

**CASE  
MANAGEMENT  
SERVICES  
PROCEDURES**



## CASE MANAGEMENT SERVICES PROCEDURES

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## CASE MANAGEMENT SERVICES PROCEDURES

*(Providers need not be licensed by the Michigan Department of Community Health  
Substance Abuse Licensing Section as a Substance Abuse Program with a*

*Service Description of CASE MANAGEMENT in order to perform case management as described below)*

### PHILOSOPHY

Many times, the client is not able to focus on his/her recovery in treatment until case management intervention is used to address the client’s specific needs first. Case Management is an effective intervention that allows the client’s needs to be taken care of immediately and, once specific needs are addressed, allows for a better therapeutic atmosphere whereby the client may concentrate on recovery without the extra worry of specific needs.

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## **I. FIXED UNIT RATE REIMBURSEMENT CASE MANAGEMENT**

*(For the following providers: AARC, Clearview, NCA/LRS, NCA/Glass House, NCA/Holden House, HOC, Insight, Kairos, VC/III, VC/Lansing)*

### **A. EXPECTATIONS**

1. All clients receive a bio-psychosocial assessment. If, during the assessment, it is determined a client needs case management, a separate case management needs plan form is completed. An example of a case management needs plan form is located on the Mid-South web site under Policy tab. Providers may develop their own case management needs plan form as long as it contains the following areas:
 

a. Mental health	g. Legal
b. Dental health	h. Social Services
c. Financial assistance	i. Other services and supports
d. Housing	(i.e. transportation, specialized counseling not provided on site)
e. Employment	
f. Education	
  
2. The Case Management Needs Plan must meet the following guidelines:
  - a. It must be in a written format (electronic is accepted).
  - b. It must be kept in the client’s file; and
  - c. It must be incorporated into the client’s treatment plan(s).
  
3. An Activity Log Sheet may be used to record less significant case management activities such as phone calls, email contacts, leaving messages, etc., rather than using a formal case management progress note. The less significant case management activities are not entered into CareNet.
  
4. The formal case management progress note is for such activities as face-to-face and non-face-to-face contacts 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 (ODCP Policy #08. Substance Abuse Case Management Program Requirements, January 1, 2008, p. 1).* It is not to be used for e-mailing clients, calling a client for no-showing, listening to a voice-mail message from a client, completing a monthly report to a social worker, etc.

5. The core elements of case management include assessing for specific needs, planning, linking, coordinating, following up, monitoring, and connecting the client to community resources.
6. Case management services will be guided by the client's Treatment Plan(s) and Treatment Plan Review(s) which will incorporate case management goals and outcomes with targeted achievement dates and are consistent with the rest of the client's individualized, coordinated, and comprehensive treatment plan of service.
7. The frequency of case management encounters is to be determined by the individualized needs of the client based on the results of a needs assessment. **At a minimum, one (1) encounter per month is to be face-to-face** with the client.
8. Case management services may be utilized prior to treatment, during treatment, and may continue up to six (6) months post discharge from episodic SUD treatment services, as long as there is justification for case management services.
9. Services are provided in a responsive, coordinated, effective, and efficient manner that is written into the client's treatment plan(s) and treatment plan review(s) with planned target dates of achievement.
10. The case management services provided are to be documented within the client's file either in an activity log sheet or appropriate progress notes, depending on the significance of the activity.
11. Case management progress notes are to reflect progress made toward case management goals and objectives.

#### **B. CASE MANAGEMENT SCENARIOS**

1. There are a variety of scenarios whereby a client receives case management services.
  - a. A screening determines the client is not appropriate to receive treatment services at the provider who performed the screening and the client needs to be referred to another provider. The case management services provided to refer the client to the appropriate provider are documented within the client's file in a progress note or in an activity log sheet. Nothing is entered on the CareNet system.
  - b. An assessment determines the client is not appropriate to receive treatment services at the provider who performed the assessment and the client is referred to another provider due to need for appropriate level of care. The case management services provided to refer the client to the appropriate provider are to be documented in the CareNet system. In the order of sequence for CareNet entry, the SARF, the Admission Form (using the case management service category), the Initial Authorization Request (will need to be requested before the Discharge page is entered on CareNet), and the Discharge page (using the case management service category).
  - c. If case management is provided before the first treatment encounter, the case management activity must be face-to-face in order to be used as the CareNet Treatment Admission Date. All case management activities provided before the first case management face-to-face encounter are to be documented within the client's file in an activity log sheet or appropriate progress notes and not on CareNet.
  - d. Transfer during or after treatment. If it is determined the client needs to transfer to a higher/lower level of care, it may be necessary to provide case management services when transferring the client to a higher/lower level of care. When case management services occur when transferring the client to the next level of care provider, the appropriate case management services provided are to be documented in the CareNet system. The discharge date would reflect the last case management encounter. Reminder: the minimum requirement of one (1) encounter per month is to be face-to-face.

#### **C. AUTHORIZATIONS**

1. Authorizations for case management services are to be requested by the treatment provider either at the time of the initial authorization or at any time during the treatment episode, if the need for such services arises.

2. *The clinician/case manager is to complete a **Case Management Needs Plan** to substantiate the need for case management services. The clinician is to indicate the reasons why case management is being requested in the comment section of the **Request for Initial Authorization** on the CareNet system and identify how many encounters are requested.*
3. The Care Coordination Center will review the comments in the comment section of the Request for Initial Authorization to authorize the level of care and case management encounters for those Initial Authorization requests not meeting criteria for auto authorization.
4. Case management will be authorized as an **encounter**. An encounter is **defined** as any case management activity that is **a minimum of twenty (20) minutes in duration**. Case management services are to be authorized under **CPT H0006** (with a modifier when appropriate).
5. **Minimum**  
The encounter minimum of twenty (20) minutes is counted as: at least twenty (20) minutes of continuous activity, for example: a phone call that lasts twenty minutes, a face-to-face session lasting sixty (60) minutes, a wraparound session lasting four hours, etc. The minimum is not counted as an accumulation of less time to equal twenty minutes. Documentation of each encounter is to be in the client's file as stated above. This documentation will be reviewed during the annual Claims/Billing site review.
6. Billable services would include, but are not limited to, face-to-face contact with the client, telephone contact with the client of a minimum of 20 minute duration, wrap-around meetings, and collateral family contact of a minimum of 20 minute duration (collateral family contact is defined as any contact that are not direct treatment services), collateral professional contact of a minimum of 20 minute duration, in-home visits, transportation, and referrals to other needed services.
7. If a Request for Re-Authorization of Services is needed for case management, progress regarding the case management issues must be indicated on the re-authorization request. The case management activities are to be incorporated into the Treatment Plan and updated as the Treatment Plan is reviewed.
8. **Maximum**  
There is a maximum of two (2) Case Management encounters per day. For example, if the case manager has phone contact regarding a client for at least 20 minutes or more in the morning and sees the client face-to-face for at least 20 minutes or more in the afternoon, that can be counted as two (2) encounters. It is to be documented in the client file as two (2) separate encounters.

#### **D. DISCHARGE**

1. **Completed Treatment without Continuing Case Management**  
If a client was admitted on CareNet into outpatient treatment services, received both outpatient treatment services and case management services, and completed treatment with *no continuation of case management services*, the client is discharged from outpatient services on CareNet. The discharge date would reflect the last treatment or case management service provided to the client.
2. **Completed Treatment and Continuing Case Management**  
Once a client completes episodic SUD treatment and is in need of case management services to be delivered by the same provider, the client will not be discharged from treatment on CareNet until completion of case management services for up to six (6) months post episodic SUD treatment. Upon completion of case management services, rather than using the last episodic SUD treatment encounter for the discharge date, the last case management service encounter post episodic SUD treatment will be the discharge date. Reminder: the minimum requirement of one (1) encounter per month is to be face-to-face.

3. **Unplanned Discharges**

Not all discharges are planned. Clients may no show, cancel, or disappear. During this time, the provider may perform case management activities to locate the client and try to re-engage for return to treatment. At some point, prior to the 45-day mark, the decision to discharge the client is to be made. At that time, the **last date of contact** for discharge will be the **last date of case management activity rather than the last date of face-to-face contact**.

**E. DOCUMENTATION IN CLIENT’S FILE**

1. The client’s file must contain documentation of the case management plan and either case management activity notes or case management progress notes indicating the following information:
  - a. Date of contact and/or service.
  - b. Duration of case management contact/services.
  - c. Name of agency and/or person being contacted.
  - d. Nature of case management services requested and extent of services requested and/or nature of case management services provided and extent of services provided.
  - e. Place of service and/or referral.
  - f. Case management activity reflected in goals and objectives in the treatment plan during active episodic SUD treatment.
  - g. Case management activity log located in the client’s file, if used.
  - h. Case management notes reflect progress made toward case management goals and objectives.

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**II. WOMEN/FAMILIES’ SPECIALTY SERVICES CASE MANAGEMENT**

*(In addition to Section I above, (Information in this section is applicable to the following providers: Arbor Circle, ASCC, FSCA/Born Free, Cristo Rey, Eaton Behavioral Health (ESAP), FSCA/Lenawee, ICSAI/ICHHD, MVA/Hillsdale, and MVA/Lenawee)*

**A. ELIGIBILITY**

Pregnant women, post-partum women, women with dependent children, and for women whose children have been removed from the home or are at risk of being removed, because of substance abuse, according to the Protective Services Laws of Michigan. In addition to women, men who are the sole caretakers of dependent children may be eligible for these services.

**B. EXPECTATIONS**

1. All women who qualify for Women and Families Specialty Services will at least be assessed for case management needs beyond transportation and/or child care.
2. Case management services must be provided at least once per month face-to-face.
3. Each of the dependent children residing with the client must have a children’s needs assessment completed for each child and this must be kept within the client’s file.

**C. FIVE FEDERAL REQUIREMENTS**

Providers are either to provide or arrange to meet the **five federal requirements** as follows:

1. Primary **medical** care for women who are receiving substance use disorder treatment.
2. Primary **pediatric** care for their children including immunizations.
3. **Gender specific** substance use disorder treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting.

4. **Child care** while the women are receiving these services, therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect.
5. Sufficient **case management and transportation** services to ensure that women and children have access to the services provided in the first four requirements.

#### **D. LEVEL OF CARE**

Women and Families' specialty services are available at all levels of care and substance use disorder (SUD) treatment is to be gender specific.

#### **E. GENDER COMPETENT TREATMENT**

##### **1. Definition**

- a. Capacity to identify where the difference on the basis of gender is significant, to provide services that appropriately address gender differences, and enhance positive outcomes for the population.
- b. Gender competence may be a characteristic of anything from individual knowledge and skills, to teaching, learning and practice environments, literature, and policy. Wherever present, gender competence promotes equality in treatment and outcomes for men and women. Those treatment programs engaged in the practice of gender competence will be providing specialized programming. Focused not only on substance use disorder, but also, for example, on trauma, relationships, self-esteem, and parenting. Staff serving this population should have training in women's issues relating to the previously mentioned programming areas, as well as HIV/STDs, family dynamics, and potentially child welfare.
- c. The treatment plan(s)/treatment plan review(s) must include women specific goals and objectives with targeted achievement dates.

#### **F. ANCILLARY SERVICES**

1. Ancillary services must be provided to clients and be available throughout the entire fiscal year.
2. The mandated services for Women & Families Case Management are as follows:
  - a. Childcare
  - b. Transportation
  - c. Primary health/physicals for the woman and/or her children.
3. The expectation regarding primary health/physicals for the client and her children is for the women's case manager to facilitate access to appropriate services. For most women, either her Medicaid or local health department funds should cover most of this cost. If you have a woman who cannot access any other resources to pay for her physical, ancillary service funds of up to \$90.00 may be used.
4. If a child does not have Medicaid, other insurance and/or is not eligible for MICHild funds, ancillary service funds of up to \$70.00 may be used.
5. Drug Testing/Screening is to be a limited allowable service for reimbursement within the following guidelines:
  - a. It will be limited in use, as not all women funded for case management will be automatically drug tested and ancillary service funds may be utilized only when all other sources of payment have been exhausted, i.e., courts, probation, DHS, Child Welfare, etc.
  - b. Supporting documentation for the ancillary services is to be kept on site in the client file, available for review during the annual financial and quality site review.
6. When entering the encounter into CareNet, one (1) cent will automatically display for monitoring purposes for H006 and the following HCPCS codes: A0110:HD, H0048:HD, T1009:HD, and T2003:HD. H0006:HD:

Women's Specialty Case Management services are not held to the 20 minute minimum standard for reimbursement.

7. If case management is provided before the first treatment encounter, the case management activity must be face-to-face in order to be used as the CareNet Treatment Admission Date. All case management activities provided before the first case management face-to-face encounter, are to be documented within the client's file in an activity log sheet with appropriate progress notes and not on CareNet.
8. An Activity Log Sheet may be used to record less significant case management activities such as phone calls, email contacts, leaving messages, etc., rather than using a formal case management progress note. The less significant case management activities are not entered into CareNet.
9. The formal case management progress note is for such activities as face-to-face and non-face-to-face contacts 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 (ODCP Policy #08, Substance Abuse Case Management Program Requirements, January 1, 2008, p. 1)*. It is not to be used for e-mailing clients, calling a client for no-showing, listening to a voice-mail message from a client, completing a monthly report to a social worker, etc.

#### **G. AUTHORIZATIONS**

1. Authorizations for women specialty case management services and ancillary services are to be requested by the treatment provider either at the time of the initial authorization or at any time during the treatment episode, if the need for such services arises, by using the HD modifier for all requested services.
2. The clinician/case manager is to complete a **Case Management Needs Plan** to substantiate the need for case management services. The clinician is to indicate the reasons why case management is being requested in the comment section of the **Request for Initial Authorization** on the CareNet system and identify how many encounters are requested.
3. The Care Coordination Center will review the comments in the comment section of the Request for Initial Authorization to authorize the level of care and case management encounters for those Initial Authorization requests not meeting criteria for auto authorization.
4. Case management for **women specialty clients** is **not** authorized as an **encounter** and therefore does not have to be a case management activity that is a minimum of twenty (20) minutes duration. Case management services are to be authorized under **CPT H0006** with an HD modifier.
5. If a **Request for Re-Authorization of Services** is needed for case management, progress regarding the case management issues must be indicated on the re-authorization request. The case management activities are to be incorporated into the Treatment Plan and updated as the Treatment Plan is reviewed.

#### **H. CASE MANAGEMENT SCENARIOS**

1. There are a variety of scenarios whereby a client receives case management services.
  - a. A screening determines the client is not appropriate to receive treatment services at the provider who performed the screening and the client needs to be referred to another provider. The case management services provided in order to refer the client to the appropriate provider are to be documented within the client's file in a progress note or in an activity log sheet. Nothing is entered on the CareNet system.
  - b. An assessment determines the client is not appropriate to receive treatment services at the provider who performed the assessment and the client is referred to another provider due to need for appropriate level of care. The case management services provided to refer the client to the appropriate provider are to be documented in the CareNet system. In the order of sequence for CareNet entry, the SARF, the Admission Form (using the case management service category), the Initial Authorization Request (will

need to be requested before the Discharge page is entered on CareNet), and the Discharge page (using the case management service category).

- c. If case management is provided before the first treatment encounter, the case management activity must be face-to-face in order to be used as the CareNet Treatment Admission Date. All case management activities provided before the first case management face-to-face encounter, are to be documented within the client's file in an activity log sheet or appropriate progress notes and not on CareNet.
- d. Transfer during or after treatment. If it is determined the client needs to transfer to a higher/lower level of care, it may be necessary to provide case management services when transferring the client to a higher/lower level of care. When case management services occur when transferring the client to the next level of care provider, the appropriate case management services provided are to be documented in the CareNet system. The discharge date would reflect the last case management encounter.

## **I. DISCHARGE**

### **1. Completed Treatment without Continuing Case Management**

If a client was admitted on CareNet into outpatient treatment services, received both outpatient treatment services and case management services, and completed treatment with *no continuation of case management services*, the client is discharged from outpatient services on CareNet. The discharge date would reflect the last treatment or case management service provided to the client.

### **2. Completed Treatment and Continuing Case Management**

Once a client completes episodic SUD treatment and is in need of case management services to be delivered by the same provider, the client will not be discharged from treatment on CareNet until completion of case management services for up to six (6) months post episodic SUD treatment. Upon completion of case management services, rather than using the last episodic SUD treatment encounter for the discharge date, the last case management service encounter post episodic SUD treatment will be the discharge date. Reminder: the minimum requirement of one (1) encounter per month is to be face-to-face.

### **3. Unplanned Discharges**

Not all discharges are planned. Clients may no show, cancel, or disappear. During this time, the provider may perform case management activities to locate the client and try to re-engage for return to treatment. At some point, prior to the 45-day mark, the decision to discharge the client is to be made. At that time, the **last date of contact** for discharge will be the **last date of case management activity rather than the last date of face-to-face contact**.

## **J. DOCUMENTATION IN CLIENT'S FILE**

- 1. The client's file must contain documentation of the case management plan and either case management activity notes or case management progress notes indicating the following information:
  - a. Date of contact and/or service.
  - b. Duration of case management contact/services.
  - c. Name of agency and/or person being contacted.
  - d. Nature of case management services requested and extent of services requested and/or nature of case management services provided and extent of services provided.
  - e. Place of service and/or referral.
  - f. Case management activity reflected in goals and objectives in the treatment plan during active episodic SUD treatment.
  - g. Case management activity log located in the client's file, if used.
  - h. Case management notes reflect progress made toward case management goals and objectives.

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### III. PERFORMANCE-BASED CASE MANAGEMENT SERVICES

*(In addition to Section I above, the information in Section III is applicable to the following providers: Arbor Circle, ASAS, ASCC, CCCC, CATS, C&FS, Eaton Behavioral Health (ESAP), and ICSAI/ICHD)*

#### A. EXPECTATIONS

1. All Case Management services are to be authorized by the Mid-South Care Coordination Center.
2. When entering into CareNet for reporting purposes, one (1) cent will automatically be displayed for monitoring purposes.
3. If case management is provided before the first treatment encounter, the case management activity must be face-to-face in order to be used as the CareNet Treatment Admission Date. All case management activities provided before the first case management face-to-face encounter, are to be documented within the client's file in a progress note or activity log sheet and not on CareNet.
4. Case management services under performance-based contracts are not held to the 20-minute minimum standard for reimbursement.
5. An Activity Log Sheet may be used to record less significant case management activities such as phone calls, email contacts, leaving messages, etc., rather than using a formal case management progress note. The less significant case management activities are not entered into CareNet.
6. The formal case management progress note is for such activities as face-to-face and non-face-to-face contacts 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 (ODCP Policy #08, Substance Abuse Case Management Program Requirements, January 1, 2008, p. 1)*. It is not to be used for e-mailing clients, calling a client for no-showing, listening to a voice-mail message from a client, completing a monthly report to a social worker, etc.
7. Progress notes should reflect services provided for the billed date and time and reflect progress made toward case management goals and objectives.

#### B. AUTHORIZATIONS

1. Authorizations are to be requested by the treatment provider either at the time of the initial authorization or at any time during the treatment episode, if the need for such services arises.
2. The clinician/case manager is to complete a **Case Management Needs Plan** to substantiate the need for case management services. The clinician is to indicate the reasons why case management is being requested in the comment section of the **Request for Initial Authorization** on the CareNet system and identify how many encounters are requested.
3. The Care Coordination Center will review the comments in the comment section of the Request for Initial Authorization to authorize the level of care and case management encounters for those Initial Authorization requests not meeting criteria for auto authorization.
4. Case management for **performance-based case management clients** is **not** authorized as an **encounter** and therefore does not have to be a case management activity that is a minimum of twenty (20) minutes in duration. Case management services are to be authorized under **CPT H0006**.
5. If a **Request for Re-Authorization of Services** is needed for case management, progress regarding the case management issues must be indicated on the re-authorization request. The case management activities are to be incorporated into the Treatment Plan and updated as the Treatment Plan is reviewed.

## **C. CASE MANAGEMENT SCENARIOS**

1. There are a variety of scenarios whereby a client receives case management services.
  - a. A screening determines the client is not appropriate to receive treatment services at the provider who performed the screening and the client needs to be referred to another provider. The case management services provided to refer the client to the appropriate provider are to be documented within the client's file in a progress note or in an activity log sheet. Nothing is entered on the CareNet system.
  - b. An assessment determines the client is not appropriate to receive treatment services at the provider who performed the assessment and the client is referred to another provider due to need for appropriate level of care. The case management services provided to refer the client to the appropriate provider are to be documented in the CareNet system. In the order of sequence for CareNet entry, the SARF, the Admission Form (using the case management service category), the Initial Authorization Request (will need to be requested before the Discharge page is entered on CareNet), and the Discharge page (using the case management service category).
  - c. If case management is provided before the first treatment encounter, the case management activity must be face-to-face in order to be used as the CareNet Treatment Admission Date. All case management activities provided before the first case management face-to-face encounter, are to be documented within the client's file in an activity log sheet with appropriate progress notes and not on CareNet.
  - d. Transfer during or after treatment. If it is determined the client needs to transfer to a higher/lower level of care, it may be necessary to provide case management services when transferring the client to a higher/lower level of care. When case management services occur when transferring the client to the next level of care provider, the appropriate case management services provided are to be documented in the CareNet system. The discharge date would reflect the last case management encounter.

## **D. DISCHARGE**

### **1. Completed Treatment without Continuing Case Management**

If a client was admitted on CareNet into outpatient treatment services, received both outpatient treatment services and case management services, and completed treatment with *no continuation of case management services*, the client is discharged from outpatient services on CareNet. The discharge date would reflect the last treatment or case management service provided to the client.

### **2. Completed Treatment and Continuing Case Management**

Once a client completes episodic SUD treatment and is in need of case management services to be delivered by the same provider, the client will not be discharged from treatment on CareNet until completion of case management services for up to six (6) months post episodic SUD treatment. Upon completion of case management services, rather than using the last episodic SUD treatment encounter for the discharge date, the last case management service encounter post episodic SUD treatment will be the discharge date. Reminder: the minimum requirement of one (1) encounter per month is to be face-to-face.

### **3. Unplanned Discharges**

Not all discharges are planned. Clients may no show, cancel, or disappear. During this time, the provider may perform case management activities to locate the client and try to re-engage for return to treatment. At some point, prior to the 45-day mark, the decision to discharge the client is to be made. At that time, the **last date of contact** for discharge will be the **last date of case management activity rather than the last date of face-to-face contact**.

## **E. DOCUMENTATION IN CLIENT'S FILE**

1. The client's file must contain documentation of the case management plan and either case management activity notes or case management progress notes indicating the following information:
  - a. Date of contact and/or service.
  - b. Duration of case management contact/services.
  - c. Name of agency and/or person being contacted.
  - d. Nature of case management services requested and extent of services requested and/or nature of case management services provided and extent of services provided.
  - e. Place of service and/or referral.

- f. Case management activity reflected in goals and objectives in the treatment plan during active episodic SUD treatment.
- g. Case management activity log located in the client's file, if used.
- h. Case management notes reflect progress made toward case management goals and objectives.