Addictive and Mental Disorders Division Severe and Disabling Mental Illness, Home and Community Based Services Waiver Manual	
Date effective: July 1, 2020 **Date revised:**	
Policy Number: *SDMI HCBS 310*	**Subject:** Case Management

Definition

Case Management as defined in 42 CFR 440.169, are services furnished to assist members in gaining access to needed medical, social, educational, and other services. Case management includes the following assistance:

(1) Comprehensive assessment and periodic reassessment at least once every 90 days of an eligible member to determine service needs, including activities that focus on identification for any medical, educational, social or other services. These assessment activities include:

(a) taking member history;

(b) identifying the member's needs and completing related documentation; and

(c) gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible member.

(2) Development and periodic revision of a specific care plan (Person-Centered Recovery Plan) that is based on the information collected through the assessment that:

(a) specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

(b) includes activities to ensure the active participation of the eligible member, and working with the member (or the member's authorized health care decision maker) and others to develop those goals; and

(c) identifies a course of action to respond to the assessed needs of the eligible member.

(3) Referral and related activities, such as scheduling appointments for the member, to help the eligible member obtain needed services including activities that help link 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; and

(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible member's needs, and may also be with the member, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

(a) services are being furnished in accordance with the member's care plan;

(b) services in the care plan are adequate; and

(c) changes in the needs or status of the member are reflected in the care plan.

Determination of Need

(1) Case management may be provided to members who are referred to the SDMI waiver prior to the member's being assessed for Level of Impairment (LOI) or Level of Care (LOC) to assist with transition to the waiver program.

(2) Members must receive case management to access other waiver services.

Provider Requirements

(1) Case management activities as defined above may only be provided by an entity contracted by the department and may not be proved by any other programs or other providers.

(2) The case management team (CMT) must consist of:

(a) a Registered Nurse or Licensed Practical Nurse; and

(b) at least one social worker with a bachelor's degree and two consecutive years' experience providing case management services to adults with severe disabling mental illness.

(3) The CMT must have knowledge of:

(a) case management components, methods, procedures, and practices;

(b) the application of diagnostic and crisis intervention skills; and

(c) the problems and needs of long-term care individuals.

(4) The CMT team must have the ability to complete the duties and responsibilities as stated in the definition of case management services.

Service Requirements

(1) CMTs must follow all policies, rules, and regulations established for the Severe and Disabling Mental Illness (SDMI), Home and Community (HCBS) waiver.

(2) CMTs must meet all of the requirements established in their contracts.

(3) CMTs must maintain a record for all members for six years and three months. The CMT record must include at least the following:

(a) LOI and LOC;

(b) SLTC-55;

(c) person-centered recovery plan (PCRP);

(d) cost sheets;

(e) progress notes;

(f) psychosocial/strengths assessment;

(g) recovery markers;

(h) reevaluation forms;

(i) amendment forms;

(j) letter(s) of notification;

(k) prior authorization forms;

(l) complete copy of the resident agreement for individuals in residential habilitation facilities;

(m) standard health and safety initial screen;

(n) risk negotiation;

(o) bill of rights;

(p) medication monitoring form, if required; and

(q) supporting documentation as required for each service.

(4) A case management team progress note must be entered:

(a) when a member is enrolled and discharged from services;

(b) when any type of contact is made with or on behalf of the member;

(b) for initial evaluation, three, six, nine month and annual re-evaluations and must be concurred by the nurse or social worker or a separate progress note entered;

(c) for prior authorization requests to the department;

(d) for all Serious Occurrence Reports (SORs) entered into the Quality Assurance Management System (QAMS) database;

(e) for retainer days; and

(f) for pass through payments authorized.

Utilization

(1) Case Management is based on the member's assessed need and is a required service for the SDMI HCBS waiver.