake/screening activities that occur no more than 90 days prior to the date the client accepts service. For clients in an acute care general hospital whose discharge is imminent, providers may bill for intake/screening activities for clients who accept services.

When provided to the following individuals, intake and screening may not be billed;

- For non-Medicaid individuals;
- For individuals who do not meet the target population characteristics;
- For Medicaid-eligibles in the target population who refuse or do not voluntarily accept services;

- For institutionalized individuals (in settings other than acute care general hospitals).

Program Specific Variations for Intake and Screening

Teen Age Services Act (TASA)

At least two contacts must be made to schedule an interview within 30 days of a referral to the TASA provider by the LDSS.

> In their referral agreement with the provider, the LDSS may require an additional number of contacts.

All contacts and attempts to contact a client must be recorded in the case record (i.e. date, type of contact completed or attempted).

> If the required number of contacts fails to secure an interview, the client may be deemed to have refused services. The provider may recontact the client at some future date, but should check MEVS to verify Medicaid eligibility.

Office of Mental Health (OMH)

All Medicaid clients who are on the OMH Intensive Case Management (ICM) roster are potentially eligible for CMCM services; however, providers may bill only for enrolled, active cases who have voluntarily accepted services.

> For purposes of Medicaid billing, clients may not be enrolled as active ICM clients while they are institutionalized (in settings other than acute care general hospitals).
>
> Engagement contacts prior to client's enrollment by ICM are not billable by ICM providers for institutionalized clients.

Office of Mental Retardation and Developmental Disabilities (OMRDD)

Upon determining that the client is potentially eligible for CMCM service, the provider of service to the OMRDD target population must, on forms provided by OMRDD, contact the appropriate OMRDD Revenue Management Field Office to receive verification of program acceptance.

Early Intervention

Initial service coordinators should follow the parameters for the intake and screening activities as set forth in 10 NYCRR 69-4.7 and in guidance memoranda issued by the DOH Early Intervention Program.

Assessment and Reassessment

During this process, information about the client and the resources available to the client are gathered to develop a plan specific to the client's needs.

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

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

Upon the client's acceptance of case management services, an initial assessment must be completed by a case manager within 15 days of referral from the LDSS or, if not a referral by the local district, within 15 days of the client's acceptance of services.

If the client has been referred to CMCM by another source, the referral for service may include a plan of care containing significant information developed by the referral source, which should be included as an integral part of the case management assessment.

Assessment is a continuous process, which is the result of each encounter with the client and the dialogue between the client and case manager. However, a reassessment of the client'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 client's condition or circumstances.

In CMCM services the case manager must secure:

- An evaluation of any functional impairment on the part of the client and, if necessary;
- Refer the individual for a medical assessment;
- A determination of the client's functional eligibility for services;
- Information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the client; and
- A comprehensive assessment of the individual's service needs including medical, social, psychosocial, educational, financial and other services.

Program Specific Variations for Assessment and Reassessment

TASA

An initial assessment and interim plan must be completed at the initial interview to determine:

- The client's emergency needs and how to fulfill them;
- Whether the adolescent is pregnant and if prenatal care is being provided;
- How to access prenatal care for a pregnant adolescent not currently in receipt of such care.

If an interview is scheduled **within** 30 days of referral:

- A comprehensive assessment and plan must be completed within 90 days of the referral, and should address all of the client's needs;
- A reassessment and plan update must be performed within 6 months of the referral;

If an interview is scheduled **after** the first 30 days subsequent to the referral:

- A comprehensive assessment and plan must be completed within 60 days of the initial interview;
- A reassessment and plan update must be performed within 6 months of the interview.

Early Intervention

The timelines specified in regulation (10 NYCRR 69-4), guidance memoranda issued by the DOH Early Intervention Program and local contract language should be followed.

Case Management Planning and Coordination

At this point in the process, the case manager, with the client, identifies the course of action to be followed, the informal and formal resources that can be used to provide services, and the frequency, duration and amount of service(s) that will satisfy the client's need.

A written case management plan must be completed by the case manager for each client of case management services within 30 days of the date of referral from the social

services district or, if not referred from the LDSS, within 30 days of the client's acceptance of services.

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

- Identification of the nature, amount, frequency, duration and cost of the case management services to a particular client;
- Selection of the services to be provided to the client;
- Identification of the client'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;

A primary program goal, such as self sufficiency, must be chosen for each client of CMCM. Additionally, the client's personal goal for the coming year should be specified. Intermediate objectives leading toward these goals and tasks required for the client to achieve a stated goal should be identified in the plan with the time period within which the objectives and tasks are to be attained.

- Collaboration with the social services district, health care providers and other formal and informal service providers, including discharge planners and others as appropriate.

This may occur through case conferences or other means and is intended to encourage exchange of clinical information and to assure:

- Integration of clinical care plans throughout the case management process;
- Continuity of service;
- Avoidance of duplication of service (including case management services); and
- Establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational, and financial needs of the client.

For clients temporarily hospitalized in acute care general hospitals, case management should concentrate on the needs of the client once discharged from the hospital. It should not duplicate the efforts of the hospital social service worker or discharge planner, but should concentrate on implementing and monitoring the plan for the client.

> The case manager should meet with the hospital social service worker and/or discharge planner to review their recommendations, medical orders and follow-up care and to advise them of plans for ongoing case management of the client.

The case management plan must be reviewed and updated by the case manager as required by changes in the client's condition or circumstances, but not less frequently than every six months subsequent to the initial plan.

> Each time the case management plan is reviewed, the objectives established in the initial case management plan must be maintained or revised, and/or new objectives and new time frames established with the participation of the client.

The case management plan must specify:

- Those activities which the client or the case manager is expected to undertake 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 or service providers to which the individual will be referred;
- The method of provision and those activities to be performed by a service provider or other person to achieve the individual's related objectives; and
- The type, amount, frequency, duration and cost of case management and other services to be delivered or tasks to be performed.

Program Specific Variation for Planning and Coordination

TASA

Plans should be established within the time frames listed in this manual under Program Specific Variations for Assessment and Reassessment.

Early Intervention

The case management plan is called an individualized family services plan in early intervention. The timelines specified in regulation (10 NYCRR 69-4), guidance memoranda issued by the DOH Early Intervention Program and local contract language should be followed.

Implementation of the Case Management 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 client needs;

- Working with various community and human services programs to determine which tasks/functions of the case plan will be carried out by the case manager and which by other community and human services agencies. This activity may involve negotiating functions. The CMCM is responsible for case coordination;

- Securing the services determined in the case management plan to be appropriate for a particular client, through referral to those agencies or persons who are capable of providing the identified services;

- Assisting the client with referral and/or application forms required for the acquisition of services;

- Advocating with all providers of service when necessary to obtain/maintain fulfillment of the client's service needs; and

- Developing alternative services to assure continuity in the event of service disruption.

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 client's presenting circumstances;

- Determination of the client's emergency service needs;

- Securing the services to meet the emergency needs; and

- Revision of the case management 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.

Monitoring and Follow-Up of Case Management Services

Monitoring the acquisition/provision of service and following up with clients guarantees continuity of service. Monitoring and follow-up includes:

- Verifying that quality services, as identified in the case management plan, are being received by the client and are being delivered by providers in a cost conscious manner;
- Assuring that the client is adhering to the case management plan and ascertaining the reason for the decision not to follow the agreed upon plan;
- Ascertaining the client's satisfaction with the services provided and advising the preparer of the case management plan of the findings if the plan has been formulated by another practitioner;
- Collecting data and documenting in the case record the progress of the client (this includes documenting contacts made to or on behalf of the client);
- Making necessary revisions to the case management plan;
- Making alternate arrangements when services have been denied or are unavailable to the client; and
- Assisting the client and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

Counseling and Exit Planning

The counseling referred to in case management is that which is provided to a CMCM client enabling him/her to cooperate with the case manager in carrying out the objectives and tasks required to achieve the goal of CMCM services. It is **not** the provision of an actual service such as employment counseling.

Counseling as a function of case management includes:

- Assuring that the client obtains, on an ongoing basis, the maximum benefit from the services received;
- Developing support groups for the client, the family and informal providers of services;
- Mediating among the client, the family network and/or other informal providers of services to resolve problems with service provision;
- Facilitating access to other appropriate care if and when eligibility for the targeted services ceases; and

- Assisting clients to anticipate the difficulties which may be encountered subsequent to admission to or discharge from facilities or other programs including case management.

Program Specific Variation for Counseling and Exit Plan

Early Intervention

Service coordination providers should follow guidance memoranda issued by the Department of Health's Early Intervention Program regarding Transition Planning.

Recipient Enrollment in the Restriction/Exception Subsystem

The Comprehensive Medicaid Case Management client must be enrolled with an Exception Code **35** in the *Welfare Management System (WMS) Restriction/Exception Subsystem (R/E)* by the local department of social services (LDSS) responsible for the client's Medicaid benefits.

If you bill monthly, the enrollment "From" date of the enrollment request must be the first of the month of service. If the client is not Medicaid eligible on the date of service, the LDSS will be unable to enroll the client with the R/E Code 35, and thus, the claim for reimbursement will be rejected.

Enrollment in the WMS R/E Subsystem accomplishes the following:

- It identifies the client as an appropriate member of the target population;
- It confirms that the client has freely chosen to participate in the program;
- It links the client to the provider number of the specific Case Management Program providing service; and,
- It establishes a specified "From and Thru Date". Claims for Case Management services provided outside the enrollment time frames will not be paid.

The client must be enrolled in the Case Management program providing services. Registration in that program in the WMS R/E Subsystem will only continue as long as the client is willing to accept services from that provider.

If the client decides to change providers, the LDSS must be notified so that the registration will be changed to reflect the new provider's Medicaid identification number, effective as of the date the new provider rendered Case Management services.
A Medicaid-eligible client is referred to a Case Management provider either by the LDSS, another agency, or through self-referral. The client may choose to accept

professional services from the referred provider, to seek service from another provider, or to reject case management services completely.

If the client has been determined to be Medicaid eligible, is enrolled in the WMS R/E Subsystem, and is enrolled with the Case Management Program providing services, the initial Medicaid claim submission should be no sooner than two weeks after the provider received verification of successful enrollment in Case Management by the LDSS.

To assist Case Management Providers with enrollment, disenrollment, and changes to the Case Management information in the WMS R/E Subsystem, the Office of Medicaid Management (OMM), in conjunction with LDSS, is offering forms, plus instruction sheets for enrollment and disenrollment of recipients into Comprehensive Case Management. These forms are modeled on forms used in New York City, and are being offered for use by OMM and the LDSS providers serving the rest of the State.

> *Please contact your LDSS Case Management contact to obtain forms and instructions.* Return completed forms to the contact person in the LDSS responsible for the Medicaid coverage of the client to whom you are providing Case Management services. Please enclose a self-addressed, stamped envelope, so that verification of the processed enrollments, disenrollments, and/or changes can be returned to you promptly.
>
> If the enrollment or disenrollment forms have not been returned to the provider within 30 days of the date they were sent to the LDSS, the provider should contact the LDSS to determine the status of the enrollment/disenrollment/change.
>
> It is the provider's responsibility to keep track of the form requests sent to and returned from the LDSS. Providers may not submit a claim until successful enrollment verification has been sent to them by the LDSS.

The LDSS responsible for the client's Medicaid eligibility is also responsible for notifying providers within ten calendar days of the denial of a registration, or termination of an existing registration.

> *The LDSS **is not responsible** for notifying providers when a client loses Medicaid eligibility*.

Providers are encouraged to notify the LDSS within ten calendar days of any changes which would affect the client's need or eligibility for Case Management services. Providers should also notify the LDSS on a timely basis when they no longer are providing Case Management services to the client.

Program Specific Variations

OMRDD

OMRDD clients receive Medicaid Service Coordination (MSC) directly from OMRDD. Each recipient who receives MSC services must be authorized for the services by OMRDD through one of the 13 Developmental Disabilities Service Offices (DDSOs).

> These DDSOs enter R/E Code 35 into the WMS R/E Subsystem for appropriate clients. In a limited number of counties where the DDSOs cannot enter the code, the DDSO will send a letter to the LDSS to initiate the entry of the R/E code 35 by the LDSS.

Early Intervention

Each client who receives early intervention service coordination must be approved by the municipal early intervention agency.

The municipal early intervention agency is responsible for notifying the LDSS of the client's EI enrollment or disenrollment. The LDSS in turn is responsible for updating the WMS R/E subsystem accordingly.

Section II - Requirements for Participation in Medicaid

All persons accepting Comprehensive Medicaid Case Management (CMCM) services must be registered/authorized in the Welfare Management System - Recipient Restriction/Exception subsystem by the local department of social services (LDSS) responsible for Medical Assistance.

Except as noted below, CMCM registration/authorization forms and information should be obtained from the LDSS. This registration/authorization will:

(1) link one provider of CMCM services to one client;

(2) assure that the client is an appropriate member of the target population and

(3) assure the client has freely chosen to participate in a particular case management program.

The effective date of registration/authorization may be retroactive to the date on which the client accepts CMCM services (as long as this date does not precede the date of the provider's enrollment in the Medicaid Program).

In general, initial registration for CMCM can occur while a client is residing in the community or when discharge from an acute care general hospital is imminent.

For institutionalized clients (i.e. settings other than acute care general hospitals), the initial registration date must be after the institution discharge.

When a Medicaid eligible individual is referred to the case management provider, whether by the LDSS, by another agency or by self-referral, the individual has free choice to accept services from that case management provider, to seek services from any other approved case management provider or to reject case management services.

- Only if the individual accepts services can the provider request registration/authorization from the LDSS.
- This registration/authorization, being provider specific, will only continue as long as the client is willing to accept services from that provider.
- If the individual decides to change providers, the registration/ authorization will be changed to the new provider, effective the first day of the following month. The first provider will no longer be able to bill for services, which might be rendered to that individual after the effective date of the change.

The LDSS which is responsible for the client's Medical Assistance is responsible for notifying providers within 10 calendar days of the denial of a registration/authorization request or termination of an existing registration/authorization.

> Local departments of social services are **not** responsible for notifying providers when clients lose Medicaid eligibility. The provider must verify a client's eligibility via MEVS before service is provided.

Providers of case management services are responsible for notifying the LDSS within 10 calendar days of any changes which would affect the individual's need or eligibility for CMCM services.

CMCM services must not duplicate case management services that are provided under any program, including the Medicaid Program.

> Since case management/coordination services may be a component of a Federal Home and Community Based Services (HCBS) waiver program, *individuals who are participating in an HCBS waiver program that includes case management/service coordination are **not eligible** to participate in a CMCM program.*
>
> If an individual is participating in such an HCBS waiver they may choose to be isenrolled from the waiver and enroll instead in the CMCM program.

Qualifications of Provider Entities and Case Managers

Provider Entity Qualifications

Case management services may be provided by social services agencies, facilities, persons and groups possessing the capability to provide such services who are approved by the Commissioner of Health pursuant to a proposal submitted in accordance with Section 505.16 of Social Services Regulations, found at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

Prospective providers of CMCM may include, but are not limited to:

- Facilities licensed or certified under New York State Law or regulations;
- Health care or social work professionals licensed or certified in accordance with New York State Law;
- State and local government agencies; and
- Home health agencies certified under New York State Law.

Program Specific Variations on Provider Entity Qualifications

TASA, CONNECT and Neighborhood Based Initiatives (NBI)

The Department of Health (DOH) will enter into a Medicaid provider agreement with a community agency who has an approved agreement with a social services district to provide either TASA, CONNECT or NBI case management services in accordance with a plan submitted by the social services district to the Department.

> The designated community agencies must apply to become a CMCM provider under Medicaid.

OMH

The DOH will enter into a Medicaid provider agreement with the community agencies with a current and valid designation by the State Office of Mental Health (OMH) as an Intensive Case Management provider.

The Department also has an agreement with the OMH to permit claiming for State-employed case managers located within the community agencies.

> Community agencies may claim for services rendered by their own employees.

The State OMH will claim for the services of State-employed case managers. Only those individual case managers identified on the OMH designation worksheet are qualified to claim for service. Changes in staffing should be reported to:

Office of Mental Health
Bureau of Reimbursement Operations
Policy and Analysis
44 Holland Avenue
Albany, New York 12229

OMRDD

The DOH will enter into a Medicaid provider agreement with community agencies having a current and valid designation by the State Office of Mental Retardation and Developmental Disabilities (OMRDD).

> Providers are qualified to serve only the type and number of clients with the residential status specified on the designation letter from the State OMRDD.

Early Intervention

The DOH will enter into a provider agreement with only the designated municipal early intervention agencies. Providers who wish to provide EI service coordination must apply to the State Early Intervention Program for approval.

Applications should be sent to:

New York State Department of Health
Early Intervention Program
Corning Tower, Room 208
Albany, New York 12237

Early Intervention providers with a municipal contract to provide service coordination services must bill the municipal Early Intervention agency directly for the delivery of these services.

Only designated municipal Early Intervention agencies are able to claim Medicaid reimbursement.

Case Management Staff

Individual case managers must meet the education and experience qualifications listed below or the requirements specified in the approved State (Medicaid) Plan amendment for the target population.

According to 18 NYCRR 505.16 (http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm), the individual providing case management must have two years of experience in a substantial number of case management activities, including the performance of assessments and development of case management plans. Voluntary or part-time experience, which can be verified, will be accepted on a pro-rated basis.

The following may be substituted for this requirement:

- One year of case management experience and a degree in a health or human service field; or
- One year of case management experience and an additional year of experience in other activities with the target population; or
- A bachelor's or master's degree which includes a practicum encompassing a substantial number of case management activities, including the performance of assessments and development of case management plans; or

- The regulatory requirements of a State department or division for a case manager.

Record Keeping Requirements

A separate case record must be maintained for each client served and for whom reimbursement is claimed.

In addition to the record requirements listed in Information For All Providers, General Billing, **the case record** must contain, at a minimum:

- the client characteristics which constitute program eligibility;
- a notation of program information given to the client at intake;
- the date and manner of the client's voluntary acceptance of CMCM;
- the initial client assessment and any reassessments done since that time;
- the initial case management plan and subsequent updates, containing goals, objectives, timeframes, etc. as agreed to by the client and the case manager; progress notes;
- a statement on the part of the client of the acceptance of case management services;
- copies of any releases of information signed by the client;
- written referrals made;
- correspondence, and a record of client, and
- collateral contacts.

The **case record entries which record the client and collateral contacts** must contain at a minimum:

- the date of service,
- name of the client or other contact,
- place of service,
- the nature and extent of the service provided,

- name of the provider agency and person providing the service, and
- a statement of how the service supports the client or advances a particular task, objective or goal described in the case management plan.

Program Specific Variation on Case Records

TASA

All plans and assessments must be completed on forms submitted to the DOH with their LDSS referral agreement.

Early Intervention

All plans, assessments and other reports must be completed on forms as promulgated by the Early Intervention Program and/or specified in the municipal contract.

Other Records

The provider of case management services shall maintain other records to support the basis for approval or payment for the case management program, including but not limited to:

- referral agreements,
- provider agreements,
- work plans,
- records of costs incurred in providing services,
- employment and personnel records which show staff qualifications, and
- time worked, statistical records of services provided and any other records required as a result of any agreements with either the Department of Health or a local social services district.

All records must be maintained for at least six years after the service is rendered or six years after the client's 18th birthday, whichever is later.

Section III - Basis of Payment for Services Provided

Payment for case management services will be made through the Medicaid Program's fiscal agent. Payment will be client specific and available only for Medicaid eligible members of the target population. Payment will be based on a rate approved by the New York State Department of Health and the New York State Division of the Budget, which was developed from cost estimates, and other relevant information submitted by the local social services district or State-supervising agency.

Billing will be done, whether by units of service, rates, fees or on a capitated basis, according to the proposal submitted by the LDSS or the State supervising agency and approved by the New York State Department of Health.

A minimum of one case contact per month is expected for clients to be considered in receipt of CMCM services. Except for client interviews to make assessments and plans, case contacts need not all be face-to-face encounters. They may include contacts with collaterals or service providers in fulfillment of the client's plan.

Program Specific Variation on Frequency of Service

TASA

The TASA Program requires a minimum of one contact per month. Contacts need not be all face-to-face encounters; but may include contacts with service providers or other collaterals in fulfillment of the client's case management plan.

The frequency of routine case contacts are specified in the approved LDSS provider referral agreement. The case manager should document the need for more frequent contacts in the client's case record.

OMH

Enrolled ICM clients must be seen in face-to-face meetings at least four (4) times per month in order to be considered active and for a provider to submit a claim.

OMRDD

The case manager must be aware of any change in the individual's status and maintain the minimum of monthly case contact.

> Case contact is defined as direct face to face contact with the individual or his/her family.

Section IV - Non-Billable Services

Certain activities, which are necessary to the provision of case management services, cannot be billed as a service.

Fundable Activities

The following activities are considered a necessary part of a case management program and may be included in the development of the rate methodology, but may not be billed for separately:

- Case recording, completion of progress notes and other administrative reports;
- Training workshops and conferences attended by case management staff and/or clients;
- Supervisory conferences, meetings unless specifically for the purpose of advancing the case or making changes to the client's case management plan;
- Administrative work, including interagency liaison and community resource development related to serving clientele;
- Intake and screening activities for Medicaid clients who while meeting program participation criteria do not accept services;
- Pre-discharge CMCM engagement activities for clients in institutional settings other than acute care general hospitals;
- For CMCM clients who are temporarily hospitalized/ institutionalized for a period anticipated to be **over 30 days**, it is expected that there would be no Medicaid billing for the period of the hospitalization/ institutionalization. When the admission is initially expected to last **30 days or less**, the case manager/client relationship may be continued, and Medicaid billing is allowed only for CMCM services provided in the first 30 days of hospitalization. The basis for the initial expectation should be documented in the CMCM record for audit purposes.

Non-fundable Activities

Certain other activities, while they may be closely related to case management, or necessary to the achievement of the client's case management goals and objectives, are not included in the definition of case management services and, therefore, may not be either billed or funded through the rate methodology. These activities are:

- Outreach to non-eligible populations when the client does not accept case management services;

  - ► Client transportation;
  - ► Employment counseling;
  - ► Drug and alcohol counseling;
  - ► Discharge planning;
  - ► Social work treatment;
  - ► Preparation and mailing of **general** mailings, flyers, and newsletters;
  - ► Child care.

- ➢ MA eligibility determinations, redeterminations, intake processing and prioritization;

  - ► Nursing supervision;

- ➢ Fiduciary activities related to the CMCM client's personal funds;

- ➢ Any other activity which constitutes or is part of another Medicaid or non-Medicaid service.

Note: It may be necessary for a case manager to escort a client to a service provider in order to help them negotiate and obtain services specified in the client's case management plan. At the same time, the case manager should be encouraging the client's maximum independent functioning in the community.

> The ongoing need to escort the client should be well documented in the client's case record.

Furthermore, if the case manager is escorting the client to medical appointments or services, the case management should document in the case why the client was unable to obtain needed medical transportation services from the LDSS.

> In these instances, client transportation may be a billable case management actitvity.

Section V - Definitions

For the purposes of the Medicaid program and as used in this Manual, the following terms are defined to mean:

Active

Active means that the client who is enrolled in intensive case management is seen in face-to-face contacts at least four times a month.

Case Management

Case management is a process, which assists persons to access necessary services in accordance with goals contained in a written case management plan.

CONNECT CMCM

CONNECT CMCM is targeted to women of child bearing age who are pregnant or parenting, and infants under one year of age who reside in urban areas with a high incidence of infant mortality.

Early Intervention Service Coordination

The target group consists of infants and toddlers from birth through two years of age who have or are suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. These children are referred by the municipal early intervention agency and are known to the New York State Department of Health and are in need of ongoing and comprehensive rather than incidental case management.

Engagement

Engagement means that the intensive case management is working with the rostered client to determine viability to become an active client.

Enrolled

If a client is enrolled in intensive case management, then the client has been selected from a roster to be serviced by the intensive case management case manager.

Free Choice

Free choice is the decision to accept or reject CMCM services or any part of the case management plan, the choice of case management provider, or the choice of provider of any Medicaid service included in the case management plan is that of the Medicaid eligible individual who is referred for case management services.

Neighborhood Based Initiatives (NBI) CMCM

NBI was established through Chapter 657 of the Laws of 1990 aimed at developing a unified strategy in distressed communities which will build upon the community's strengths.

Case management is targeted to individuals who are struggling with the effects of multiple problems compounded by poverty and poor access to services.

OMH Intensive Case Management

OMH ICM is an intensive case management program operated by the Office of Mental Health (OMH) for the seriously and persistently mentally ill with services provided by locally employed intensive case managers at designated community agencies or State OMH employees working at those agencies or out of a State psychiatric facility.

OMRDD CMCM

OMRDD CMCM is a case management program operated by the Office of Mental Retardation and Developmental Disabilities (OMRDD) for developmentally disabled individuals residing at home or in voluntary operated community residences.

Rostered Clients

Rostered means the client is on the list of those who meet Intensive Case Management program participation criteria. The list is maintained by each OMH Regional Office.

Target Group

A target group is a group of individuals, sharing common characteristics, such as diagnosis, high service utilization, difficulty in accessing services or vulnerability to certain high risk behaviors.

TASA CMCM

TASA CMCM is a program based upon the Teenage Services Act of 1984 in which a LDSS enters into an agreement with community agencies in fulfillment of the LDSS' obligation to provide case management to pregnant and parenting teens.