SECTION 13 **TARGETED CASE MANAGEMENT SERVICES** ESTABLISHED 4-29-88
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13.01 DEFINITIONS

13.01-1 **An adult** is any person who is eighteen (18) years of age or older or who is a legally emancipated minor. Adults aged eighteen (18) through twenty (20) years of age and children who are emancipated minors may choose to receive children's behavioral health or developmental disabilities services **or** adult behavioral health or developmental disabilities services, whichever best meets their individual needs.

13.01-2 **Antibody** is a protein belonging to a class of proteins called immunoglobulins. Antibodies are produced by the body to counteract specific antigens as a response to the infection.

13.01-3 **Authorized Agent:** shall mean the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.

13.01-4 **Case Management Agencies** are a firm, partnership, association, corporation, or an organization approved to provide case management services by the Department or its Authorized Agent.

In order for these agencies to provide case management services they must execute a MaineCare Provider Agreement, and any other contract required by the Department of Health and Human Services. They must also be able to meet DHHS policy and contract requirements for case management services.

13.01-5 **Case Management Services** are those covered services provided by a social services or health professional, or other qualified staff, to identify the medical, social, educational and other needs (including housing and transportation) of the eligible member, identify the services necessary to meet those needs, and facilitate access to those services. Case management consists of intake/assessment, plan of care development, coordination/advocacy, monitoring, and evaluation.

13.01-6 **Child** is a person between the ages of birth to eighteen (18) years of age. Adults aged eighteen (18) through twenty (20) years of age and children who are emancipated minors may choose to receive children's behavioral health or developmental disabilities services **or** adult behavioral health or developmental disabilities services, whichever best meets their individual needs.

13.01-7 **Child and Adolescent Functional Assessment Scale (CAFAS)** is a multi-dimensional rating scale, which assesses a member's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems.

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13.01-8 **Child and Adolescent Needs and Strengths (CANS)** assessment is a multipurpose tool that assesses the needs and strengths of children and adolescents with mental illness, developmental disabilities/intellectual disabilities, and autism spectrum disorders. The CANS may be used to support decision making (including level of care and service planning), to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. There are multiple versions of the CANS tool tailored to particular age ranges, including the Child and Adolescent Needs and Strength assessment-Preschool Comprehensive (CANS-PC) (ages 0-5), the Child and Adolescent Needs and Strengths assessment-Mental Health (CANS-MH) (ages 5-17), the Child and Adult Needs and Strengths assessment Transition Mental Health (CANSAT-MH) (ages 18-21), the Child and Adolescent Needs and Strengths assessment Autism Spectrum Profile (ASP) (0-18) and the Child and Adult Needs and Strengths assessment Transition Developmental Disabilities (CANSAT-DD) (18-21).

13.01-9 **Child and Family Team** refers to a group of individuals who develop an Individualized Service Plan (ISP) for the eligible child. The team shall consist of the following persons:

a. The eligible child or adolescent, unless clinically contraindicated; and/or

b. The eligible child or adolescent's parent(s) or other legal or designated representative, such as guardian or advocate; and

c. The comprehensive case manager; and

d. at least one (1) of the following individuals:

i. A health/mental health care professional (physician, psychiatrist, psychologist, social worker, nurse, crisis intervention worker, according to the needs of the child or adolescent);

ii. Other key providers, deemed appropriate by the Child and Family Team to address the eligible child or adolescent's specific needs (e.g., child protection or substitute care worker, rehabilitation counselor, physical, speech, occupational or recreational therapist, child development worker, substance abuse counselor, criminal justice worker);

iii. Other persons identified and approved by the family, such as extended family members, neighbors, friends, and others who provide informal support;

iv. A special education or other education professional.

13.01 DEFINITIONS (continued)

13.01- 10 **Children's Habilitation Assessment Tool (CHAT)** assesses functioning in three domains: behavior, social skills, and life skills using interviews for individuals 6 to 18 years of age diagnosed with mental retardation or a pervasive developmental disorder.

3.01-11 **Collateral Contact** is a contact on behalf of a member by a comprehensive case manager to seek or share information about the member in order to achieve continuity of care, coordination of services, and the most appropriate mix of services for the member. Discussions or meetings between staff of the same agency (or contracted agency) are considered to be collateral contacts only if such discussions are included in the development of the Care Plan. Collateral contacts occur as a component under covered services (13.02).

13.01-12 **Comprehensive Case Manager** is the one reimbursable case manager per member beginning 11/1/09. Comprehensive Case Managers must focus on coordinating and overseeing the effectiveness of all providers and benefits in responding to the member's assessed needs. Comprehensive Case Managers ensure that the individual care plan is effectively implemented and adequately addresses the assessed needs of the member.

13.01-13 **Contracted Services** are Comprehensive Targeted Case Management Services provided by private agencies.

13.01-14 **Danger: A** situation or condition of abuse, neglect, or exploitation as defined in 22 M.R.S.A. §3472, or the inability to give informed consent when there is no responsible substitute decision-maker.

13.01-15 **Department** means the State of Maine, Department of Health and Human Services, also referred to as DHHS.

13.01-16 **Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood:** (also known as DC 0-3), formulates categories for the classification of mental health and development disorders manifested early in life. The DC: 0-3 is published by Zero To Three: National Center for Infants, Toddlers and Families.

13.01-17 **Diagnostic and Statistical Manual of Mental Health Disorders** (DSM) is published by the American Psychiatric Association. The most recently published manual is used to classify mental health diagnoses and provide standard categories for definition of mental health disorders grouped in five axes.

13.01-18 **Emergency Shelter** means a facility, the primary purpose of which is to provide a temporary place for homeless persons to sleep and which meets the criteria established by the Maine State Housing Authority for Emergency Shelter Funds.

13.01-19 **Homeless Person** means an individual who lacks a fixed, regular and adequate nighttime residence and whose primary nighttime residence is an emergency shelter or

13.01 DEFINITIONS (continued)

public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings.

13.01-20 **Human Immunodeficiency Virus** (HIV) is the virus which causes AIDS (Acquired Immune Deficiency Syndrome).

13.01-21 **Informed consent** is a decision made with all relevant information about the issue, with an understanding of the consequences of a decision, and in the absence of duress.

13.01-22 **Member** is a MaineCare member.

13.01-23 **Primary Care Provider (PCP)** is a provider who has contracted with the Department to provide primary care case management services.

13.01-24 **Prior Authorization** is the process of obtaining prior approval as to the medical necessity and eligibility for a service; see also Chapter I of the MaineCare Benefits Manual.

13.01-25 **Professional Approved by The Department** refers to a professional who satisfies the same qualifications as are set forth in Section 13.07-2(B)(3).

13.01-26 **Utilization Review** is a formal assessment of the medical necessity, efficiency and appropriateness of services and treatment plans on a prospective, concurrent or retrospective basis.

13.02 **COVERED SERVICES**

A Covered Service is a MaineCare service for which payment can be made by the Department. The following services are covered when provided to an eligible member by an approved Targeted Case Management Agency and qualified staff:

A. **Comprehensive Assessment and Periodic Re-assessment** of an eligible member to determine service needs, including those activities that focus on needs identification, to determine the need for any medical, educational, social or other services. The comprehensive assessment and re-assessment must be conducted through face-to-face contact with the member and, where appropriate, consultation with other providers and with the member's family. A comprehensive assessment must be completed within the first thirty (30) days of initiation of services, and reassessment must occur as change in the member's needs warrants or at a minimum on an annual basis. These activities include but are not limited to the following:

1. Taking client history;

13.02 COVERED SERVICES (continued)

2. Identifying the needs of the individual and completing related documentation; and

3. Gathering information from other sources (family members, medical providers, social workers, and educators) if necessary, to form a complete assessment.

B. **Development and Periodic Revision of the Individual Plan of Care** is based on information collected through a comprehensive assessment or re-assessment that:

1. Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.

   Because the assessment of the member's needs must be comprehensive, the individual plan of care must also be comprehensive to address all identified needs. Re-evaluation of the individual plan of care must occur as a change in the member's needs occurs or at a minimum every ninety (90) days. A member may decline to receive services that have been identified as needs in the individual care plan. If the member declines services listed in the individual care plan, this must be documented in the individual's case record. This 90 day re-evaluation may be completed by the comprehensive case manager.

2. Develops and periodically revises the Individual Care Plan and to the extent possible:

   a. Ensures the active participation of the member and as appropriate, the member's parent(s) or legal guardian;

   b. Works with the member (and others as appropriate) to develop goals; and

   c. Identifies a course of action to respond to the member's assessed needs. For a child, the plan of care must be developed with a Child and Family Team.

C. **Referral and Related Activities that** help an eligible member obtain needed services. As part of the coordination function, the comprehensive case manager must avoid the duplication of services. The case management referral activity is completed once the referral and linkage has been made. (Referral and related activities do not include providing transportation to the service to which the member is referred, escorting the individual to the service, or providing child care so that an individual may access the service.) These activities are for the purpose of linking the member with medical, social, educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

These activities include:

13.02 COVERED SERVICES (continued)

1. Making referrals to providers for needed services, including documentation, and

2. Scheduling appointments for the member.

D. **Monitoring and Follow-Up Activities** that include activities and contacts that are necessary to ensure that the individual care plan is effectively implemented and adequately addresses the needs of the eligible member. This includes contact with the member as needed to monitor the care plan objectives and, if appropriate, periodic contact with the member's family, providers, or other entities. Monitoring may involve either face-to-face or telephone contact. These activities may be conducted as frequently as necessary, but not less than annually, to help determine whether:

1. Services are being furnished in accordance with the individual care plan;

2. Services in the care plan are adequate to address the needs of the member; and

3. Needs or status of the member has changed which requires necessary adjustments in the care plan and service arrangements with providers or service termination.

13.03 **ELIGIBILITY FOR SERVICES**

An individual may be found eligible to receive MaineCare Targeted Case Management services if the following requirements are met:

13.03-1 **General Eligibility Requirements**

Individuals must meet the eligibility criteria as set forth in the MaineCare Eligibility Manual, Chapter I, Section 1. Some members may have restrictions on the type and amount of services they are eligible to receive.

Designated case management agencies shall be responsible for confirming the member's eligibility for case management services. If the individual is not currently receiving MaineCare, he or she will be referred to a district office of the Department of Health and Human Services, Office of Integrated Access and Support, to determine eligibility for MaineCare.

13.03-2 **Specific Eligibility Requirements**

In order to receive Targeted Case Management Services, members must meet criteria for one of the four following target groups:

A. Members must meet the eligibility criteria for one of the following targeted population groups:

1. Case Management Services for Children with one of the following:

13.03 ELIGIBILITY FOR SERVICES (continued)

a. Behavioral Health Disorders,
b. Developmental Disabilities, and/or
c. Chronic Medical Conditions.

2. Case Management Services for Adults with one of the following:

a. Developmental Disabilities,
b. Substance Abuse Disorders, and/or
c. HIV.

3. Case Management Services for Members Experiencing Homelessness AND

B. Render a diagnosis, if a diagnosis is a requirement of a Targeted Case Management Eligibility Group. The diagnosis must be rendered, within the scope of the individual's license, by a physician, a physician assistant or an independently licensed clinician (as defined in state statute or rule). Functional limitations, as set forth below, must be identified, supported, and documented in assessments using accepted standardized instruments that are developmentally appropriate to the members being assessed.

Functional Limitations mean:

Vocational
Impairment in vocational functioning as manifested by (1) an inability to be consistently employed at a self-sustaining level or (2) an ability to be employed only with extensive supports (A person who is able to earn sustaining income, but is recurrently unemployed because of acute episodes of mental illness or addictions does not meet this functional limitations requirement).

Education
Impairment in educational functioning as manifested by an inability to establish and pursue educational goals within a normal time frame or without extensive supports.

Instrumental Activities of Daily Living (IADL)
Impairment in IADL functioning as manifested by an inability to consistently and independently accomplish home management tasks, including household meal preparation, washing clothes, grocery shopping and budgeting.

Social or Interpersonal
Impairment in social or interpersonal functioning as manifested by an inability to independently develop or maintain social relationships, or to independently participate in social or recreational activities. This may be evidenced by:

- Repeated inappropriate or inadequate social behavior (defined as an inability to behave appropriately or adequately without extensive or consistent support or

13.03 ELIGIBILITY FOR SERVICES (continued)

coaching; or only in special contexts or situations such as social groups organized by the provider), or

- Consistent participation in activities only with extensive support or coaching, and when involvement is mostly limited to special activities established for persons with interpersonal impairments.

Community

Impairment in community functioning as manifested by a pattern of significant community disruption, including family disruption or social unacceptability or inappropriateness, which may not recur often but is of such magnitude that it results in severe consequences (including exclusion from the member's primary social group) or in severe impediments to securing basic needs such as housing.

Self-care, Independent Living or Activities of Daily Living

Impairment in self-care or independent living as manifested by an inability to consistently perform the range of practical daily living tasks required for basic functioning in the community, including:

- Bed mobility, transfer, locomotion, eating, toilet use, bathing, and dressing
- Grooming, hygiene, and meeting nutritional needs
- Care of personal business affairs
- Transportation and care of residence
- Procurement of medical, legal, and housing services
- Recognition and avoidance of common dangers or hazards to self and possessions.

13.03-3 Case Management Services for Children

A. Eligibility Criteria for Children with Behavioral Health Disorders

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Acceptable standardized instruments means, for behavioral health, Child/Adolescent Functional Assessment Scale (CAFAS) (ages 6 through 20), Child and Adolescent Needs and Strength assessment Preschool Comprehensive (CANS-PC) (ages 0-5), Child and Adolescent Needs and Strengths assessment Mental Health (CANS-MH) (ages 5-17), the Child/Adult Needs and Strengths Assessment Transition Mental Health (CANSAT-MH) (18-21), Preschool and Early Childhood Functional Assessment Scale (PECFAS) (ages 3 through 6), and Ages and Stages (and Ages and Stages Social Emotional scales) (up through age 5).

Children must meet the criteria listed below in subsections 1 OR 2. In addition children must meet the criteria listed in subsection 3a or 3b to be eligible for TCM Services.

1. A child with a completed multi-axial evaluation of an Axis I or Axis II mental health diagnosis(es) as described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or a diagnosis described in the most recent version of the Diagnostic Classification of Mental Health and Developmental Disabilities of Infancy and Early Childhood

13.03 ELIGIBILITY FOR SERVICES (continued)

(DC: 0-3). Axis I mental health diagnoses do not include the following: Learning Disabilities (LD) in reading, mathematics, written expression, Motor Skills Disorder, and LD NOS (Learning Disabilities Not Otherwise Specified); Communication Disorders (Expressive Language Disorders, Mixed Receptive Expressive Language Disorder, Phonological Disorder, Stuttering, and Communication Disorder NOS); OR

2. A child under five (5) years of age who:

   a. is determined by a professional approved by the Department as being at risk of developing a mental health disorder due to known environmental or biological risks using DHHS adopted tools, AND

   b. has significant impairment or limitation in adaptive behavior or functioning according to criteria as established by the Department (See 13.03-2 B), and determined by a qualified professional approved by the Department.

3. Level of Care Criteria

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   a. Level of care criteria for services assessed through the CAFAS:

      (1) Case management service is authorized for up to thirty (30) days from the date of the first billed encounter if the eight (8) scale composite CAFAS score is fifty (50) or less.

      (2) Case management services may continue beyond thirty (30) and up to ninety (90) days from the date of the first billed encounter if the eight (8) scale composite CAFAS score is at least between fifty-one (51) and seventy (70).

      (3) Clinical information will be considered in addition to the composite CAFAS scores above as the scores are not the sole criteria for eligibility and review.

      (4) Case management services <u>may</u> continue beyond 90 days if the 8 scale CAFAS score is above (70). Service continuation will be dependent upon clinical information submitted

   b. Level of care criteria for services assessed through the CANS:

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      (1) Case management service is authorized for up to ninety (90) days from the date of the first billed encounter if the assessment scores are 2 or higher for both the "Behavioral/Emotional needs" AND "Life domain Functioning" sections of the CANS-PC, the CANS-MH or the CANSAT-MH.

      (2) Clinical information will be considered in addition to the CANS scores as the scores are not the sole criteria for eligibility and review.
      (3) Case management service may continue beyond ninety (90) days dependent on clinical information submitted.

B. **Eligibility Criteria for Children with Developmental Disabilities**

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Acceptable standardized instruments means, for developmental disabilities, CHAT (ages 6 through 20), Child and Adolescent Needs and Strengths assessment-Preschool Comprehensive (CANS-PC) (ages 0-5), Child and Adolescent Needs and Strengths assessment-Mental Health (CANS-MH) (5-17), Child and Adolescent Needs and Strengths assessment Autism Spectrum Profile (CANS-ASP) (0-18), Child/Adult Needs and Strengths Assessment Transition Developmental Disabilities (CANSAT-DD) (18-21), Vineland Adaptive Behavior Scales (up through age 20), Battelle Developmental Inventory (up through age 7), Bayley Scales of Infant and Toddler Development (age 1 month through 2 years), and Ages and Stages (and Ages and Stages Social Emotional scales) (up through age 5).

Children must meet the criteria listed below in subsection 1 OR 2 OR 3. In addition children must meet the criteria listed in 4a. OR 4b. to be eligible for TCM Services.

1. Meet the definition of developmental disabilities as defined in 22 M.R.S.A. §3573 or have an Axis II diagnosis of mental retardation as described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders; OR

2. Have an Axis I diagnosis of pervasive developmental disorder as described in the most recent Diagnostic and Statistical Manual of Mental Disorders; OR

3. For children between birth and five (5) years of age:

   a. Are determined by a professional approved by the Department as being at risk of developing a Pervasive Developmental Disorder due to known environmental or biological risks using DHHS adopted tools, AND

   b. Have significant impairment or limitation in adaptive behavior or functioning according to criteria established by the Department (See Section 13.03-2(B)) and as determined by a qualified professional approved by the Department.

4. Level of Care Criteria

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   a. Level of care criteria for services assessed through the CHAT:

      (1) Case management service is authorized for up to thirty (30) days from the date of the first billed encounter if the CHAT score is twenty (25) or less.

      (2) Case management services may continue beyond thirty (30) and up to ninety (90) days from the date of the first billed encounter if the CHAT score is at least between twenty-six (26) and thirty-five (35).

      (3) Clinical information will be considered in addition to the CHAT scores above as the scores are not the sole criteria for eligibility and review.

      (4) Case management services may continue if the CHAT score is above 35. Service continuation will be dependent upon clinical information submitted.

13.03 ELIGIBILITY FOR SERVICES (continued)

b. Level of care criteria for services assessed through the CANS:

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(1) Case management service is authorized for up to ninety (90) days from the date of the first billed encounter if the assessment scores are 2 or higher for:

i. Both the "Behavioral/Emotional Needs" and "Life Domains" sections of the CANS-PC;

ii. The "Maladaptive Behaviors" section of the CANS-ASP;

OR

iii. The "Needs" section of the CANSAT-DD.

(2) Clinical information will be considered in addition to the CANS scores as the scores are not the sole criteria for eligibility and review.

(3) Case management service may continue beyond ninety (90) days dependent on clinical information submitted.

C. **Eligibility Criteria for Children with Chronic Medical Conditions**

1. A child who is infected with the human immunodeficiency virus (HIV), as determined by a positive HIV antibody or antigen test, or who has a diagnosis of HIV disease or AIDS; OR

2. A child who has:

a. been diagnosed with an autoimmune disease, diabetes, respiratory disorder, a neurological disorder, brain injury or other chronic condition specifically recognized by the Department or its authorized agent; AND

b. three (3) or more documented functional limitations as defined in 13.03-2(B) (Functional Limitations); OR

3. A child who has:

a. a diagnosed physical condition or the presence of a documented history by a professional approved by the Department of prenatal, perinatal, neonatal, or early physical developmental events or conditions suggestive of damage to the central nervous system or of later atypical physical development, such as, but not limited to, cerebral palsy, meningitis, heart defects, or bronchiopulmonary dysplasia which, without

13.03 ELIGIBILITY FOR SERVICES (continued)

intervention, has a high probability of resulting in physical developmental delay, AND

b. significant impairment or limitation in adaptive functioning according to criteria as established by the Department and determined by a qualified professional approved by the Department.

4. Level of Care Criteria for services for Children Chronic Medical Conditions

a. Case management service is authorized for up to thirty (30) days from the date of the first billed encounter if one of the assessed functional limitations is severe and two or more are moderate in severity as evidenced by approved standardized instruments completed by a specialist in adaptive functioning and there is a documented need for TCM service to provide referral services for the member.

b. Case management services may continue beyond thirty (30) and up to ninety (90) days from the date of the first billed encounter if two of the assessed functional limitations are severe and 1 or more functional limitations are moderate in severity as evidenced by approved accepted standardized instruments completed by a specialist in adaptive functioning and there is a documented need for TCM service to provide referral services with limited monitoring and follow up for the member.

c. Case management services may continue if 3 or more of the assessed functional limitations are severe as evidenced by approved accepted standardized instruments completed by a specialist in adaptive functioning and there is a documented need for TCM service to provide referral services with monitoring and follow up of those services, for the member. Service continuation will be dependent upon clinical information submitted

13.03-4 **Case Management Services for Adults**

Adults must meet the following criteria to be eligible for TCM Services.

A. **Eligibility Criteria for Adults with Developmental Disabilities**

An individual is eligible for case management services if he or she is age eighteen (18) or older and meets the eligibility requirements of Title 34B M.R.S.A.§3573, which defines developmental disabilities, or Title 34B

13.03 ELIGIBILITY FOR SERVICES (continued)

M.R.S.A. §6002, which defines autism. A person who has reached his or her eighteenth (18th) birthday and is under age twenty-one (21) may choose to receive case management services as an adult.

B. **Eligibility Criteria for Adults with Substance Abuse Disorders**

1. An adult who has an Axis I diagnosis(es) of substance abuse disorder(s) described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) AND

2. Who is currently seeking substance abuse treatment services by a DHHS approved substance abuse treatment provider; AND

3. Who is pregnant, who is living with his or her minor children, and/or who is an intravenous drug user, AND

4. Who is enrolled in a substance abuse program which receives funding by the Substance Abuse Prevention Treatment Block Grant as provided by 42 U.S.C. section 300x-22(b).

C. **Eligibility Criteria for Adults with HIV**

An adult who is infected with the human immunodeficiency virus (HIV), as determined by a positive HIV antibody or antigen test, or who has a diagnosis of HIV disease or AIDS.

A designated case management agency shall be responsible for confirming the person's eligibility for case management services. Case management services for persons with HIV infection are covered services only when provided by approved staff of agencies designated by the Department's Center for Disease Control, Division of Infectious Disease, HIV, STD and Viral Hepatitis Program Administrator.

13.03-5 **Case Management Services for Members Experiencing Homelessness**

Members experiencing homelessness but who otherwise are not eligible for TCM must meet the following Eligibility Criteria to be eligible for TCM under this Section;

A. A member must be either:

1. Currently residing or has in the past ninety (90) days resided in an emergency shelter in the State of Maine, OR

2. An individual who does not otherwise have a permanent address, residence, or facility in which they could reside

B. In addition to meeting the criteria in (A) above, an individual must meet ALL of the following:

1. require treatment or services from a variety of agencies and providers to meet the individual's medical, social, educational, and other needs; AND

13.03 ELIGIBILITY FOR SERVICES (continued)

2. will access needed services only if assisted by a qualified targeted comprehensive case manager who, in accordance with the individual plan of care, locates, coordinates, and regularly monitors the services; AND

3. The member must meet at least one of the following criteria:

   a. is in need of immediate medical care; OR

   b. is in need of an immediate crisis evaluation or mental health assessment to address a behavioral health issue; OR

   c. has a current medical or mental health condition and is at risk of losing or has lost access to medically necessary services; OR

   d. has an immediate need for medications to address an existing medical and/or behavioral health condition; OR

   e. is demonstrating physical or mental impairment such that services are necessary to improve, restore or maintain health and well-being; OR

   f. has experienced immediate or recent trauma and is demonstrating a need for assistance with gaining and coordinating access to necessary care and services appropriate to their needs.

13.03-6 **Eligibility Procedures**

Eligibility for case management services will be determined by either a case manager of the Department or a comprehensive case manager of a designated provider. Eligibility procedures are specific to the targeted case management groups and/or program offices within the Department. The procedure for determining eligibility for case management services is as follows:

A. Individuals who may be eligible for case management services may be referred by any source, such as a physician, psychologist, other health or mental health provider, school, parent, guardian, or public and private community agency. (Written permission from the applicant or legal guardian is required whenever a referral is made by any person or agency acting on behalf of the applicant.)

B. Documentation of eligibility must be in a format approved by the Department or its Authorized Agent. Eligibility information from case management agencies may be used in planning, management and quality assurance activities.

C. If the individual is not currently receiving MaineCare, the comprehensive case manager will refer the individual to a district office of the Department of Health and Human Services, Office of Integrated Access and Support to determine eligibility for MaineCare.

D. All members who are eligible for case management will be assigned a comprehensive case manager with reasonable promptness after initial referral. For children ages birth through twenty (20) a comprehensive case manager must be assigned within one hundred and eighty (180) days after initial referral.

13.03 ELIGIBILITY FOR SERVICES (continued)

E. If it is determined that the individual does not meet the established criteria for targeted case management services, the applicant shall be informed in writing and given notice of his or her right to appeal that decision. (For more information regarding Appeal Rights, refer to Chapter I of the MaineCare Benefits Manual.)

F. Additional requirements specific to the targeted case management groups and/or program offices within the Department, as applicable.

13.03-7 Quality Assurance

Providers must cooperate with the Department or its authorized agent in conducting quality assurance activities including, but not limited to the following:

1. Periodic review of cases to assure quality and appropriateness of care conducted in accordance with the quality assurance protocols specific to each target group.

2. Review of all records to assure that documentation is signed and dated by the reviewers, and included in the member's record, or kept in a separate and distinct file parallel to the member's record.

3. Providers are subject to all guidelines in MaineCare Benefits Manual, Chapter I.

13.04 DURATION OF CARE

Each eligible member may receive covered services that are medically necessary within the limitations of this section. The Department reserves the right to request additional information to evaluate medical necessity and review utilization of services. The Department will require prior authorization (PA) for some targeted case management services reimbursed under this section (refer to 13.07-2). The Department may require utilization review for all services reimbursed under this section. Providers must work with the Department or its Authorized Agent to provide this information.

Members may receive case management services for as long as they meet the general criteria for eligibility described above and the specific criteria in the appropriate sections, below.

Case management services will discontinue if:

1. The member or legal guardian no longer desires case management services; or

2. The member is no longer eligible to receive benefits pursuant to 13.03.

13.05 NON-COVERED SERVICES

1. Payment for Targeted Case Management Services must not duplicate payments made to public agencies or private entities under other program authorities for case management or service coordination services.

2. Case Management does not include the direct delivery of an underlying medical, educational, social or other service to which an eligible member has been referred.

3. Payments for case management services under this Section must not duplicate payments for similar services made under other sections of MaineCare policy or other funding sources.

4. Only **one** Comprehensive Targeted Case Manager is allowed.

5. Payments for the documentation of progress notes are not allowable under this Section.

13.06 LIMITATIONS

13.06-1 One Comprehensive Case Manager

1. New members to this service must choose only one approved Comprehensive Targeted Case Management provider.

2. Documentation of the member's choice of comprehensive case management services must be retained in the member's record and will serve as an enrollment, dis-enrollment, or reenrollment of the member with the provider.

3. MaineCare Services will reimburse only for Targeted Case Management Services provided by the approved provider chosen by the member new to the service and only for one Comprehensive Targeted Case Manager.

4. A member may choose a new Comprehensive Targeted Case Management provider at any time.

5. In specific circumstances and through prior authorization, members may be eligible to receive a 30 (thirty) day transition period in which two (2) comprehensive case managers may provide services concurrently. This applies only when members are transitioning from one eligibility category to another (e.g. child to adult).

13.06-2 Prior Authorization and Utilization Review

A. Section 13 (TCM) services provided to children with behavioral health needs, chronic health conditions, and/or developmental disabilities require prior authorization.

B. The providers of Targeted Case Management are required to submit a Prior Authorization request to the Department or its Authorized Agent. The provider and recipient will receive prior authorization with a description of the type, duration and costs of the services authorized. The provider is responsible for providing services in

13.06 LIMITATIONS (continued)

accordance with the prior authorization letter. The prior authorization number is required on the CMS 1500 claim form. All extensions or amendment of services beyond the original authorization must be prior authorized by this same procedure.

C. DHHS or its Authorized Agent reserves the right to approve continuation of any covered services as described in this Section, applying the standards established by this Section for eligibility and for continuation of services. All case management services may require utilization review.

13.07 **POLICIES AND PROCEDURES**

13.07-1 **Service Requirements**

A. The member must be given the option of whether or not to utilize Targeted Case Management Services.

B. If the member chooses Targeted Case Management Services, he/she must also be given a choice of providers approved by the Department.

C. Services must be provided in settings accessible to the member.

D. Each member must have an Individual Care Plan based on a Comprehensive Assessment or Re-Assessment. The Individual Care Plan and Comprehensive Assessment and Re-Assessment must contain all of the necessary components as stated in 13.07-3.

13.07-2 **Provider Requirements**

Targeted Case Management services must be provided by agencies and providers that meet all of the following criteria:

A. Agency Qualifications:

1. Targeted Case Management agencies must execute a MaineCare Provider Agreement

2. Targeted Case Management agencies must complete the "MaineCare Targeted Case Management Provider Enrollment" form.

3. Targeted Case Management agencies must promote effective operation of the various programs and agencies in a manner consistent with applicable State and Federal laws, regulations, and procedures.

4. Targeted Case Management agencies must maintain clear policy guidelines for decision making, program operations, and provision for monitoring the same.

5. Targeted Case Management providers must:

13.07 POLICIES AND PROCEDURES (continued)

a. Provide orientation, continuing education, and on-going communication with all applicable governing boards;

b. Have policies and procedures to protect the rights of members of service;

c. Have a comprehensive set of personnel policies and procedures;

d. Have job descriptions and qualifications, including licensure, for all staff employed either directly or by contract with the provider; and

e. Ensure that staff or contractors possess the skills, attitudes, and knowledge needed to perform job functions, and provisions for performing regular staff evaluations. Written definitions and procedures for use of all volunteers must be maintained.

6. Targeted Case Management providers must exhibit effective inter-agency coordination that demonstrates a working knowledge of other community agencies. This means the provider and its contracting agencies must be aware of information regarding the types of services offered and limitations on these services. Similarly, providers must ensure that other human service agencies are provided with accurate, up-to-date information regarding the provider's services, service limitations, and priorities within those services.

7. Providers must meet and comply with any and all additional agency requirements as defined in contract and/or MaineCare provider agreements between the Department and the designated case management agency, as applicable.

B. Staff Qualifications

1. Comprehensive Case Manager Qualifications

a. Staff must have a minimum of a:

1. Bachelor’s Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field, OR

13.07 POLICIES AND PROCEDURES (continued)

2. Master's Degree in social work, education, psychology, counseling, nursing or closely related field from an accredited graduate school, OR

3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience, OR

4. For staff of children's TCM service providers serving children with special cultural needs only, have necessary linguistic and cultural background and have parented a child or adolescent with special needs; OR

5. Have been employed on 8/1/2009 as a case manager providing services under the former subsections of Section 13. A person so employed will be considered qualified for the purposes of this section.

b. Additional staff qualifications as defined in contract agreements between the Department and the designated case management agency, as applicable, must be met.

2. Case Management Supervisor Qualifications

a. Supervision of comprehensive case managers must be provided by a:

1. Licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapists, advanced practice nurse, psychiatric nurse, registered nurse or a licensed social worker as defined below in Section 13.07-2 B.3., Professional Staff, OR

2. Person who was employed on 8/1/2009 as a case management supervisor providing supervision under the former subsections of Section 13. Such staff will be considered qualified for the purposes of this section.

b. Additional case management supervisor qualifications as defined in contract agreements between the Department and the designated case management agency, as applicable, must be met.

2. Professional Staff Qualifications

All professional staff must be conditionally, temporarily, or fully licensed in the State or Province in which services are provided and approved to practice as documented by written evidence from the appropriate governing body. All

13.07 POLICIES AND PROCEDURES (continued)

professional staff must provide services only to the extent permitted by Qualified Professional Staff licensure and approval to practice. Services provided by the following staff are reimbursable under this Section:

a. Physician

b. Physician Assistant

c. Psycologist

d. Social Worker

A social worker must: (a) hold a Master's degree from a school of social work accredited by the Council of Social Work Education, and (b) be either licensed or certified in accordance with 32 M.R.S.A., Chapter 83, §7001or be eligible for examination by the Maine Board of Social Worker Registration, which eligibility is documented by written evidence from such Board.

f. Licensed Marriage and Family Therapist

g. Registered Nurse

h. Psychiatric Nurse

A psychiatric nurse must be licensed as a registered professional nurse and certified as a psychiatric nurse by the American Nursing Credentialing Center or other acceptable national certifying body for this specialty.

i. Advanced Practice Registered Nurse

An advanced practice nurse must be licensed as a registered professional nurse and approved to practice as an advanced practice registered nurse by the Maine State Board of Nursing and certified by a national certifying body acceptable by the Maine State Board of Nursing.

j. Advanced Practice Psychiatric Nurse
An advanced practice nurse must be licensed as a registered nurse by the Maine State Board of Nursing, certified as a psychiatric nurse practitioner or psychiatric and mental health clinical nurse specialist by the American Nurse's Credentialing Center, and approved to practice as an advanced practice registered nurse by the Maine State Board of Nursing or other acceptable national certifying body for this specialty, within the specialty of psychiatric nursing.

13.07 POLICIES AND PROCEDURES (continued)

4. Personnel Requirements

Comprehensive Targeted Case Management providers must:

a. Maintain documentation of staff qualifications in staff personnel files. Documented evidence includes, but is not limited to: transcripts, licenses, and certificates.

b. Have a review process to ensure that employees providing Targeted Case Management Services possess the minimum qualifications outlined above. The review process must occur upon hiring new employees and on an annual basis to assure that credentials remain valid.

c. Plan staff development and continuing education activities for their employees and contractors that broaden their existing knowledge in the field of developmental disabilities, mental health, substance abuse, long term care, chronic medical conditions and related areas, as applicable.

d. Provide staff orientation specific to Targeted Case Management prior to the staff assuming their Targeted Case Management duties.

e. Maintain documentation of staff continuing education, staff development, and Targeted Case Management Training in staff personnel files.

13.07-3 **Provider Documentation Requirements**

The provider must complete and maintain all documentation requirements as set forth below:

A. **Content of Member Case Record**

The provider must maintain a specific record for each member, which must include but not be limited to:

1. A comprehensive assessment that must be completed within the first thirty (30) days of initiation of services, and reassessment must occur as change in the member's needs warrants or at a minimum on an annual basis.

Assessments and re-assessments must be conducted on a face-to-face basis. The comprehensive assessment must minimally include:

a. The member's name, address, and birth date;

13.07 POLICIES AND PROCEDURES (continued)

b. The member's history (including physical and social environment) including: past service use, health/medical status, determination of chronic or severe medical problems; a social and family history; determination of educational status, developmental status, substance abuse problems; assessment of social, daily living and other habilitative skills; and

c. The member's needs, strengths and preferences including: current functional level, level of risk, individual needs, existing strengths and supports, and available family support/social networks; and

d. Documentation of an evaluation by a psychiatrist, physician, physician assistant, psychologist, advanced practice psychiatric nurse, advanced practice registered nurse, LCSW, LMSW or an LCPC, which includes appropriate diagnosis.

2. An Individual Plan of Care based on the Comprehensive Assessment including:

a. The amount, frequency, and duration of each service to be provided, a record of service delivery, target dates for completion, and person responsible;

b. The procedures and instruments to be used in evaluating the member's progress with re-evaluation as change in the member's needs occur or at a minimum every ninety (90) days;

c. Documentation of member and/or family involvement in the development of the plan/plan of care must include their signatures;

d. The problems to be resolved, measurable goals and objectives to be attained and/or outcomes to be realized through provision of identified services;

e. Documentation if the member declines services listed in the individual care plan;

f. The psychiatric, medical, social, educational and family support and other services and resources identified to address each identified problem or need and how and by whom the services and resources may be most appropriately delivered;

g. Referrals to appropriate providers of services and follow-up documentation;

13.07 POLICIES AND PROCEDURES (continued)

h. Plans for coordination with other agencies and providers, as appropriate; and

i. identification of any other case management providers and what services they are currently providing, and

j. Documentation that the individual or their guardian or legal representative has been offered choice of provider of TCM services which includes documentation of their choice.

3. Other Documentation, including:

a. Written progress notes and status reports, including dates of service; and

b. Accountability as evidenced by signature and date; and

c. Relevant assessment and evaluation reports and correspondence from and to other providers; and

d. Release of information statements as necessary, signed by member or when necessary, by guardian as required by law.

B. **Record Entries**

Entries are required for each case management service provided and must include:

(1) The name of the individual.

(2) The dates of the case management services.

(3) The name of the provider agency (if relevant), the person providing the case management service and the place of service delivery.

(4) The nature, content, units of the case management services received, progress toward goals specified in the care plan and/or if the goals have been achieved or modified.

(5) Whether the individual has declined services in the care plan.

(6) A timeline for obtaining needed services.

(7) A timeline for re-evaluation of the plan.

13.07-4 **Program Integrity Unit**

Refer to Chapter I, General Administrative Policies and Procedures of the MaineCare Benefits Manual for a definition and description of Program Integrity.

13.07 POLICIES AND PROCEDURES (continued)

13.07-5 Interpreter Services

Please refer to Chapter I, General Administrative Policies and Procedures of the MaineCare Benefits Manual for a definition and description of Interpreter Services.

13.08 ACCESS TO RECORDS AND CONFIDENTIALITY

A. Records

Members' records compiled under this policy shall be kept current. Records shall be retained for a period of not less than five (5) years from the date of service provision. If an audit is initiated within the five (5) year retention period, the records must be retained until the audit is completed and a cost settlement has been made.

B. Confidentiality and Disclosure of Confidential Documents

The disclosure of information regarding individuals participating in the MaineCare program is strictly limited to purposes directly connected with the administration of the MaineCare program. Providers shall maintain the confidentiality of information regarding these individuals in accordance with 42 CFR §431 *et seq*. and other applicable sections of state and federal law and regulation.

Any release of medical records containing information on HIV infection status shall be in compliance with 5 M.R.S.A. §19201 *et seq*. and other applicable sections of state and federal law and regulation.

13.09 REIMBURSEMENT

13.09-1 Rates

Reimbursement is specified in Chapter III, Section 13, Allowances for Targeted Case Management Services.

Providers of services reimbursed on a quarter hour basis under this Section will be reimbursed for any substantive contact at a minimum of fifteen (15) minutes. Providers are subject to the rounding requirements in Chapter I of the MaineCare Benefits Manual (Provider Participation).

13.09-2 Reimbursement Allowances

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from every other source that is available for payment of a rendered service before billing MaineCare.

MaineCare will pay the lowest of the following:

13.09 REIMBURSEMENT (continued)

A. The fee established by MaineCare;

B. The lowest payment allowed by Medicare; or

C. The provider's usual and customary charge.

Payment will be made under this Section of the MaineCare Benefits Manual for case management services provided to an eligible member at any given point in time so long as the service provided is not duplicative.

13.09-3 **Certified Public Expenditure ("Certified Seed")**

All agencies that provide case management services must follow all state and federal requirements as set forth in Chapter I of the MaineCare Benefits Manual.

13.10 **BILLING**

The documentation must demonstrate that only one staff person's time is billed for any specific activity provided to the member. Billing must be accomplished in accordance with the Department's "Billing Instructions for Targeted Case Management Services" provided by the Office of MaineCare Services, Division of Customer Service (http://www.maine.gov/dhhs/oms/providerfiles/billing_instructions.html).