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CHAPTER IV
COVERED SERVICES AND LIMITATIONS

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CHAPTER IV COVERED SERVICES AND LIMITATIONS

DEFINITION OF CASE MANAGEMENT SERVICES

Case management services are an integral component of the service delivery system for elderly and persons with disabilities. Virginia offers case management services to enable the assessment, coordination, and monitoring of the needs of the elderly. Case management enables more efficient and effective delivery of direct services such as personal care, chore, companion, home-delivered meals, adult day health care, and respite care which assist to avoid more cost institutional care.

Eligibility for Case Management Services

- Are age 60 and over; and

Are screened through one of the Case Management agencies and found dependent in two or more of the following activities of daily living: bathing, dressing, eating, toileting or continence;

Reside in one of the following service areas:

Area 1: Fairfax County, Fairfax City and Falls Church;

Area 2: Lee, Scott, Wise, Russell, Buchanan, Dickenson, Tazewell, Smyth, Wythe, Bland, Carroll, Grayson, Montgomery, Floyd, Pulaski, Giles Counties and Radford and Galax Cities.

Area 3: Rappahannock, Lancaster, Northumberland, Richmond, Westmoreland, Essex, Gloucester, King William, Mathews, Middlesex, Isle of Wight, Southampton, Accomac, Northampton Counties and Norfolk, Virginia Beach, Portsmouth, Chesapeake, Franklin, Suffolk, Newport News, Williamsburg and Hampton Cities; and

Each recipient must have a clearly documented unmet need that requires case management or coordination of services in order for them to continue to reside safely in the community.

An identified need for case management services is defined as:

- The individual requires coordination of multiple services and does not currently have support available to assist with identifying, accessing and coordinating of these services, and a referral to a formal or informal support system will not meet the individual's needs; or

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- An unmet need exists in one of the following areas: physical environment, support system, financial support, emotional health or physical health and must be addressed to ensure the individual's health and welfare.

CASE MANAGEMENT PROVIDER RESPONSIBILITY

Each recipient referred for case management services must be assessed by an agency participating in the Elderly Case Management Program which has a current DMAS provider agreement. The agency must also:

- Employ case managers who meet DMAS qualifications;
- Serve individuals who are Medicaid eligible;
- Be located in one of the service areas; and
- Authorize case management services and refer those individuals to appropriate case management provider agencies.

CASE MANAGER RESPONSIBILITIES AND AUTHORIZATION PROCESS

Once an assessment is completed and the recipient is found to qualify for case management services, the four-page Uniform Assessment Instrument (UAI) is forwarded to the Case Management provider chosen by the recipient. If more than one provider is available in the locality where the recipient resides, he or she must be provided/assisted with freedom of choice of participating providers. A case manager must be assigned to:

- Develop a plan of care that specifies the resources, referrals, and activities the case manager will use to meet the identified needs documented on the UAI. Specify the time frame for each activity and the expected length of stay in case management services;
- Verify the individual's status as a Medicaid eligible recipient. Providers may also contact the Audio Response System at the toll free number 1-800-884-9730;

Providers access the Audio Response System using their Virginia Medicaid provider numbers as identification.;

- Send a copy, if requested, of the plan of care and the first four pages of the UAI to DMAS prior-authorization contractor for enrollment. Initial Medicaid-funded Elderly Case Management service authorizations may be enrolled for a maximum of six (6) months;
- Maintain a recipient record including the assessment instrument, plan of care, daily log, and progress report; and

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- Terminate services upon completion of the activities on the plan of care, or request an extension if there is an identified need for additional case management services beyond the authorization period.

Any time the provider is not able to render care to a recipient, the case manager must transfer services to another provider if one is available within the specified geographical area.

A Medicaid eligible individual residing in a nursing facility within the service areas may be authorized to receive case management services for a maximum period of 30 days prior to discharge. Upon discharge, the individual must reside within the approved service area to continue to receive case management. Services rendered more than 30 days prior to discharge will not be reimbursed by DMAS. The activities of the case manager may not duplicate those which are the responsibility of the nursing facility discharge planner.

The case manager is the individual designated by the case management provider as responsible for developing the initial plan of care, conducting the re-evaluation, and reviewing the individual's plan of care.

COVERED SERVICES

Case management services will be reimbursed only for those contacts made directly by the case manager.

The case manager may provide any assessment, coordination, monitoring, or referral services necessary as a part of managing the recipient's care in the community. This activity must be documented in the monthly log maintained by the agency and must, upon review by DMAS staff, be deemed necessary with high-quality care assurance.

Typical case management activities which are reimbursable by DMAS include, but are not limited to:

- An initial assessment visit with the recipient in the recipient's residence during which the plan of care is developed;
- Contacts with the direct service providers for the purposes of referral for service, monitoring of current service delivery, problem solving and technical assistance, changes to the case management plan of care, etc.;
- Contacts with the recipient, friends, family, physician, and other professionals involved in the recipient's care for the purposes of assessment, coordination, and monitoring;
- Occasional revisions to the case management plan of care; and
- Subsequent re-evaluations conducted with the recipient and case management team during which the UAI, and case management plan of care if necessary, are updated.

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Case management services are not appropriate if the only service needed is to manage routine medical appointments or to wait for nursing facility placement after preadmission screening and other arrangements have been made.

FORMS REQUIRED FOR ENROLLMENT IN THE ELDERLY CASE MANAGEMENT PROGRAM

The case management agency which is initiating a referral will send the case management provider a copy of the UAI, (pages 1-4), and a letter of referral indicating that the individual is eligible for the case management program, and the Medicaid identification number. The case management provider will complete a Plan of Care. The provider will submit need information to the DMAS Prior Authorization contractor .to receive a prior-authorization for the services.

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The provider will receive notification from the VaMMIS system of recipient enrollment in or denial to the program.

CASE RECORD DOCUMENTATION REQUIREMENTS

Upon the receipt of a referral and the four-page UAI, the case management provider will contact the recipient and initiate the Plan of Care. The case manager will begin documentation on a monthly log by recording the first contacts with the recipient, to develop the Plan of Care, and with direct service providers, to refer the recipient for needed services and to monitor service implementation. The case manager must record a summary of the first 30 days of service delivery to the recipient on the progress report. Every 30 days thereafter, the case manager must record a summary of the recipient's status and the status of his or her service delivery system in the recipient progress report. The use of the Elderly Case Management monthly log and recipient progress report are not mandatory. However, the case management provider must record in a format which allows review by state and federal review staff and includes all of the required information (as stated in Chapter VI) when the DMAS form is not used.

CASE MANAGEMENT PLAN OF CARE

The case manager is responsible for developing the Case Management Plan of Care prior to initiation of any services. The following information should be documented:

- Problems identified on the UAI and the services to be implemented including in detail the specific activities, resources, and referrals that will be used to meet the needs of the recipient;
- The expected time frame needed for completion of each activity and the expected length of stay in case management services not to exceed 6-months;
- The start of care date, the recipient's name, Medicaid number, the recipient's signature, and the date must be on the form; and
- The case management provider's name and provider number, the signature of the case manager, and the date.

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The Case Management Plan of Care and the four-page UAI must be completed and retained by the provider, any bill submitted for reimbursement prior to the receipt of these documents and the enrollment of the recipient will not be paid.

CASE MANAGEMENT AGENCY MONITORING OF RECIPIENT SERVICES

The case management agency is responsible for monitoring the ongoing provision of services to each Medicaid elderly case management recipient. This monitoring includes:

- The adequacy of the service to meet the recipient's needs;
- The functional and medical needs of the individual and any modification necessary to the Plan of Care due to a change in these needs; and
- The individual's need for additional services that is not available in the community, which includes an overall assessment of the individual's health, safety and welfare in the home.

The case management provider agency is responsible for taking the appropriate action to assure adequate, and timely service to case management recipients who are elderly. Appropriate actions may include: discussions with direct service providers regarding the services to be provided to the recipient and discussions with the recipient and his or her family about the need for additional services.

REAUTHORIZATION

Case management services may not continue for more than the authorized time frame without approval from the prior-authorization contractor... The case manager may request reauthorization of case management services. The request for a reauthorization for additional services must be submitted to the prior-authorization contractor prior to the end of the current authorization period.

The request must include:

- A summary of the case management services to-date and the reason that case management services continue to be required to safely maintain the individual in the community;
- A copy of the most recent Plan of Care; and
- An estimate of the additional length of time that case management services will be needed.

TERMINATION

Once a recipient is determined to no longer require Elderly Case Management services, the case manager shall terminate services. The case manager must complete a Case Management Outcome Report, and submit a copy to the prior-authorization contractor who will end the prior-authorization providing the recipient appeal rights via a letter.

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RIGHT OF APPEAL

Individuals must be informed in writing of actions taken that affect their receipt of services. Any adverse action may be appealed. Adverse actions include denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed.

If an appeal is filed before the effective date of the action, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the client will be expected to repay DMAS for all services received during the appeal period. For this reason, the client may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable.

Appeals must be requested in writing within 30 days of receipt of the notice of adverse action. The client or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at the local department of social services or by calling (804-371-8488).

A copy of the notice or letter about the action should be included with the appeal request.

The appeal request must be signed and mailed to the:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
Appeal request may also be faxed to:
(804) 371-8491