South Carolina
Department of Disabilities and Special Needs

Case Management Standards

Effective July 1, 2014

Note: The term "Service Coordination/Service Coordinator" previously used by DDSN is being changed to "Case Management/Case Manager." Over time, this terminology change will be made in other policies, standards, and documents issued by DDSN. In the interim, the terms will be used interchangeably.

STANDARDS	GUIDANCE
I. STAFF QUALIFICATIONS AND PROVIDER REQUIREMENTS	
A. Case Management (CM) services shall be rendered by qualified staff. 1. Case Management Supervisors (CMSs) must possess a bachelor's degree from an accredited college or university, or licensure from the South Carolina Labor Licensing and Regulation Board as a Registered Nurse and have two (2) years of supervisory experience and two (2) years of case management experience. 2. Case Managers (CMs) must possess a bachelor's or graduate degree from an accredited college or university, or licensure from the South Carolina Labor, Licensing and Regulation Board as a Registered Nurse, and at least one (1) year of experience working with the target population.	Case Management activities or activities, functions of Case Management Supervisors and Case Managers who do not meet qualifications are NOT reportable. There are no exceptions. Case Managers must have at least one (1) year of experience working with the target population for which they are providing case management (i.e., ID/RD, HASCI). A person with a family relationship to a consumer may not provide Case Management to that consumer.
B. Each Case Manager or Case Management Supervisor must be an employee of DDSN, a DSN Board, or a DDSN qualified Case Management provider.	
C. Each Case Management provider shall maintain: 1. a current list of staff members 2. a signature sheet for Case Managers and Case Management supervisors which includes all signatures and initial variations used by those staff 3. a credentials folder for each staff member which includes: a. Resume'/Equivalent Application; b. Certified copies of transcripts from an accredited university or college;	

c. Training records; d. Job description; e. Criminal Checks (including SLED Background checks and/or FBI Checks); f. Child Abuse and Neglect Registry Checks; g. Registry for Centers for Medicare and Medicaid Services (CMS) List of Excluded Individuals/ Entities (LEIE); h. Nurse Registry, if applicable; i. Sex Offender Registry; j. Proof of current licensure as a Registered Nurse, if applicable; k. TB Test results; l. Department of Motor Vehicles Driving Record, if applicable;	
D. Case Management staff must be trained. 1. Case Management staff must be provided training in the following topic areas: a. DDSN Case Management Standards including, but not limited to Assessment, Care Planning, Referral and Linkage, Monitoring and Follow Up, and reportable and non-reportable activities and service note documentation; b. Basic Case Management skills; c. DDSN policies and procedures applicable to Case Management; d. Rights of consumers; e. Local, state, and national resources that comprise the system of care for DDSN's target populations;	Documentation must reflect that information presented in training was understood by the Case Manager. Training beyond the minimum established by these standards in order to ensure knowledge and skills competency is encouraged. Training in a classroom setting is not required. Other venues for training may be used such as: • Shadowing an experienced Case Manager or other professional staff • One on one instruction (not routine supervision) by a supervisor or other designated staff • Site visits to disability programs and services of other community service providers for the purpose of understanding the disability community and its service provider network.

f. Access to and use of CDSS/STS; g. Nature of Developmental and Intellectual Disabilities, Autism, Traumatic Brain Injury, Spinal Cord Injury and Similar Disability (as appropriate); h. Abuse and Neglect; i. Confidentiality. 2. Annually, Case Management staff must receive training on Procedures for Reporting Abuse, Neglect or Exploitation of People (DDSN Directive 534-02-DD) and Confidentiality of Personal Information (DDSN Directive 167-06-DD). 3. As needed, Case Management staff must be provided training on programmatic changes and/or updates.	
E. Case Management providers must be accessible to people served and must have a system in place which allows people served to receive assistance with any crisis situation 24 hours a day, 7 days a week.	If necessary, a back-up on-call system may be implemented which will allow immediate accessibility for people receiving services. People receiving services and providers should be encouraged to call 911 in the event of a medical or police emergency; however, Case Management providers must still be accessible to provide assistance as needed. It is acceptable to have a general on-call number (beyond working hours) provided there is a response to crisis calls within two hours.

STANDARDS	GUIDANCE
II. REQUESTING ACTIVE CASE MANAGEMENT	
A. When a person is Medicaid eligible and referral for MTCM is received from DHHS. 1. The person's file must contain a copy of the DHHS authorization letter. 2. The person's file must contain documentation that establishes the person in a MTCM target group. 3. The person's file must contain an appropriately signed Freedom of Choice (FOC) form for Case Management services. Forms signed after May 1, 2014 should specify the provider agency's name. 4. DDSN must be notified when the initial Case Management Assessment and Plan (CMAP) or Support Plan is completed.	DHHS MTCM staff will establish target group and offer choice of provider. If a DDSN contracted provider is chosen: • DDSN will receive the referral through the Phoenix system. • DDSN will determine if the consumer is currently DDSN eligible. • If DDSN eligible, DDSN will update CDSS precertification dates, and email chosen provider a copy of the DHHS authorization letter. • If not DDSN eligible, DDSN screening will contact the consumer/family to screen for eligibility determination. If screened in, the case will be forwarded to DDSN Intake division. • The CDSS will be updated with precertification and chosen provider will be notified via email with copy of DHHS authorization letter attached. • The chosen provider will ensure file contains documentation to establish person in the target group (eligibility information or screening form). • The chosen provider will have the consumer sign the DHHS Freedom of Choice Form. • The chosen provider will proceed with completion of the initial assessment and plan within 45 days of the date of authorization. • The provider will notify DDSN when the initial assessment/Plan is completed.
B. When a person is Medicaid eligible, <u>and</u> DDSN eligible, but has <u>not</u> been continuously (has had a break) receiving active Case Management: 1. The person's file must contain a copy of the DHHS authorization letter.	The provider agency will: • Inform the consumer about MTCM and ask if they are interested. • Ensure that documentation in the file establishes person in a target group (i.e., eligibility information) • Obtain consumer/family's signature on the DHHS Freedom of Choice Form

2. The person's file must contain documentation that establishes the person in a MTCM target group. 3. The person's file must contain an appropriately signed Freedom of Choice form for Case Management services. 4. DDSN is notified when the initial Case Management Assessment and Plan (CMAP) is completed.	• Make a referral through DHHS/Phoenix portal: https://phoenix.scdhhs.gov/initial_electronic_referrals/new • Indicate in the comments section under referral information that the person is currently receiving services through DDSN from the specific provider agency and needs active MTCM. • DDSN will be notified through the Phoenix portal when services are approved. • DDSN will update the precertification screen on CDSS. • An email will be sent to the provider with a copy of the DHHS authorization letter. • The chosen provider will proceed with completion of the initial assessment and plan within 45 days of the date of authorization. • The provider will notify DDSN when the initial assessment/Plan is completed.
C. Person is DDSN eligible but is not eligible for MTCM. 1. The person's CDSS record must reflect a precertification date range.	DDSN Directive 700-06-DD: State Funded Case Management (SFCM) must be followed. Case Management Services are not available to those who: • Are enrolled in a Medicaid Home and Community Based Waiver that covers Case Management; • Reside in an institutional placement (ICF/IID, nursing homes, etc.) except during the last 180 days prior to discharge, and/or • Are incarcerated, in an evaluation center, in jail and/or prison or detention center; unless approved for State Funded Case Management by DDSN.

STANDARDS	GUIDANCE
III. SERVICE DESCRIPTION	
A. Case Management services will be provided in accordance with all applicable DDSN policies and procedures.	Please refer to: http://ddsn.sc.gov/about/directives-standards/Pages/CurrentDDSNDirectives.aspx.
B. ASSESSMENT 1. The Case Management Assessment and Plan (CMAP) must be used for those who receive MTCM or SFCM but do not participate in a DDSN operated HCB Waiver or the State Funded Pervasive Developmental Disabilities Program (PDD Program). 2. The Service Coordination Annual Assessment (SCAA) must be used for those who participate in a DDSN operated HCB Waiver or State Funded Pervasive Developmental Disabilities Program (PDD Program). 3. The assessment (CMAP or SCAA) must: a. Be completed within 45 days of the authorization date for case management. b. Be completed prior to the initiation of the Plan. c. Include a face-to-face visit in the person's residence to gather information. d. Be reviewed/updated at least every 180 days in conjunction with a face –to-face contact with the person. **e.** Be completed at least annually in conjunction with a face-to-face visit in the person's residence.	Assessment and periodic reassessment of an individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following: • Taking individual history • Identifying the needs of the beneficiary individual and completing related documentation • 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 individual. Both assessment and plan can be completed on the same day. A face-to-face contact in the beneficiary's natural environment is permissible in lieu of the visit in the residential setting under the following circumstances: • Homelessness • Beneficiary or homeowner's refusal to allow access to the home • Documented criminal, violence, or isolation that places the case manager in danger When these circumstances exist, the assessment and case management plan should address safety issues or housing concerns for the beneficiary.

C. CARE PLANNING 1. The Case Management Assessment and Plan (CMAP) must be used for those who receive MTCM or SFCM but are not in a DDSN operated HCB Waiver or the PDD Program. 2. The CMAP must: a. Be completed within 45 calendar days of authorization for case management services. b. Be reviewed/updated every 180 days. c. Be completed annually (must be completed every 365 calendar days). d. Include a statement of need(s), the case management action(s) to address the need(s), the name or type of provider to which the person will be referred and a projected completion date. e. Be signed, titled and dated by a qualified Case Manager (can be an electronic signature when CAP is used). f. Be signed by the person, his/her parent, guardian, or legal representative if available. This signature can be obtained on a separate form indicating the person's agreement with the Plan if the Plan is completed in CAP. g. Be placed in the person's file within 10 business days of the Plan completion date if completed entirely on paper. Plans completed in CAP are not required to be in the file. h. Be current at all times i. Be provided to the person or his/her representative. 3. The Support Plan must be used for those who participate in a DDSN operated HCB Waiver or PDD Program.	Development and periodic revision of a specific care plan based on the information collected through the assessment, that includes the following: • Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual. • Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals. • Identifies a course of action to respond to the assessed needs of the eligible individual. If a plan is not signed by the person, parent, legal guardian or legal representative at the time of plan completion, document why the signature could not be obtained and have the Plan (or separate form) signed at the next face to face contact. A copy of the completed plan must be provided to the person, parent, legal guardian or legal representative and documented in the service notes. The Case Manager must document that the person, parent, legal guardian and/or legal representative participated in the planning process. Documentation may be in the form of a plan meeting sign-in sheet when the above persons were present and/or documented in service notes describing participation in the planning process. Service note documentation that the completed plan was provided to the person, parent or other legal representative is also indicative of participation in planning. Participation in planning may also be documented as participation in completion of the Assessment. Case Managers must sign plans for them to be valid. A current manually signed plan must be maintained in the file at all times or there must be a completed current plan in CAP with an electronic signature. Payment for any services that are being provided for a person without a current/valid Plan may be subject to sanctions/recoupment when identified through quality assurance reviews, Medicaid audits, or other means.

4. The Support Plan must: a. Be completed within 45 calendar days of authorization for case management services. b. Be completed prior to waiver service provision. c. Be reviewed/updated every 180 days. d. Be completed annually (must be completed every 365 calendar days). e. Reflect if consideration is being given to the need for contact in excess of the minimum requirements. f. Include information about the person's plan for responding to emergencies. g. Address identified health and safety needs for persons placed in DDSN residential settings or in contractual residential settings. h. Include the following: • a statement of need(s), • the service or intervention to address the need(s), • type of provider to which the person will be referred, • the funding source, • the amount, frequency and duration of the service, • a projected completion date, • The responsibilities of the person/responsible party, • The responsibilities of the case manager, i. Be electronically signed, titled and dated by a qualified Case Manager.	

j. Be signed by the person, his/her parent, guardian, or legal representative if available. This signature should be obtained on a separate form indicating the person's agreement with the Plan. k. Be placed in the person's file within 10 business days of the Plan completion date if completed entirely on paper. Plans completed in CAP are not required to be in the file. l. Be current at all times. m. Be provided to the person or his/her representative**.**	
D. REFERRAL AND LINKAGE 1. Case Managers will implement/follow the Plan. 2. The Case Manager must ensure that the person's freedom of choice of providers is offered. These choices must be documented. 3. Annually, all people receiving active Case Management must be provided information on what is abuse, neglect and exploitation are and how to report incidents.	Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social and education 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. CHOICE OF PROVIDERS – The person receiving services or legal guardian must be given a choice of all qualified providers of services and supports. Choice should be offered at a minimum of annually during plan development, any time the person receiving services or legal guardian requests a change in services or providers, or when a new need is identified. It must be documented in service notes that a choice of providers was offered and what the person receiving services/legal guardian's choice was. If there is only one potential provider for a particular area, the person receiving services/legal guardian must be informed and the Case Manager must document this discussion in a service note. Case Managers should be responsive to preferences of the person/legal guardian and to a request for a change in <u>any</u> service provider. Documentation must reflect that a choice was offered. Information regarding abuse, neglect, and exploitation will be provided to those actively receiving Case Management.

E. MONITORING OR FOLLOW UP

1. Face-to-face, email or telephone contact must occur with the consumer, his or her family, authorized representative, legal guardian or provider at least every 60 calendar days (beginning on the date of the Plan) or more frequently based on the consumer's need.

2. At least every 180 days, the assessment and plan[1], must be reviewed.

3. For non-Waiver Participants, the Plan must be reviewed to determine if the assessment information remains current and if actions included in the CMAP should continue, be updated or be discontinued.

4. For those participating in a DDSN operated HCB Waiver; the review must determine if:

   a. services are received and are effective;

   b. person/legal guardian is satisfied;

   c. that the Plan continues to be appropriate to address needs.

5. Plan Review must be done every 180 days and completed in consultation[2] with the person being served and/or their legal guardian.

6. For those participating in a DDSN Operated HCB Waiver, when a referral is made by the Case Manager to a new service provider (for both new and ongoing services), the Case Manager will follow up with the consumer and the service provider to determine whether the service and provider appears appropriate to address the need.

Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring and follow-up may be with the individual, family members, service providers, or other entities or individuals. These activities may be conducted as frequently as necessary, and including at least monitoring every 60 days to help determine whether the following conditions are met:

- Services are being furnished in accordance with the individual's care plan.
- Services in the care plan are adequate to meet the needs of the individual.
- There are changes in the needs or status of the eligible individual. If there are changes in the needs or status of the individual, monitoring and follow-up activities include making necessary adjustments in the care plan and service.
- Arrangements with providers.

[1] **"**Assessment and plan" means the Case Management Assessment & Plan (CMAP) for those <u>not</u> participating in a DDSN operated HCB Waiver. For those participating in a DDSN operated HCB Waiver, it means the Service Coordination Annual Assessment and Support Plan.

[2]In consultation means that a face to face contact is made with the person in his/her natural environment.

Note: DDSN HCB Waivers have specific monitoring requirements in addition to those noted in this section in order to ensure continued access to Medicaid-funded services. Please refer to specific waiver manuals/guidelines for monitoring waiver services.

STANDARDS	GUIDANCE
IV. RECORD KEEPING AND DOCUMENTATION	
A. A primary case record will be maintained for each person receiving services.	Case records (paper files and electronic records) maintained by the Case Manager are considered to be the person's primary case record with DDSN.
B. The primary case record must follow a File Index as determined by the provider agency.	Primary case records should be logically and consistently organized such that the identification of needs, referrals, follow-up, plan development and monitoring can be easily and clearly reviewed, copied, and audited. Case Management providers will have the flexibility to use the filing system of their choice (i.e., six-section divided files, 3-ring binders, etc.).
C. As appropriate records will include, but are not limited to, the following: 1. Assessment Information. 2. Current Plan and previous year's plan in paper or electronic format as applicable. The paper file will identify records that are maintained electronically. 3. Initial Social History Assessment (CIS) and updates (If applicable). 4. Medical information as applicable and when available. 5. Psychological Assessment, if applicable. 6. IEPs, IFSPs, FSPs, if applicable by age. 7. Eligibility Letter (after 1988). 8. Valid Service Agreement. 9. Contact/Service Notes in paper or electronic format as applicable. The paper file will indicate records that are maintained electronically. 10. HIPAA Acknowledgement.	Service notes should provide a clear/concise description of the circumstances being recorded. The contents should be current, complete, timely, and meet documentation requirements. Documentation and record organization should also permit someone unfamiliar with the person receiving services to quickly assume knowledge sufficient to provide Case Management, or to review the records to assure compliance with contracts, policies, standards and procedures. Purged record contents should also be maintained according to the provider agency's File Index and in close proximity to the primary case record. HASCI Waiver recipient's files must follow the HASCI Waiver index (refer to the HASCI Waiver Manual). Closed records and backup records will also be retained according to the provider's primary case record index. Closed case records must be retained for a period of no less than six years after the end of the annual contract period. If any litigation, claims or other actions involving the records are initiated prior to the expiration of the six year period, the records must be retained until completion of the actions and resolution of all issues which arise from it, or until the end of the required period whichever is later. (For more detailed information regarding record retention, please refer to DDSN Directive 368-01-DD: Individual Service Delivery Records Management.

11. DHHS Freedom of Choice Form (for MTCM authorized cases). 12. DHHS Authorization letter (for MTCM authorized cases). 13. Correspondence, including emails, and any other documentation intended to support Medicaid reimbursement for Case Management. 14. Legal records determining competency or determining a change in legal guardianship or documenting a legal name change, if applicable. 15. Information from other service agencies providing services to the person. 16. Other documents which from time to time may be deemed essential by DDSN or the state Medicaid agency.	
D. For participants who are enrolled in a DDSN operated HCB Waiver; the person's record contains the required forms as outlined by the Waiver manual.	Waiver Forms including but not limited to: a. Waiver enrollment and disenrollment forms. b. Waiver budget information. c. **ALL** Level of Care forms. d. Freedom of Choice form. e. Waiver Acknowledgement of Choice form. f. Waiver Acknowledgement of Rights and Responsibilities form. g. Waiver authorization and termination forms. h. Other Waiver forms as required in the PDD, ID/RD, CS, and HASCI Waiver manuals.
E. The primary case record including the electronic assessment, planning, monitoring and service note system will be kept secure according to DDSN and HIPAA security, confidentiality and privacy policies.	Refer to DDSN Directives: • 167-06-DD: Confidentiality of Personal Information.

	• 368-01-DD: Individual Service Delivery Records Management • 367-12-DD, Computer Data Security
F. Service notes must document all Case Management activity on behalf of the specific person represented by the primary case record and, upon review, must justify the need for Case Management.	Multiple actions which support the same activity and which occurred on the same day may be incorporated into a single service note provided all necessary information is included and is clear to any other readers or reviewers. A contact is defined as any of the following: • A face to face visit for the purpose of performing a core function. • A telephone call, letter or email when a face to face contact is not required or is not practical due to circumstances. A Signature Sheet must be maintained by each provider agency. The Signature Sheet must include each way a case manager has abbreviated his or her name in the record, as well as his/her professional title and the user ID for electronic files.
G. Service notes will include the following if a reportable activity is being documented: • Type of activity and type of contact. • Place of contact or activity. • Person with whom the contact occurred and relationship to the beneficiary. • Purpose of the contact or activity. • Description of the MTCM intervention delivered. • Outcome(s) of the contact activity, and next step(s) for that activity note – follow-up needed (if applicable). • Each case management activity performed and the case management component being provided. • Be authored, signed, titled and signature dated	

by the qualified staff person(s) who rendered the case management activity Be filed or entered in the beneficiary's record within seven calendar days of delivery of the activity.	
H. All service notes must: 1. Be entered on CDSS be completed within seven (7) calendar days of the activity/event being documented. 2. Be completed on CDSS so that activities may be reported to DDSN for billing. 3. Be labeled as a "Late Entry" when the Case Manager is not able to complete a note within seven (7) calendar days from the time that the activity occurred. 4. Be completed by a qualified Case Manager.	The Best Practice (not mandatory) is to complete service notes on the day that a service or activity is rendered. Service notes on CDSS are the electronic documentation of core functions and other activities performed by the Case Manager. The service note module of CDSS is in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. 26-6-10 et seq.) When a service note for a core function activity is completed on CDSS, it is automatically transmitted to DDSN for possible billing. If a note is "Saved" (not completed), the note is still in progress and will not be reported to DDSN for possible billing. Having "saved" service notes (i.e., notes not completed) will prevent the transfer of the person to another provider until the note is either completed or terminated. Service notes completed on CDSS do not have to be printed and placed in the primary case record.
I. All manual service notes must be typed or handwritten in black or dark blue ink.	Electronic service notes can only be typed and printed in black.
J. All service notes must be legible and kept in chronological order according to the date of entry.	Any notes done out of chronological order should be labeled as "Late Entry". If a provider chooses to print electronic service notes for the primary case record and for non-electronic service notes, late entries must be filed according to the date they were completed, not on the date of the activity that is described in the notes.
K. All manual and electronic service notes must be dated and legibly signed with the Case Manager's name or initials, professional title, and dated.	Non-electronic service notes must be manually signed by a Case Manager. Case Management staff is given exclusively assigned pin numbers as electronic signatures to validate an electronic assessment, plan, monitoring, and service note as a genuine and true reflection of

	Case Management activity. Electronic signatures will be placed at appropriate locations on electronic documents and will be recognized by the phrase "Electronically signed by…" The date that the document was signed will also appear along with the title of Case Manager. Pin numbers may be obtained by contacting the Help Desk of DDSN's IT Department.
L. A list of any abbreviations or symbols used in the records must be maintained.	This list must be clear as to the meaning of each abbreviation or symbol, and only abbreviations and symbols on this approved list may be used.
M. Any person(s) referenced in service notes or any supporting correspondences must be identified in each entry.	Identify person(s) in service notes by their full name and title or relationship to the person. References in service notes must be done at least one time for each entry/service note.
N. Errors in service notes must be corrected appropriately.	When an error is made in a non-electronic service note, the Case Manager should clearly draw one line through the error, write "error" to the side in parentheses, enter the correction, and add the Case Manager's signature or initials and date. If additional explanation about the correction is appropriate, this must also be included in a service note. The information contained in the error must remain legible, and no correction fluid or erasable ink may be used. When an error is made in an electronic service note, the Case Manager will follow error correction procedures identified in the system as "Revision to the Completed Service Note." The corrected service note and the previous incorrect note for a specific person may be seen together in "Print/View History" when the original service note date is clicked on CDSS.
O. Service notes must be individualized to the specific person represented by the primary case record.	A single identical service note cannot be used to document activity about two or more consumers.

STANDARDS	GUIDANCE
V. SERVICE REPORTING	
Electronic service notes intended to document Case Management activities must be sufficient in content to support billing to Medicaid.	Reportable Case Management activities must represent at least one of the four Case Management activities (assessment, care planning, referral and linkage, monitoring and follow up). Service notes must correspond to reporting in type of activity, length of activity, units of service, and date of delivery. Case Managers may back-report for any activities for which a "Late Entry" service note is completed for a period of up to 12 months after the date the activity actually occurred. INITIAL REPORTING No Case Management activity is reportable unless a Pre-certification date range is available in CDSS (Refer to Section III-Requesting Active Case Management) regardless of the number of service notes or the type of activity that they describe. Electronic service notes, including Case Management activities and non-reportable activities may be entered as soon as the person is assigned to a Case Manager. SUPPORT PLAN Case Management activity may be reported only when a current Support Plan is in place or when a plan is in process according to established timeframes. If a plan is not in place or not in process within established time frames, the activity must be documented as non-reportable. PERSON/APPLICANT NOT LOCATED If a DDSN applicant or DDSN eligible person is missing and his/her whereabouts cannot be determined within 30 calendar days, Case Management activity must not be reported until that person is located. Reporting must be discontinued after 30 calendar days from the date the Case Manager is made aware of the person missing, not the actual date the person went missing. After 30 calendar days, all Case

	Management activity is <u>not reportable</u> until such time as the person is located and documented by a service note. As mentioned previously, Case Management activities and non-reportable electronic service notes may be entered at any time. **EXAMPLES OF REPORTABLE ACTIVITIES** • Assessing needs, access to services or client functioning. • Assessing the medical and/or mental needs through review of evaluations completed by other providers of services. • Assessing of physical needs, such as food and clothing. • Assessing of social and/or emotional status. • Assessing for housing, financial and/or physical environmental needs. • Assessing for familial and/or social support system. • Assessing for vocational and/or educational needs. • Assessing for independent living skills and/or abilities. • Ensuring the active participation of the beneficiary. • Working with the beneficiary and others to develop goals. • Identifying a course of action to respond to the assessed needs of the beneficiary. • Linking beneficiaries with medical, social, educational, and/or other providers, programs, and services that are capable of providing the assessed needed services. • Ensuring the CMP is implemented effectively and is adequately addressing the needs of the individual.

	• Contacting the individual, family members, outside service providers, or other entities to ensure services are being furnished In accordance with individual's CMP. • Ensuring the adequacy of the services in the CMP, and changes in the needs or status of beneficiaries. • Assisting in obtaining required educational, treatment, residential, medical, social, or other support services by accessing available services or advocating for service provision. • Contacting social, health, and rehabilitation service providers, either via telephone or face-to-face, in order to promote access to and appropriate use of services. Additionally, services by multiple providers may be coordinated. • Monitoring the progress through the services and performing periodic reviews and reassessment of treatment needs. When an assessment indicates the need for medical treatment, referrals or arrangements for such treatment may be included as MTCM services, but the actual treatment **must not** be included. • Arranging and monitoring the beneficiary's access to primary healthcare providers including written correspondence sent to a primary health care provider, which gives a synopsis of the treatment the individual is receiving. • Coordinating and monitoring other health care needs by arranging appointments for medical services with follow-up and documentation. • Staffing's related to receiving consultation and supervision on a specific case to facilitate optimal case management. This includes recommending and facilitating movement from one program to another or from one agency to another. • Contacting the beneficiary to deal with specific and identifiable problems of service access and requiring the case manager to guide

	or advise his or her in the resolution of the problem. • Contacting the family, representatives of human service agencies, and other service providers to form a multidisciplinary team to develop a comprehensive and individualized CMP. The individualized CMP describes the problems, corresponding needs, and details services to be accessed or procured to meet the beneficiary's needs. • Preparing a written report that details a psychiatric and/or functional status, history, treatment, or progress (other than for legal or consultative purposes) for physicians, other service providers, or agencies **EXAMPLES OF <u>NON-REPORTABLE</u> ACTIVITIES** • Attempting but not completing a contact whether in person or by telephone. • Reviewing case management record (of own agency files). • Referring and monitoring of one's own activities. • Completing special requested information regarding consumers or the provider, public agencies or other private entities for administration purposes. • Participating in recreation or socialization activities with a consumer or his or her family. • Rendering case management to individuals in institutional placements [*i.e.*, Intermediate Care Facilities (ICFs) or ICF-IIDs (Intellectual Disabilities), nursing homes, etc.], except during the last 180 days of the stay for the purpose of transition and/or discharge planning. • Rendering services while incarcerated, an evaluation center (formerly known as reception and evaluation centers), a local jail and/or prison, or a detention center.

	• Documenting Service Notes. • Performing administrative duties such as copying, filing, mailing of reports, etc. • Rendering activities (SC Family Court, General Sessions or Federal Court), which are convened to address custody, criminal charges, or other judicial matter by the individual or others. • Rendering services on behalf of a consumer after Death. • Rendering services as Case Management components that are mandated functions required by another payer source (*i.e.*, an assessment that has been completed as a program intake requirement). A treatment plan that covers court mandated services only should not be the basis for MTCM services. • Rendering services provided as administrative case management including Medicaid eligibility determination, intake processing, and preadmission screening for inpatient care. • Performing utilization review and prior authorization for Medicaid. • Rendering the actual or direct provision of medical services or treatment: o Training in daily living skills o Training in work skills and social skills o Grooming and other personal services o Training in housekeeping, laundry, cooking o Individual, group or family therapy services o Crisis intervention services o Diagnostic testing and assessments • Rendering services which go beyond assisting individuals in gaining access to needed services: o Paying bills and/or balancing the beneficiary's checkbook o Completing application forms, paperwork, evaluations and reports including applying

	for Medicaid o Escorting or transporting beneficiaries to scheduled medical appointments o Providing childcare so the beneficiary can access services o Shopping or running errands for the beneficiary o Delivering groceries, medications, gifts o Reading the mail for the beneficiary o Setting up the beneficiary's medication o Traveling to and from appointments on behalf of o the beneficiary • Performing Beneficiary Outreach – Outreach activities in which a state agency or other provider attempts to contact potential beneficiaries of a service do not constitute Case Management services. • Rendering Case Management services when there is no Plan in place.

Standards	Guidance
VI. Case Transfers	
Transfer to a newly chosen Case Management provider who is within the DDSN network of DSN Boards and qualified providers must occur on CDSS and the file be mailed/postmarked or otherwise delivered within 10 business days of the request.	The following steps should be followed to prevent any disruption in services: The sending Case Management provider should: • The sending provider should contact the chosen provider by email or phone or fax to determine if the provider will accept the case. • If a person independently contacts/chooses another provider or if any circumstances prohibit the sending provider from doing so, the receiving provider/Case Manager can contact the sending provider to initiate the transfer. • If case is accepted, Case Management providers should discuss the logistics of transferring, discuss services and providers, and set a date for mailing the case record and transfer on CDSS. Within 10 business days of the transfer on CDSS the sending provider must: • Reconcile waiver budget to close out services Complete any outstanding service notes. • Update/change CDSS as needed. • Review case record with Case Management Supervisor. • Terminate services, if necessary, and notify all service providers. (Note: Service termination may not be necessary when the person is not moving out of the immediate area or is choosing a different Case Manager provider) • Copy the case record and maintain a copy of all records of service according to DDSN Directive 368-01-DD: Individual Service Delivery Records Management. • Send originals of the paper case record to the receiving Case Management provider. The receiving Case Management provider should: • Ensure that the home board provider on the CDSS

	(county to county transfers only) is correct. • Notify Case Management DDSN Cost Analysis Division to set up a new waiver budget (waiver recipients only). • Update budget and services on the CDSS (for waiver recipients, complete new waiver budget within 20 business days of transfer on CDSS). • Contact chosen providers and authorize services if necessary. • Update existing plan or complete a new plan as necessary. • Organize all case record information and insert into a file. **** When a case is transferred for a consumer currently approved for MTCM through DHHS, the receiving provider must:** • Have the DHHS Freedom of Choice form signed by the consumer/family. • Make a referral through DHHS/Phoenix portal (https://phoenix.scdhhs.gov/initial_electronic_referrals/new). • Indicate in the comments section under referral information that the person is currently receiving services through DDSN has transferred providers within the DDSN network. • Once approval is received through DHHS, DDSN will be notified and will email the provider a copy of the DHHS authorization letter.