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For Human Services use only:

General Letter No. 8-AP-478

Employees' Manual, Title 8
Medicaid Appendix

May 4, 2018

**TARGETED CASE MANAGEMENT, CASE MANAGEMENT, AND CARE
COORDINATION MANUAL TRANSMITTAL NO. 18-1**

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **Targeted Case Management, Case Management, and Care
Coordination**, Title page, revised; Contents (page 1), revised; Chapter
III, *Provider-Specific Policies*, Contents (page 1), revised; pages 1
through 15, revised; and pages 16 and 17, new.

Summary

The **Targeted Case Management, Case Management, and Care Coordination
Manual** is revised to:

- ◆ Change the provider manual's name from **Targeted Case Management**.
- ◆ Align with current policies, procedures, and terminology.

Effective Date

Immediately.

Material Superseded

This material replaces the following pages in the **Targeted Case Management
Manual**:

<u>Page</u>	<u>Date</u>
Title page	Undated
Contents (page 1)	April 1, 2014
Chapter III	
Contents (page 1)	January 1, 2016
1-15	January 1, 2016

Additional Information

The updated provider manual containing the revised pages can be found at:
<http://dhs.iowa.gov/sites/default/files/CaseMgm.pdf>

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

Targeted Case Management, Case Management, and Care Coordination

Provider Manual



**Iowa Department
of Human Services**



Iowa
Department
of Human
Services

Provider and Chapter

**Targeted Case Management, Case
Management, and Care Coordination**

Chapter III. Provider-Specific Policies

Page

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Date

May 1, 2018

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. ORGANIZATIONS ELIGIBLE TO PARTICIPATE

Targeted case management (TCM) provider organizations are eligible to participate as Iowa Medicaid enrolled providers if they meet the following qualifications:

- ◆ They meet the standards in 441 Iowa Administrative Code (IAC) Chapter 24 (*Division I, "Core Standards for All Providers on MH/ID/DD Services,"* and *Division II, "Standards for Individual Case Management Services"*), and
- ◆ They are:
 - A Mental Health and Disabilities (MHDS) Region, or
 - An agency or provider under subcontract to an MHDS Region, or
 - An agency or provider under subcontract to the Iowa Department of Human Services (DHS). DHS is eligible to be a TCM provider organization.

Waiver case management (WCM) provider organizations are eligible to participate as Iowa Medicaid enrolled providers for WCM under the elderly and brain injury waivers if they meet the qualifications outlined in the Home- and Community-Based Services Provider Manual.

Care coordination is provided to the AIDS/HIV, health and disability, and physical disability waivers through a separate contract with the DHS. Care coordination is also provided by an integrated health home (IHH). Enrollment criteria is outlined in 441 IAC 77.47(249A).

For the purposes of this manual, the term case management will incorporate TCM, WCM, and care coordination. If any section of the manual is applicable to only one type of case management, the appropriate full term will be used.



B. COVERAGE OF CASE MANAGEMENT SERVICES

Case management is a service to manage multiple resources effectively for the benefit of Medicaid members. Case management services assist members in gaining access to appropriate and needed medical and interrelated social, educational, housing, transportation, vocational, and other services. The goal of case management is to ensure that:

- ◆ Necessary evaluations are conducted.
- ◆ Individual services and treatment plans are developed, implemented, monitored, and modified as necessary.
- ◆ Reassessment of service provision occurs on an ongoing and regular basis (*minimum of once a year*).

1. Eligible Members

Payment will be approved for targeted case management services for members of the following populations who are not enrolled in an IA Health Link Managed Care Organization (MCO), not eligible for MCO enrollment, or not enrolled in an IHH:

- ◆ Medicaid members who are 18 years of age or over and have a primary diagnosis of:
 - Intellectual disability, or
 - Developmental disabilities, or
 - Chronic mental illness.
- ◆ Medicaid members under 18 years of age receiving:
 - HCBS intellectual disability or
 - HCBS children's mental health (CMH) waiver services.

Residents of medical institutions are **not** eligible to receive targeted case management services, except for qualified discharge planning activities provided within 60 days of discharge.



Payment will be approved for WCM and care coordination for members of the following populations who are not enrolled in an IA Health Link Managed Care Organization (MCO) or who are not eligible for MCO enrollment:

- ◆ AIDS/HIV waiver
- ◆ Brain injury waiver
- ◆ Elderly waiver
- ◆ Health and disability waiver
- ◆ Physical disability waiver

a. Intellectual Disability

“Person with intellectual disability” means a person who meets the following definition:

“Intellectual disability” means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person’s condition was during the developmental period and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

b. Chronic Mental Illness

A person with chronic mental illness means a person who is 18 years of age or over and has a persistent mental or emotional disorder that seriously impairs the person’s functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment.



People with chronic mental illness typically meet at least one of the following criteria:

- ◆ They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).
- ◆ They have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

- ◆ They are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
- ◆ They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
- ◆ They show severe inability to establish or maintain a personal social support system.
- ◆ They require help in basic living skills.
- ◆ They exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness. For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

c. Developmental Disabilities

A person with developmental disabilities means a person with a severe, chronic disability which:

- ◆ Is attributable to mental or physical impairment, or a combination of mental and physical impairment.
- ◆ Is manifested before the person attains the age of 22.
- ◆ Is likely to continue indefinitely.



- ◆ Results in substantial functional limitation in three or more of the following areas of life activities:
 - Self care
 - Receptive and expressive language
 - Learning
 - Mobility
 - Self-direction
 - Capacity for independent living
 - Economic self-sufficiency
- ◆ Reflects the person's need for a combination and sequence of services which are of lifelong or extended duration.

d. Need for Service

The case manager's documentation must show the initial and ongoing need for service based on evidence presented by the provider, including diagnostic reports, documentation of provision of services, and information supplied by the member and other appropriate sources. The evidence shall demonstrate that all of the following criteria are met:

- ◆ The member has a need for case management to manage multiple resources pertaining to medical and interrelated social and education services for the benefit of the member.
- ◆ The member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services.
- ◆ The member is not receiving other paid benefits under the Medicaid program or under a Medicaid managed health care plan that serve the same purpose as targeted case management.

For members in the intellectual disability or developmental disability population, the TCM documents the need for service by completing the *TCM Service Authorization Form* in ISIS.



2. Service Provisions through Fee-for-Service (FFS)

Fee-for-service case management functions are provided to members not enrolled in an MCO, not eligible for MCO enrollment, or not enrolled in an IHH. Case management services are described in 441 IAC 90.5(249A) and include:

- ◆ [Assessment](#)
- ◆ [Person centered service plan](#)
- ◆ [Referral and related activities](#)
- ◆ [Monitoring and follow-up](#)
- ◆ [Contacts](#)

a. Assessment

The Core Standardized Assessment (CSA) contractor will perform a functional assessment and periodic reassessment of the member's individual needs. The contractor will use the CSA tools designated by the Department. A reassessment must be conducted, at a minimum, annually and more frequently if changes occur in the member's condition.

The assessment will aid the case manager in determining the need for any medical, social, educational, housing, transportation, vocational, or other services. The functional assessment shall address all of the member's areas of need, strengths, preferences, and risk factors, considering the member's physical and social environment.

Following the assessment and reassessment activities, the case manager will perform the following:

- ◆ Making annual updates to the member's history (including social history).
- ◆ Identifying the needs of the member and completing related documentation.
- ◆ Gathering information from other sources, such as family members, medical providers, social workers, legally authorized representatives, and others as necessary.



b. Person Centered Service Plan

The case manager shall develop and periodically revise a person centered service plan based on the functional assessment.

The service plan must include a discharge plan and be revised at least annually and more frequently if significant changes occur in the member's medical, social, educational, housing, transportation, vocational, or other service needs or risk factors.

The person centered service plan:

- ◆ Includes people chosen by the member.
- ◆ Provides necessary information and support to the member to ensure that the member directs the process to the maximum extent possible.
- ◆ Is timely and occurs at times and locations of convenience to the member.
- ◆ Reflects cultural considerations and uses plain language.
- ◆ Includes strategies for solving disagreements.
- ◆ Offers choices to the member regarding services and supports the individual receives and from whom.
- ◆ Provides a method to request updates.
- ◆ Reflects what is important to the member to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.
- ◆ Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the member.
- ◆ Includes whether, and what, services are self-directed.
- ◆ Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education, and others.
- ◆ Includes risk factors and plans to minimize them.
- ◆ Is signed by all individuals and providers responsible for its implementation and a copy of the plan must be provided to the member and the member's representative.



The person centered service plan documentation:

- ◆ Reflects the member's strengths and preferences.
- ◆ Reflects clinical and support needs.
- ◆ Includes observable and measurable goals and desired outcomes.
- ◆ Identifies interventions and supports needed to meet those goals with incremental action steps, as appropriate.
- ◆ Identifies the staff people, businesses, or organizations responsible for carrying out the interventions or supports.
- ◆ Identifies for a member receiving home-based habilitation:
 - The member's living environment at the time of enrollment,
 - The number of hours per day of on-site staff supervision needed by the member, and
 - The number of other members who will live with the member in the living unit.
- ◆ Reflects providers of services and supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS including:
 - Name of the provider,
 - Service authorized, and
 - Units of service authorized.
- ◆ Includes risk factors and measures in place to minimize risk.
- ◆ Includes individualized backup plans and strategies when needed.
 - Identifies any health and safety issues applicable to the member based on information gathered before the team meeting, including a risk assessment.
 - Identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.
 - Providers of applicable services shall provide for emergency backup staff.
- ◆ Includes individuals important in supporting the member.
- ◆ Is written in plain language and understandable to the member.



- ◆ Documents who is responsible for monitoring the plan.
- ◆ Documents the informed consent of the member for any restrictions on:
 - The member's rights, including maintenance of personal funds and self-administration of medications,
 - The need for the restriction, and
 - Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

Any rights restrictions must be implemented in accordance with [441 IAC 77.25\(4\)](#).

- ◆ Includes the signatures of all individuals and providers responsible.
- ◆ Is distributed to the individual and others involved in plan.
- ◆ Includes purchase and control of self-directed services.
- ◆ Excludes unnecessary or inappropriate services and supports.

c. Referral and Related Activities

The case manager shall perform activities to help the member obtain needed services, such as scheduling appointments for the member, and activities that help link the member with medical, social, educational, housing, transportation, vocational, or other service providers. The case manager shall also help link the member with programs that are capable of providing services to address identified needs and risk factors and to achieve goals specified in the service plan.

d. Monitoring and Follow-Up

The case manager shall perform activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person centered service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home when applicable), and all services. Monitoring may also include review of service provider documentation.



Monitoring shall be conducted to determine whether:

- ◆ Services are being furnished in accordance with the member's service plan, including the amount of service provided and the member's attendance and participation in the service.
- ◆ The member has declined services in the service plan.
- ◆ Communication is occurring among all providers to ensure coordination of services.
- ◆ Services in the service plan are adequate, including the member's progress toward achieving the goals and actions determined in the service plan.
- ◆ There are changes in the needs or status of the member. Follow-up activities shall include making necessary adjustments in the service plan and service arrangements with providers.

e. Contacts

Case management contacts shall occur as frequently as necessary and shall be conducted and documented as follows:

- ◆ The case manager shall have at least one face-to-face contact with the member every three months.
- ◆ The case manager shall have at least one contact per month with the member, the member's legally authorized representative, the member's family, service providers, or other such entities or individuals.

This contact may be face-to-face or by telephone. The contact may also be by written communication, including letters, email, and fax, when the written communication directly pertains to the needs of the member. A copy of any written communication must be maintained in the case file.

- ◆ The case manager may bill for contacts with non-eligible persons if the contacts are directly related to identifying the member's needs and care as necessary for the purpose of helping the member:
 - Access services,
 - Identify needs and supports to assist the member in obtaining services,
 - Provide case managers with useful feedback, and
 - Alert case managers to changes in the member's needs.



- ◆ When applicable, documentation of case management contacts shall include:
 - The name of the service provider.
 - The need for and occurrences of coordination with other case managers within the same agency or of referral or transition to another case management agency.

3. Exclusions

Payment shall not be made for activities otherwise within the definition of case management when any of the following conditions exist:

- ◆ The activities are an integral component of another covered Medicaid service. This includes care coordination through an IHH.
- ◆ The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational, or other services to which a member has been referred. Such services include, but are not limited to:
 - Services under parole and probation programs
 - Public guardianship programs
 - Special education programs
 - Child welfare and child protective services
 - Foster care programs
- ◆ The activities are integral to the administration of foster care programs, including 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



The activities for which a member may be eligible are integral to the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

- ◆ The activities duplicate institutional discharge planning.

C. BASIS OF PAYMENT

For members not enrolled with an MCO or IHH, or who are not eligible for MCO enrollment, the basis of payment for case management services is a case management activity of 15 minutes in duration. The following rounding rules apply when billing for services:

- ◆ 1 through 7 minutes of service should be rounded down to zero.
- ◆ 8 through 14 minutes of service should be rounded up to 15 minutes.

Providers shall add the total minutes of service provided for the day and then round once. The rate is established on the basis of cost information submitted to the Iowa Medicaid Enterprise Cost Audit Unit.

Providers are required to submit a projected cost report by July 1 of each year. This form is used to establish a projected rate for the new fiscal year, thus, avoiding underpayment or overpayment. A cost report showing actual costs shall be submitted 90 days after each state fiscal year end. Providers may contact the Iowa Medicaid Enterprise Cost Audit Unit for a copy of the cost report form and instructions for completion.

State and local government entities that enroll in the Medicaid program as case management providers must establish their rates in accordance with the cost principles contained in the Office of Management and Budget Circular No. A-87, "Cost Principles for State and Local Governments." Case management agencies include the costs of translation and interpretation services in their cost reports. Translation and interpretation services are not separately billable by case management agencies.



1. Case Management Billable Activities

Below are listed those activities that are billable case management activities when done by a case manager or case management supervisor for members not enrolled in an MCO or IHH, or who is not eligible for MCO enrollment. Any activity undertaken by an employee who is not a case manager or case management supervisor is not a billable activity. This listing is not meant to be all-inclusive.

a. Assessment, Social History, and Reassessment

Legal reference: 441 IAC 90.5(1)"a"

- ◆ Taking member history.
- ◆ Gathering and reviewing information pertaining to the member's history from any source, including obtaining and verifying diagnoses.
- ◆ Completing *Risk Assessments*.
- ◆ Reviewing program assessments and reassessments in order to determine service needs.
- ◆ Researching funding sources, including non-Medicaid sources for services needed before the service plan implementation.
- ◆ Dictating, writing, editing, and updating the social history documents.
- ◆ Dictating, writing, typing, and signing narrative entries to document social history activities.
- ◆ Contacts to establish or verify initial Title XIX eligibility (e.g., calls to income maintenance workers). Checking eligibility via ISIS or ELVS is not billable as this is not a person-to-person contact.

b. Care Planning

Legal reference: 441 IAC 90.5(1)"b"

- ◆ Reviewing progress on previous goals.
- ◆ Completing activities to request funding, from all sources, for services (including exceptions to policy).
- ◆ Planning for development or revision of the member's comprehensive service plan (e.g., scheduling the meeting with the member, determining who the member wants to attend, etc.).



- ◆ Conducting the comprehensive service plan meeting in accordance with person centered planning guidelines.
- ◆ Dictating, writing, typing, and signing of the comprehensive service plan document.
- ◆ Dictating, writing, typing, and signing narrative entries to document care planning activities.
- ◆ Completing forms (paper or electronic) that are required to ensure access to, or funding of, needed services. (e.g., entering service plan and specific service information in ISIS).
- ◆ Closing a case and associated activities completed before the date of closing (e.g., writing a discharge summary, identifying other services that will be needed after discharge, making referrals to other agencies or providers).

c. Referrals and Linkage

Legal reference: 441 IAC 90.5(1)"c"

- ◆ Scheduling appointments for members with other providers.
- ◆ Dictating, writing, typing, and signing narrative entries to document referral activities.
- ◆ Researching service options for a member, including coordination with funders and providers, including completion of referral documents and related contacts.
- ◆ Contacts to complete service arrangements (e.g., arranging transportation, etc.).

d. Monitoring and Follow-Up

Legal reference: 441 IAC 90.5(1)"d"

- ◆ Monitoring and follow up, to determine whether services are being furnished in accordance with the member's care plan. This includes time spent reviewing service provider files.
- ◆ Monitoring and follow up, to determine whether the services in the care plan are adequate to meet the needs of the member.
- ◆ Monitoring and follow up, to determine whether there are changes in the needs or status of the member.



- ◆ Making necessary adjustments in the care plan and service arrangements with providers to address changes in needs or status of the member.
- ◆ Dictating, writing, typing, and signing case record entries to document the monitoring activities.
- ◆ Completing forms or reports to ensure the health and safety of the member, including *Incident Report* review, processing, and follow-up.

2. Examples of Non-Billable Activities

- ◆ Travel time
- ◆ Paid time off (vacation, sick leave, etc.)
- ◆ Activities provided by anyone other than a person who meets the qualifications to be a case manager, even if they are working under the supervision of a case manager
- ◆ Unsuccessful attempts to contact the member or collaterals (e.g., a home visit when member is not at home or leaving a voice mail message for the member or collateral)
- ◆ Services provided by more than one case manager to the same member at the same time
- ◆ Staff meetings, trainings, and supervision
- ◆ Time spent in case review for quality assurance purposes
- ◆ Contacts with support staff within the agency
- ◆ Scheduling case manager's appointments
- ◆ Bill submission and collection activities
- ◆ Checking Medicaid or service eligibility in ISIS or ELVS
- ◆ Calls to the ISIS helpdesk
- ◆ Preparing and mailing Notice of Decisions (NODs)
- ◆ Filing



D. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Paper claims for waiver case management and targeted case management are billed on form 470-2486, *Claim for Targeted Medical Care*. Care coordination is billed in accordance with the approved contract. IHH claims are billed on the CMS 1500 claim form.

Click [here](#) to view a sample of the Claim for Targeted Medical Care claim form.

Click [here](#) to view billing instructions for the Claim for Targeted Medical Care claim form.

The IME supports the electronic submission of claims. Through electronic submission, submission and processing errors can be reduced. Information regarding electronic submission of claims is located on the DHS website. Click [here](#) to view this information.

Bill the IME for each service rendered to each member using applicable charges or the rate determined by the Division of Medical Services.

Submit claims to the IME on a monthly basis to facilitate payment in a timely manner. To receive payment monthly, submit the claim for the month's service by the tenth of the month following the month of service.

Refer to [Chapter IV. Billing Iowa Medicaid](#) for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
<http://dhs.iowa.gov/sites/default/files/All-IV.pdf>



**APPENDIX I.
Targeted Case Management, Children’s Mental Health, and
Integrated Health Home Overview Chart**

Program	Member Status	Case Management Provided By	Service Authorization	CM Billing Submitted To
Habilitation	Fee-for-service	When the member does not qualify for TCM, CM as a habilitation service and until the member is attributed and enrolled in an IHH	IME MSU	IME
Habilitation and HCBS Brain Injury or Elderly Waivers	Fee-for-service	Targeted Case Management as a state plan service	IME MSU	IME
Habilitation and HCBS AIDS/HIV, Health and Disability or Physical Disability Waivers	Fee-for-service	CM as a habilitation service funded through the IME	IME MSU	IME
Children’s Mental Health Waiver	Fee-for-service	Targeted Case Management as a state plan service	IME MSU	IME
	Fee-for-service	TCM service funded through the IME until the member is attributed and enrolled in an Integrated Health Home (IHH)	IME MSU	IME
HCBS AIDS/HIV, Health and Disability or Physical Disability Waivers	Fee-for-service	Care coordination	Per contract with DHS	IME for waiver care coordination services, billed according to contract
All HCBS Programs	MCO eligible or MCO enrolled	MCO community-based case manager	MCO	MCO