Kenosha County Dept of Human Services

MA NEWS

Volume 1, Issue 3

June 2003

Target Populations

Targeted Case management coordinates and bills services for those who are deemed Medicaid eligible. In addition to meeting the eligibility requirements, MA recipients must also belong to at least one of the following target populations:

MA Eligibility + Target Population = MA Billable

Target Population	Billing Code	Age Limitation
Families w/ Children at-risk **("AT-RISK")**	88A	Under 21
Birth to Three	03A	0 – 36 months
Developmental Disability **(DD)**	01A	None
Chronically Mental Ill (**MI)**	31A	Over 21
Alcohol or Other Drug Abuse **(AODA)**	18A	None
Severely Emotionally Disturbed (**SED)**	64A	Under 21

Although there is no age limit for "AODA", if the individual is under 21, he or she would probably be under the "at-risk" target group. A Child who has MI will also qualify under the "at-risk" target group. Definitions of the above target populations can be found on page 2.

Billed Assessment / POC Time

An assessment is the first component of case management that deals with evaluating a client/ family's strengths and needs. "Case managers may complete some components of the comprehensive assessment as part of a determination that a recipient meets any target populations' eligibility criteria. Bill the time for completing this as part of the case management assessment when the person is found eligible for case management. If the recipient is found not eligible for case management in any of the target populations, WI Medicaid will NOT cover the assessment." (Case Management Handbook Page 10 of the "Covered & Non-covered Services" Section). If, however, the person evaluated meets the eligibility criteria but refuses to participate in further case management activities after completion of an assessment or the plan of care, the time spent on the assessment or the plan of care can be billed to Medicaid. Please ensure that the "refusal" is documented in case notes.

Please note that even though WI Medicaid allows more than one individual to complete the comprehensive assessment and to prepare the case plan, the time billed to MA should only be for those individuals that the agency incurred a cost. For example, if county employees, psychiatrists and **other** agency employees were involved in gathering information for assessment or the POC, his/her time is not billable under your agency, unless those involved are also on your payroll.

Inside this issue:

Target Population Definitions (Pages 53-54 Case Mgmt Handbook "Covered & Non-Covered Section")

AT– RISK

Families with children at risk of physical, mental or emotional dysfunction. This is comprised of five subgroups:

1. **A child with special health care needs**

a. Congenital conditions (e.g., cerebral palsy, spina bifida, congenital heart disease)
b. Acquired illness or injuries (e.g., spinal cord injury, itracranial injury)
c. Behavioral health conditions (e.g., substance abuse, attention deficit disorder)
d. Chronic health conditions (e.g., seizure disorders, juvenile diabetes)
e. Physical or sensory disorders (e.g., sensorineural hearing loss)

2. **A child who is at risk of maltreatment" by the primary caregiver(s)**

The county agency responsible for CPS services documents a finding that abuse or neglect has or is likely to occur. The file must contain the following assessment (a copy of the court disposition will suffice)

a. The manner in which caregiver(s) parent the child
b The child's current level of daily functioning
c The caregiver(s) level of functioning, including mental health functioning
d. The family's functioning, ability to cope with current stressors and the resources available to help the family cope
e The risk of maltreatment to other children in the family
f. Past allegations of maltreatment

3. **Child involved in the juvenile justice system**

a. The youth has been referred to juvenile court intake because he/she is either alleged or adjudicated delinquent
b. The youth is an alleged or adjudicated child in need of protection or services (CHIPS)

4. **Families where the primary care giver has a mental illness, developmental disability or substance abuse disorder**

The **caregiver** has a diagnosis of a developmental disability, alcohol or other drug abuse or dependence, or mental illness. **A qualified professional must make the diagnosis.** In addition to this diagnosis, the case management agency documents that as a result of the disability, the child's physical or emotional development or ability to engage in usual activities is restricted.

5. **Families where the mother required prenatal care coordination (PNCC) services**

a. Evidence that the mother was involved in a Medicaid Prenatal Care Coordination (PNCC) program **or**
b. A completed Medicaid PNCC risk assessment showing that the mother was at risk for an adverse pregnancy outcome (even though the woman may not have participated in the PNCC program)

BIRTH TO THREE

A child is eligible for Birth to 3 services if the child has been evaluated by the Early Intervention team and found to have a delay of at least 25% in one developmental area, or the child has a diagnosed condition known to cause developmental delays, or the EI team determines that the child's development is atypical from that of same age peers.

DEVELOPMENTAL DISABILITY

A disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome , mental retardation or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. DD does not include senility, caused by aging or the infirmities of aging.

CHRONIC MENTAL ILLNESS

Causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life. An inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration. Includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories. Does not include infirmities of aging, primary diagnosis of mental retardation or of alcohol or drug dependence. A qualified professional **must** make the diagnosis.

AODA

Using one or more drugs that the person's health is substantially impaired or his/her social or economic functioning is substantially disrupted. A qualified professional **must** make the diagnosis.

SED

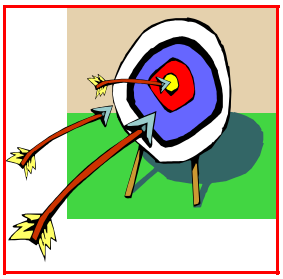
Emotional or behavioral problems that are severe in degree, expected to persist for at least 1 year, substantially interfere with functioning in his or her family, school or community and with his or her ability to cope with the ordinary demands of life and cause the individual to need services from 2 or more agencies or organizations that provide social services or treatment for mental health, juvenile justice, child welfare, special education or health. One of the following must be true:

a. A 3 person team of mental health experts (one must be a psychiatrist or psychologist) appointed by the provider must find that the child is SED. The finding and activities leading to the determination are not covered as part of MA case management services. Case mangers must document & retain these findings in the client's clinical record.

b. The recipient meets the requirements under 46.56, Wis. Stats, making him/her eligible for admission to an Integrated Services Project as a child with Severe emotional and behavioral problems.

Identifying a target population: Consider the following after reviewing the referral:

Who is the client being referred? Why was the client referred to your agency?
What services do the client/family need? What is the age of the client?
What needs are listed on the referral form? What services can your agency provide?
What services need to be outsourced?



An illustration: 21 Year old "Samantha" is referred to agency "B" for "parenting skills". Samantha's 1 yr old son has developmental delays and is enrolled in the Birth to Three program. Can Agency "B" bill the child under "at-risk" for providing "parenting skills" to the mother? Let's take a look by answering the above questions. Who is the client being referred? A: Samantha Why was the client referred? A: Parenting Skills
What needs are listed on the referral? A: Education What is the age of the client? A: 21
By answering just a few of the questions outlined, we can see that the "client" agency "B' will be serving is the mother and she doesn't fit any case management target populations. Not eligible = Not billable
The Birth to Three program, however, can bill for the child under the "birth to three" target population.

Discharge Planning?

Discharge Planning is intended only for a client who gets released from an institution.

When a recipient has been institutionalized and is WITHIN 30 days of being released into the community, the case manager can begin developing a discharge plan for the recipient. Working to transition the recipient back into the community is what the discharge plan is all about.

The Discharge plan is similar to the plan of care - it's a process of figuring out what the client/family needs and it's the actual coordination of community services in order to meet that need. When the institution notifies the case management agency that the client is ready to be discharged, the case manager should set time up to meet with the personnel involved with the client while he/she is at the institution. Discharge planning should start from here on. Examples of "discharge planning" include but not limited to:

- Meeting with the institution and identifying the services the client will need to function in the community
- Meeting with client/family to identify the needs the family may have to make this transition a success
- Reviewing the plan with all affected parties / Writing up the plan
- Coordination of needed services with service providers in the community

Everything the client needs to remain in the community is discussed and documented in this phase.

The following examples illustrate what shouldn't be billed to MA under "Discharge Planning": (Not meant to be all-inclusive)

- Time spent on calling the institution for status updates
- Calling the client's mom and discussing her worries
- Calling to advise the school that client will not be returning this week / Canceling community service hours

These functions all fall under ongoing service coordination. All ongoing monitoring on behalf of client while the client is in the institution is **NOT billable to MA**. Medicaid recognizes the institution as the sole provider for all needed case management services while the client is in its care. So, for that reason, MA cannot be billed while a client is in the hospital, nursing facility, etc. This doesn't mean that the case manager shouldn't stay involved – The case manager should keep up with the case, but the time should NOT be billed to MA.

Case Management Q & A

Q: What does Medicaid say about the frequency of ongoing monitoring and service coordination?
A: (MA Handbook – Section on "Covered and Non-Covered Services" – Page 20)

"As part of the case planning process, the case manager must discuss and document the frequency of ongoing monitoring with the recipient/guardian. This must include an indication of the frequency of contact with all of the following:

- Recipient
- Parents/guardians
- Collaterals, if applicable.

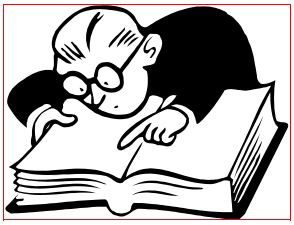
The case manager must note the rationale for the frequency of monitoring in the recipient's record if the frequency of monitoring is less than the following:

- A face-to-face recipient/family/guardian contact every three months
- A face-to-face OR telephone contact with the recipient/family/guardian or a face-to-face, telephone or written contact with collateral contact every month."

What this means is that the case manager should be doing something with the case (either directly with the recipient or on behalf of the recipient) **every** month. At least every three months, the case manager **should** include a face-to-face visit with the recipient. The "3 month contact" (as referenced above) **must be** with the recipient. However, since not all recipients are able to **"represent"** themselves, for example, a child, an individual who is cognitively delayed, etc., MA has included contacts with family and guardian. Typically, "family" means parents, but if an aunt, a cousin, an adult child, or another individual is the **"representative,"** then contact with that family member would meet the "three month face to face" requirement . The role of the family member should be defined and documented in the recipient's records. The important thing is to discuss the frequency of contacts with the recipient (or the person who speaks on behalf of the recipient) and make sure to document the determined frequency.

NEW WI MEDICAID CASE MANAGEMENT HANDBOOK

The Division of Healthcare Financing has released its updated case management handbook. Copies of the handbook were sent out in April to all contracted case management providers. You may obtain your own copy at the following Medicaid website: http://www.dhfs.state.wi.us/Medicaid2/handbooks/case_management/pdf_frame.htm
The handbook is divided into the following self-contained sections to lessen the amount of cross-referencing necessary: "General Information", "Covered & Non-Covered Services" and "Billing" A summary review of this handbook will be given at our next MA Roundtable. More information on the Roundtable



Our 3rd MA Roundtable will be held in the Room for Success at the Kenosha County Job Center - 8600 Sheridan Road

MA Roundtable Scheduled!

June 4, 2003 2:00 - 3:30 P.M

If you haven't yet done so, please RSVP to Mini Samuel with all attendees from your organization by May 23rd.
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