

DIVISION OF DISABILITY AND AGING SERVICES
INDIVIDUAL SUPPORTS UNIT
103 SO. MAIN STREET – WEEKS BUILDING
WATERBURY, VT 05671-1601

TO: Choices for Care Case Management Providers

FROM: Adèle Edelman, Medicaid Waiver Manager

DATE: August 7, 2008

RE: Clarification: Case Management Service and Payment

Recently there has been some discussion on case management service in Choices for Care. Topics have included what can be provided, what is reimbursable and what is not, under what circumstances may individual's receive or not receive the service. This memo is serves to clarify this issue.

For whom can I request case management reimbursement?

In Choices for Care (Highest, High and Moderate Needs) case management can only be reimbursed for services provided to **enrolled** participants. Enrolled means that they have been found eligible both clinically and financially and have a "long panel" in the ESD ACCESS system. Case Management **can not** be reimbursed for services provided prior to the start date of eligibility determination or when an individual is subsequently found ineligible. . Case Management **can not** be reimbursed for any service provided after a Choices for Care participant has died.

What about people who change their minds about enrolling after I have conducted an assessment?

The current rate of reimbursement for Choices for Care was established in recognition that providers may expend case management resources which result in an ineligibility determination or a change of mind by the consumer. The unreimbursed cost of those "lost leads" is included in the higher CFC case management rate.

What are the specific activities that I can be reimbursed for?

Reimbursable case management activities are:

Assessment: A comprehensive review of the individual, including social, medical, functional and environmental needs.

Care Planning: A formal process of identifying needs resultant of the assessment process and the development of a plan to meet those needs and the services to be delivered.

Service Coordination: Activities conducted through which services are obtained for individuals, including coordination with multiple providers and resources.

Information and Referral: Providing information to the individual of viable options and referral sources to meet identified needs.

Monitoring: Activities conducted in ongoing review of the individual's needs and service use.

Consumer & Surrogate Employer Certification: Process of assessing and reassessing an employer's certification for the consumer/surrogate directed option.

Documentation: Time spent completing all required CFC forms, applications for other services or public benefits as needed and the documentation of ongoing case management activities.

Travel: Time spent traveling to conduct face- to – face visits in the participant's home or other location and care-planning meetings related to service coordination for the individual.

Case Management reimbursable services **do not** include shopping for items for the individual.

What if a current participant goes into the nursing home or hospital, can I continue to provide case management services?

When an individual goes into a nursing home or hospital case management activities may be provided under certain conditions for a period of up to 180 days after admission and/or preceding discharge from the facility. **However**, the case management activities must relate to the active facilitation of assisting the individual to return to the community. Documentation in case notes must substantiate these activities.

Note: Case managers should not duplicate or supplant the hospital or nursing facility social worker/discharge planner's activities undertaken in the normal course of discharging an individual home.

What happens if the individual does not return home?

In cases where it was the intention of all parties that the individual would return home but did not occur due to an unanticipated turn of events, a request for reconsideration may be made to DAIL. Each request will be determined based upon the strength of the supporting documentation.

May I provide and be reimbursed for case management services provided to the spouse of my CFC participant?

No, you may only submit for reimbursement for case management services provided to the enrolled Choices for Care participant.

Is assisting a participant with an appeal to DAIL concerning eligibility or service plan reduction a reimbursable case management activity?

No, you may not bill Choices for Care case management for activities outside those listed above and enumerated in the Choices for Care Program manual. The case managers' role is to assist the individual in contacting Legal Aid. It is not to provide the investigation, facilitation or other legal activities related to a legal matter. You may make a referral to an appropriate resource that can assist the participant.

How long can I wait to file a case management claim for reimbursement?

Medicaid has a six (6) month timely filing rule. You must submit a claim within six (6) months of the date of providing case management service. Service dates older than six (6) months will not be reimbursed through Choices for Care.