CASE MANAGEMENT GUIDANCE DOCUMENT

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I. Case Management Services Definition

The definition of case management contained in Administrative Rule 325.14101(g) is as follows:

> Case Management means a substance use disorder case management program that coordinates, plans, provides, evaluates and monitors services or recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. A substance use disorder case management program offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process.

As defined by MDCH/BSAAS in the Substance Abuse Program Case Management Requirements, Treatment Policy #08, the case management program must be identifiable and distinct within the agency's service configuration, and the agency must offer the case management services (CMS) as a separate and distinct program among any other program services that may be offered.

II. Case Management Services -Program Specifications

Case management services (CMS) shall assist clients in gaining access to needed medical, social, educational/vocational and other services. Core elements of CMS include assessment; planning; linkage, coordination and monitoring to assist clients in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and supports (both formal and informal) developed through the individualized treatment planning process.

Providers may determine the need for case management services during the assessment process or at any time during the treatment planning process. CMS are not a case-finding activity but rather supportive activities to enhance the clients' long term recovery from their addictive disorder.

Clients can receive CMS services when they are involved in any level of care if it is determined to be a necessary adjunct to the current services. CMS services can also be provided as a step-down from a more intensive level of treatment and can be provided as a stand-alone service if eligibility requirements are met.

CMS services are designed to provide the client with support to maintain recovery during the transition from formal treatment services to self-sustained recovery, but are also designed to assist in providing additional support while the client is receiving services in the initial period of treatment.

A. Services shall be provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

B. Case managers may follow clients as they progress through the continuum of care.

   - Once a client no longer requires acute treatment services, case management services may continue for up to six (6) months. The case management encounters can be requested as a stand-alone service but must meet a minimum requirement of one (1) face-to-face encounter per month.
   - Designated Entry Providers may admit a client for stand-alone Case Management services when referring a client to residential services at another provider. The

case management services must assist the client in accessing the residential services and work to ensure that the client engages in services following discharge from the residential provider.

C. Must be guided by a client's case management goals and objectives and be consistent with the rest of the clients' individualized, coordinated, comprehensive treatment plan of service.

D. The provider must make active efforts to engage clients who are "lost" or drop out of the program and to re-engage the client in services. It is expected that the case manager will actively look for clients when they have unexpectedly moved, and will utilize emergency contacts provided by the client to re-engage them in services.

E. Must coordinate the service plan with extended family and other providers in the client's life.

F. Services should continue despite relapse or setbacks, with consideration to increasing services during this time.

G. CMS must make active efforts to coordinate primary and/or behavioral health care for the client as applicable.

H. Should be provided in a community-based setting when office-based services pose a barrier to client engagement and participation. At a minimum, the provider must have the ability to see clients in their community with capability for face-to-face client interaction outside of the office setting.

I. Must be able to work with a treatment team if needed.

J. The provider must be able to serve as an advocate to assist and/or represent the client and his/her needs with other agencies or service providers. This may include but is not limited to serving as the "voice" of the client in situations where the client is unable to effectively represent himself/herself, accompanying clients to appointments, assisting with completion of forms or meeting other requirements the client may have to secure support/services, making appointments for clients, or ensuring follow-through of appointments.

K. The provider must monitor and continually assess the changing functional and social needs of clients as they progress through recovery and document this information as required.

III. Eligibility Criteria

Only clients with a documented substance use disorder diagnoses as defined by the DSM IV and meeting criteria for CMHSP funded services are eligible for CMS. In addition, at least **one** of the following criteria must be present in order for the client to be eligible for CMS services:

A. Client has a documented need in at least one domain involving community living skills, health care, housing, employment/financial, education or another functional area in that person's life. Which may include, but is not limited to, the following:

1. There are chronic physical conditions that affect treatment. (e.g., chronic pain with narcotic analgesics)

2. There are chronic mental health conditions that affect treatment. (e.g., stable but chronic schizophrenia, affective or personality disorder problems. Psychotropic medications)
3. Client is currently receiving medication assisted treatment.
4. Client is pregnant, parenting dependent children or is at risk of losing custody of their children.
5. Client has documented involvement with multiple systems such as Department of Human Services/Protective Services or Foster Care, Probation, Drug/Sobriety SUD Treatment Courts, etc.

B. Client has a history or repeated relapses and a treatment history involving multiple treatment attempts.

C. Client has a substance use disorder involving a primary drug of choice and history of use that will require longer-term involvement in treatment services to support recovery (such as methamphetamine, heroin/opiates, inhalants).

D. The chronicity and severity of the client's disorder is such that ongoing support is needed to increase the probability of recovery. May be evidenced by the client requiring a referral for detox and/or residential services upon assessment by the Designated Entry Provider.

A client who is receiving case management services from another service or program (mental health, child welfare, justice system etc.) is **not** eligible for substance use disorder case management services regardless of whether the client meets criteria as detailed above. A client whose needs could be met through another service for which the client qualifies is **not** eligible for substance use disorder CMS services.

IV. Authorization of Case Management Services

Request for authorization of case management services shall be submitted via the CareNet system either at the time of the initial authorization or at any time during the treatment episode if the need for such services arises. If the need for case management services is identified after the initial authorization request has been submitted a separate authorization request for the case management services may be submitted but must begin and end on the same date as the existing authorization. Future authorization requests for the client must include all services.

The request should indicate the reasons why case management is being requested in the comment section of the authorization request. The CMHSP will review the comments in the comment section of the Request for Initial Authorization to authorize case management services.

Units of case management shall be counted toward the hours of service allowable within an authorization request. For clients who need a higher intensity of case management services,, the CMHSP will consider authorizations that exceed the allowable amount when adequate justification is provided within the authorization request. Clients enrolled in Enhanced Women's Services shall be authorized for up to 120 units of service per authorization request.

Additional authorizations of case management services shall be authorized as clinically appropriate and funding allows. Re-authorization requests should indicate progress regarding the case management goals and the need for continued case management services.

V. **Billing and Reimbursement**

All case management services must be preauthorized and submitted for reimbursement via the ProviderConnect system unless otherwise authorized by the CMHSP.

Services billable to Block Grant and/or PA2would include:

- face-to-face contact with the client,
- telephone contact with the client for a minimum of 15 minute duration,
- participation in wrap-around meetings,
- collateral family contact of a minimum of 15 minute duration (collateral family contact is defined as any contact that are not direct treatment services),
- collateral professional contact of a minimum of 15 minute duration,
- in-home visits, and
- transportation to other needed services.

Services billable to Medicaid include any of those listed above when the client is present. Block Grant or PA2 may be billed for non-face-to-face services for Medicaid clients when appropriate and funding is available.

Billing Codes:

- **When the Client is Present: H0050**
  - H0050 - Referral/Linking/Coordination, 15 minutes: This code should be used for all services where the client is present and is not WSS eligible.
  - H0050.HD - Referral/Linking/Coordination, 15 minutes: This code should be used for all services where the client is present and is WSS eligible but not enrolled in Enhanced Women's Services.
  - H0050.HD - Enhanced Case Coordination for WSS, 15 minutes: This code should be used for case management where the client is present and the client is enrolled in Enhanced Women's Services. (This billing code is the same, but the different description allows for tracking of services provided in EWS programming.)
- **When the Client is not Present: H0060**
  - H0006 - Case Management without client present, 15 min: This code should be used for all **non-face-to-face services** for non WSS eligible clients. May only be billed to block grant and PA2.
  - H0006.HD - Case Management without client present, 15 min: This code should be used for all **non-face-to-face services** for WSS eligible clients. May only be billed to block grant and PA2.
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VI. Service Requirements

Case management services must be delivered based on an assessment and case management specific goals designed to address the needs identified in the assessment.

CMS may be provided to a client as a supplement to other services at any level of care or they may be provided as a stand-alone service by providers possessing licensure for provision of case management.

When the client is receiving case management services as a supplement to standard treatment services the case management service plan must be coordinated with the client's individualized treatment plan and the assessment that drives case management services may be distinct from the assessment completed for the development of the client's individualized treatment plan or may rely on the bio-psycho-social completed. If a separate assessment is completed in order to develop the case management service plan goals any information already collected within the bio-psycho-social assessment should not be duplicated.

When a client receives stand-alone case management services a stand-alone case management assessment and service plan for CMS may be completed.

A. Assessment

The following elements must be included in the Assessment of a client receiving case management services. If CMS will be provided as a stand-alone service an abbreviated assessment may be completed but must include these elements.

1. Identifying information: Includes reason for referral, marital status, living arrangement, emergency contacts and source of assessment information.
2. Physical health: At a minimum should include information regarding health problems and concerns, current diagnosis, medications, treatment history (mental health and/or substance abuse), sensory impairment, physician's name and address and nutritional status.
3. Activities of Daily Living: Should include information regarding the degree of personal care ability, mobility levels, household chores, personal business, amount of assistance required.
4. Social/Emotional Status: Should include information concerning intellectual functioning, behavior problems or concerns, mental impairments, and alcohol/drug abuse history.
5. Social Relationships/Support: Should describe informal caregivers (i.e. family, friends, and volunteers), formal service providers, and significant issues in relationships or social environment.

The following elements must also be included in the assessment for Women and Families Specialty and Enhanced Women's Service clients:

1. Determination of the woman and her children's primary health care needs.
2. Determination of any special needs of the client's children, including: special child assessment, education, counseling, substance abuse prevention, and support services. If a formal developmental assessment is

recommended by a physician or education specialist, the program shall assist the client and child in obtaining these services.

3. When the provider has access to the client's children they must screen children of appropriate age using the Fetal Alcohol Syndrome (FAS) Pre-screen form attached to the Fetal Alcohol Spectrum Disorders Policy, BSAAS Treatment Policy #11.

B. **Individualized Treatment Plan**

Client's receiving case management must have specific goals and objectives related to case management services in the individualized treatment plan.

In order to ensure the treatment plan adequately addresses CMS issues the following elements should be addressed:

1. Identify the assigned Case Manager and Credentials.
2. Goals: Measurable goals to be achieved, including timeframes. If the client's case management service plan is incorporated into a broader individualized treatment plan, the goals for case management must be clearly identified and specific to the client's needs.
   a. Goals should address any formal support systems formal services that will be arranged and specifying the provider.
   b. Goals should address informal Support Systems and include efforts to develop these natural supports.
   c. Goals should address unmet needs/service gaps identified in the assessment that would hinder recovery.
3. Service Provision: Indicate schedules of CMS frequency/schedule for case management activities and reassessment.

These elements may be incorporated into the Individualized Treatment plan as an Addendum if preferred.

C. **Documentation**

Activity notes indicating the following information must be in the file for each billed CMS services:

1. Date of service;
2. Beginning and end time for case management service encounter;
3. Nature and extent of case management service provided including name of agency and/or person being contacted if applicable and place of service if located outside of the provider office setting.
4. Signature and credential of case manager

VII. **Training and Supervision**

Individuals do not require certification to provide case management services but are

required to be supervised by MCBAP certified staff. All other staff training requirements and vetting procedures as detailed within the Provider Manual apply.

Additional training should ensure that individuals working and providing case management possess knowledge and expertise in the following areas:

- Fundamentals of Addiction and Recovery
- Ethics
- Community Resources
- Confidentiality
- Motivational Interviewing
- Individualized Treatment and Recovery Planning
- Personal Safety, including home visitor training
- Advocacy, including working effectively with the legal system
- Maintaining Appropriate Relationships and Boundaries
- Trauma and Trauma Informed Services

If the trainings are not completed within one year, the case manager is not be eligible to continue until the requirements are met. Until training is completed, the case manager must be supervised by an individual who meets the requirements working within the program.

VIII. Specialized Case Management Services

a. Drug Treatment/Sobriety Court

The LRP supports the concept of drug treatment courts and the importance of the participant's substance use disorder treatment provider attending the drug court team meeting process. The LRP considers the on-going drug court team meetings as case management encounters and providers may submit for reimbursement at the current case management rate.

Documentation within the client file should indicate that drug treatment/sobriety court team meeting as the nature of the case management service provided.

Providers are encouraged to have designated therapists work with drug court clients so that multiple therapists are not required to attend team meetings. If a therapist attends a drug court meeting representing multiple clients the units must be divided and billed equally for each client. For example, if the meeting is 2 hours long (8 -15 minute units) and the therapist is representing four (4) clients, a total of two (2) units would be billed for each of the clients.

If the units divided by the number of clients does not divide equally, the remainder of the units should be applied to the client for whom the most amount of preparation was required.

b. Designated Entry Providers

In an effort to improve engagement and retention the LRP places great value upon coordination of care when multiple providers serve a client across the Levels of Care. In support of this coordination a client may be admitted for stand-alone case management services at the Designated Entry Provider when referring the client to a residential program.

Initial goals and objectives for case management within this situation would address the following elements:

i. The client successfully accessing and completing residential services;

ii. Ensuring a successful transition from detox and short-term residential to long term residential, when applicable;

iii. To engage the client in outpatient services following discharge from residential services within 5 days of discharge; and

iv. To coordinate care with the residential provider so that outpatient services may build upon the residential services received.

While the client is admitted to residential services the CMHSP will waive the requirement of face-to-face contact with the client at a minimum of every 30 days. However, CMS activity should be documented at a minimum of every 30 days, but may not be face-to-face.

c. **Women and Families Specialty Services Case Management**

Designated and Gender-competent Women's Specialty providers are required as part of the Federal Substance Abuse Prevention and Treatment block grant, to 1) provide or arrange for primary medical care for women, including prenatal care, and child care while women are receiving such services; 2) provide or arrange for primary pediatric care and immunizations for the children of women in treatment; and 3) provide sufficient transportation to ensure that women and their dependent children have access to the previously mentioned services.

These service requirements must be met in order to qualify as a WSS provider. They do not however, meet the expectations that have been established for case management services as defined in the administrative rules. The services under the women's specialty requirements are considered care coordination but can be provided as part of a case management program.

Therefore, a WSS provider seeking to provide case management as a component of their WSS programming must meet all requirements for case management in addition to these minimum WSS qualifications.

In addition to Case Management Services requirements, a provider billing Case Management under WSS funding must meet the following requirements:

1. Follow the guidelines as established in the following:
    a. MDCH/BSAAS Women's Treatment Policy (BSAAS Treatment Policy #12,
    b. MDCH/BSAAS Enhanced Women's Services Treatment Technical Advisory #08; and
    c. Women and Families Specialty Services Guidance Document
2. The case management service plan must be coordinated with extended family and other providers in the client's life. Services should link and

refer clients to appropriate community services for both the client and their dependent children as needed.

3. Assist the clients with childcare needs during services.
4. Refer clients to special child assessment, education, counseling, substance abuse prevention, and support services which address the special needs of children whose parent(s) are addicted to alcohol and/or other drugs.
5. Ensure client’s child care needs are met during the time the child's mother is in formal treatment sessions and related therapeutic activities where the child's presence is not appropriate or would be negatively distracting to the client and others.
6. Provide transportation assistance, including empowering clients to access local transportation and finding permanent solutions to transportation challenges.

   Assistance should address transportation to and from substance abuse treatment sessions, transfers between treatment providers, activities directly related to the program, and to and from medical appointments and other services to which the woman or her child has been referred by the program and/or which are necessary for the woman's continued participation and progress in treatment.
7. Staff providing CMS as part of a WSS program must meet qualifications as defined in the Enhanced Women’s Services Treatment Technical Advisory #08.

d. **Enhanced Women’s Services (EWS)**

Enhanced Women’s Services is a model that uses a three-pronged approach to target the areas where women have problems that directly impact the likelihood of future alcohol or drug exposed births:

1. To eliminate or reduce the use of alcohol or drugs. Individuals who are involved with EWS are connected with the full continuum of substance use disorder services to help the woman and her children with substance use and abuse.

2. To promote the effective use of contraceptive methods. If a woman is in control of when she becomes pregnant, there is a higher likelihood that the birth will be alcohol and drug-free. Referrals for family planning, connecting with a primary care physician, and appropriate use of family planning methods are all considered interventions for this aspect of programming.

3. To teach the woman how to effectively use community-based service providers, including accessing primary and behavioral health care. The peer advocate teaches women how to look for resources and get through the formalities of agencies in order to access needed services, and how to effectively use the services

Case Management services provided as a part of Enhanced Women's Services must meet all case management requirements as well as the additional requirements detailed for WSS Case Management. In addition EWS case management services must also meet the following requirements:

1. Follow the guidelines as established in the Enhanced Women's Services Treatment Technical Advisory #08); and
2. Allow services to operate as a home/community-based service rather than in an office setting.
3. Advocates who provide EWS must be peers, to the extent that they are also mothers and may have experienced similar circumstances as their potential clients. They do not need to have a substance use disorder (SUD), or be in recovery from a SUD.
4. Provide a client with consistent contact for not less than 18 months and for not more than three years.
5. Referral agreements must be established with appropriate community agencies to provide family planning options and instruction.
6. Offer transportation assistance through peer advocates, including empowering clients to access local transportation and finding permanent solutions to transportation challenges. Peer advocates' billable time for transporting clients to and from relevant appointments is allowable and encouraged.
7. Staff providing CMS as part of a EWS program must meet qualifications as defined in the Enhanced Women's Services Treatment Technical Advisory #08.