Case Management

ODMHSAS and OHCA Reimbursable Services & Documentation
Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs.

The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources.
The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management.
This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community.

The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits.
The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership.

Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate.
Who is the contact?

- ODMHSAS
  - Certification
    - PICIS Helpdesk
      - Ramona Gregory 522-5366
      - Kodi Pollard 522-2347
      - Michael Dickerson 522-1435
      - Dawn Talton 522-3856
  - PA*/CDC
- OHCA
  - Claims/Billing
    - Provider Services
      - 1-800-522-0114 Option 2,3
  - Policy
    - Mary Ann Dimery 522-7543
    - Crystal Hooper 522-7446
    - Hsui-Ting Cheng 522-7565
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Considerations for Billing Case Management

- The staff providing CM must have the required credentials for the level of CM billing for.

- The staff providing CM must be providing the service under an agency that has a contract with either ODMHSAS or OHCA to provide behavioral health case management.
The individual to which the service is rendered must be eligible to receive behavioral health services under either ODMHSAS or OHCA; and must be eligible to receive CM services.

- The individual must have **SoonerCare** eligibility **OR**

- The individual must be receiving services at an ODMHSAS contracted agency **(receives funding)** and have Mental Health and Substance Abuse in the member eligibility file in the system.
There must be an active Prior Authorization (PA) of services for the individual,

- that includes CM, for the period of time during which the CM service is provided.
The individual must have an active Service Plan with CM treatment objectives, and the CM service provided is related to the plan.

- (unless providing CM services under a CDC 21: Pre-Admission array)

The CM service(s) provided must include only those service functions that are allowable under CM, and should be documented in a progress note accordingly.
Levels of Case Management Services

- **Basic Case Management Services**

- Specialty Case Management Services:
  - Wraparound Facilitation Case Management Services
  - Intensive Case Management Services
What Staff Can Provide Basic Case Management Services?

- Licensed Behavioral Health Professionals (LBHP)
- Certified Alcohol and Drug Counselors (CADC)
- Certified Behavioral Health Case Managers:
  - Behavioral Health Case Manager II (CM II)
  - Behavioral Health Case Manager I (CM I)

**Certifications and licenses must be current, and not in suspended status.**
What Staff Can Provide Specialty Case Management Services?

- **Wraparound Facilitation Case Management (WFCM):**
  - LBHP, or CADC, or CM II, with completion of ODMHSAS wraparound facilitation training and participation in ongoing coaching

- **Intensive Case Management (ICM):**
  - LBHP, or CADC, or CM II, with 2 years of behavioral health CM experience, crisis diversion experience, and 6 hours of ODMHSAS Intensive CM training

*This includes individuals in PACT programs.*
Individual’s Receiving CM

The individual must be eligible to receive CM services
Who Can Receive Case Management Services?

If determined medically, the **target group** for behavioral health case management (CM) services is:

- Persons under age 21 who are either currently in, or in imminent risk of, out-of-home placement for psychiatric or substance abuse reasons &

- Adults with a serious mental illness who are institutionalized or are at risk of institutionalization
Who Can Receive Case Management Services?

- These individuals are usually unable to access needed resources on their own, or advocate successfully on their own behalf.

- Adults and children receiving treatment services who are not a part of the target group may also receive CM services as long as services are deemed medically necessary.
Who is Excluded from Receiving CM Services?

Under OHCA policy, the following individuals are excluded from receiving CM services:

- Children/Families for whom behavioral health CM services are available through OKDHS/OJA staff
- Members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting
Residents of ICF/MR and nursing facilities

Members receiving services under a Home and Community Based services waiver program (HCBS)
What does Medically Necessary mean?
FAQs

What does Medically Necessary mean?

- that the individual or family (if a child is the designated service recipient) **does not have the capacity to access needed resources, or to advocate on their own behalf (or the behalf of the child)** for needed resources, that are necessary for treatment success.
FAQs:

Can a parent of a child receiving treatment services receive CM under the child’s ID?
Can a parent of a child receiving treatment services receive CM under the child’s ID?

- Parent CM need: Typically when serving a child, the parental CM needs are often related to the success the child (ex: no electricity, food, job/income, resources, etc.).

- So if related to treatment success of the child, then it is allowable as a CM service billed under the child.
Allowable CM Services

The CM service(s) provided must include only those service functions that are allowable under CM.
**Prior to Service Plan**

Gathering necessary information for the purpose of the individual CM plan of care- (to develop CM goals & objectives)

- Strengths Based/ Needs Assessment
- Service Plan Development

**Actual CM Services:**

Services that you would expect to see on the service plan:

- Referral
- Linkage
- Advocacy
Supportive functions that are related to the Service Plan, but that you would not expect a specific tx objective for:

- **Monitoring** - checking to ensure that client is attending the internal behavioral health services reflected in the Service Plan, and determine any barriers to progress that may require resource assistance (following up with, contacting, reaching out to..., etc.)

- **Crisis Diversion** - unscheduled/unanticipated event i.e. being evicted

**not to be confused with Crisis Intervention provided by the LBHP**
Non Face-To-Face Communication

The following CM service related communication can be provided non face-to-face:

- Communication with the Individual/Family

- Communication with Tx/service providers re: implementation of activities in the Service Plan
Service Functions **NOT** Allowed Under CM

- Managing finances
- Monitoring financial goals
- Providing specific services such as shopping or paying bills
- Delivering bus tickets, food stamps, money, etc.
Service Functions **NOT Allowed Under CM**

- Counseling/Psychotherapy, Rehabilitation services, psychiatric assessment, or discharge planning
- Filling out forms, applications, etc., on behalf of the individual when the individual is not present
- Mentoring or Tutoring
Service Functions **NOT** Allowed Under CM

- Provision of CM to the same family by two separate behavioral health case management agencies
- Non face-to-face time spent preparing the CM assessment document, or CM service plan paperwork
Service Functions **NOT Allowed** Under CM

- Services to nursing home residents or residents in ICF/MR facilities
- Filling out SoonerCare forms, applications, etc.
- Physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment
Clinical Documentation
And why do we do it?
What is the purpose?

There are many reasons clinical documentation is important:

- **Communication** – Communication to other clinicians, physicians, auditors. Communication with the individual served when completing documentation together—making sure you are on the same page.

- **Direction** – Provides direction for treatment. **Assessment directs the service plan, and the plan directs actual service provision.**

- **Motivation** – When we set goals for ourselves and we accomplish steps toward the achievement, we get excited. Success breeds success.
Effectiveness of treatment – Not having a well thought out plan for treatment is like shooting in the dark; it is within the realm of possibility that you might hit the target but it’s unlikely.

A well written assessment resulting from dialog with the individual being served helps both you and the individual identify more targeted goals and objectives.

The function of the progress note and the service plan review is to help you gauge how effective the treatment you are providing.
There are three (3) primary types of clinical documentation:

- **Clinical Assessment** – Documentation reflecting current and historical information which is typically used to make a diagnosis and direct the course of treatment.

- **Service Plan** – Documentation that outlines the goals, objectives and services to be focused on during treatment. This documentation is also referred to as a treatment plan.

- **Progress Notes** – Documentation reflecting what happens during each service provided (i.e. service plan goal/objective addressed, clinical intervention provided, consumer response to intervention, etc.).
Service Plan

The individual must have an active Service Plan with CM treatment objectives, and the CM service provided is related to the plan (unless providing CM services under a CDC 21: Pre-Admission array)
Service Plan Considerations for CM

- The Service Plan should be developed with **active participation of the individual/family**

- The Service Plan should **reflect the individual’s/Family’s overarching goal(s) for recovery/resilience (life success)**

- Behavioral Health Case Management should be used as a **service/intervention to assist the individual/family with achieving their life success goals**

- Goals and objectives should be **meaningful to the consumer/family**

- Written in a way where it will **easy to determine when the objective has been accomplished**
- The consumer should always receive a copy of the plan.

- A process should be in place regularly revisit the plan – **not just at the 6 month review period**
As CM services should assist individuals/families with accessing services for themselves, CM service objectives should be developed in a way that facilitate active participation. A simple way that this can be achieved is by using the word “participate” instead of “receive” in the body of the objective.

Example:
Pebbles will participate in advocacy efforts to help her stay in school.
Case Management Goals & Objectives

- Service plans should include case management goals and objectives that are both meaningful & individualized to the consumer, written in a way that is easily understood & attainable within the treatment plan period.

- CM objectives may be written in a “broad-based” or more specific manner.
Case Management Goal & Objectives (specific)

“I want to have enough food to last all month and learn the best food for diabetics to eat every day.”

- Alex will participate in linkage and advocacy efforts to access local food banks and churches for grocery assistance.
- Alex will participate in follow up & monitor efforts to ensure that his nutritional needs are met each month.
- Alex will participate in linkage, advocacy and monitoring efforts to receive a referral to a dietician to assist with dietary planning for diabetes from his PCP.
Case Management Goal & Objectives (Broad)

“I want to have enough food to last all month and learn the best food for diabetics to eat every day.”

Alex will participate in referral, linkage, advocacy, follow-up & monitoring efforts to ensure that he is able to maintain an adequate & appropriate food for his physical & behavioral health.
Case Management Objectives

Things to Remember

- Case Management objectives do not need a numeric measure to be measurable.

- Case Management treatment plan problems need to reflect the symptoms that interfere with the consumers/families ability to access resources and advocate on their own behalf.
Progress Note

CM services shall be documented in a progress note
**Documentation of records**

- All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service plan, documentation of each session must include, but is not limited to:

  (1) date;
  (2) person to whom services are rendered;
  (3) start and stop times for each service;
  (4) original signature of the service provider;
  (5) credentials of the service provider;
  (6) specific service plan needs, goals and/or objectives addressed;
  (7) specific activities performed by the behavioral health case manager on behalf of the member related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;
  (8) progress or barriers made towards goals and/or objectives;
  (9) member (family when applicable) response to the service;
  (10) any new service plan needs, goals, and/or objectives identified during the service; and
  (11) member satisfaction with staff intervention.
Consumer Name: John Doe  Date: February 12, 2012

In 3:07pm   Out 4:02pm (55 min= 4 units)

Specific Objective Addressed, Staff Intervention, Member Response to Intervention & Progress Made Toward Goals:

Goal(s) 1&2; Objective(s) 1b & 2a

John attended his scheduled case management session today. CM provided follow up on the referrals for housing and employment that were provided during the last session. John shared barriers that hindered his ability to follow through with these referrals, such as his mother falling sick as she is his major source of transportation. He also stated that he had some unexpected expenses this month and was unable to afford fare for a cab or a bus. CM offered to help link John with the identified resources by making the phone calls together in my office. In addition, we obtained a contact person at each location for John to talk to when he arrives.

John said he is excited and agreed to follow up and share his progress during our next session in 1 week on February 19, 2012.

No new needs identified during this session.

Before this session ended, John stated “These are the things I still need your help with. I am happy we got this done today.”

Staff Signature (& Credentials): Dawn Talton, CM 12345XYZ
Consumer Name: (2) Jenny Doe  Date: (1) October 3, 2011
In 3:00pm     Out 4:30pm

(3) Specific Objective Addressed, Staff Intervention, Member Response to Intervention & Progress Made Toward Goals:
Goal 1 Objective 1a

(7) CM traveled to Jenny’s home and met with her and her Mother to complete a strengths based assessment and develop a case management service plan. (9) Jenny was very quiet and did not contribute very much input to the process; although this CM attempted to engage her on multiple occasions. Most of the information for assessment and service plan development was contributed by Jenny’s mom. She stated, “I think the goals and objectives on the service plan will be very helpful”, and Jenny agreed. (8 & 10) The needs identified during this session were included in the strengths based assessment & service plan that were developed/completed during this session. (11) Before this session ended, CM verified that there weren’t any immediate needs to be addressed during this session. Jenny stated “I’m really tired. I want to start working on this at our appointment next week (October 10,2011).

(4) Staff Signature (& Credentials): Kodi Pollard, CM (5) 5678ADC
Additional Documentation Examples
John shares that he is having difficulty communicating with his PCP about his medical needs & his psychiatrist about the side effects of his medications & the symptoms he continues to experience. John states “I have completed a few college courses and would to go back to school and take a few more college courses.” He states “I would also like to have friends and a girlfriend” but due to his limited social skills, anger issues and severe feelings of anxiety at the mere thought of approaching & interacting with people, he feels he is unable to have friends, not alone a girlfriend. John states “When I try to get to know someone, I feel that my anger outbursts scare them away.”

“I have never been able to complete anything and fear that I never will. I get overwhelmed and angered very easily. I try to do too many things at once and end up having panic attacks or getting very angry and then I don’t accomplish anything.”

In addition, John let you know he had a very close relationship with his family but it is currently strained because of his actions while he experienced his psychiatric symptoms and was off his medications. John states “I would get so angry and this sometimes caused me to hurt my family.”
Service Plan

Goal: I want to have a girlfriend, go back to school and be close to my family again”.

CM Objectives:
- John will participate in linkage efforts to access needed educational & financial aid resources to begin general education courses at the local community college.
- John will participate in advocacy efforts to help her access needed financial and ADA accommodations to be stay in school.
- John will participate in monitoring and advocacy efforts with school officials to ensure that he has the needed resources to stay in school.
- John will participate in linkage efforts to find social activities.
Consumer Name: (2) John Doe  Date: February 12, 2012 (1)
In 3:07pm Out 4:02pm (55 min= 4 units)

(6) Specific Objective Addressed, Staff Intervention, Member Response to Intervention & Progress Made Toward Goals:
Goal(s) 1&2; Objective(s) 1b & 2a

(7) John attended his scheduled case management session today. CM provided follow up on the linkage efforts for the consumer to enroll in classes at the local community college provided during the last session. John shared that his anxiety about making the needed phone calls and completing required paperwork hindered his ability to follow through with the contact at the school. He explained that he did try to go to the school but became very frustrated and angry with the receptionist. “I couldn’t understand her. She gave me too many instructions and talked too fast.” He also stated that he had some unexpected expenses this month and was unable to pay his entire electric bill. CM asked “did you call to make payment arrangements?” John said “no, you know I can’t deal with those idiots.” CM called/linked John with the electric company and advocate if needed to help make payment arrangements to ensure that services aren’t interrupted.

(9) John said he is really appreciated my help and asked could I go to the local community college with him next week to complete the enrollment process. Our next session will be in 1 week on February 19, 2012 at 10am.

(10) Unpaid electric bill - taken care of today and no other needs identified during this session.

(11) Before this session ended, John stated “These are the things I still need your help with. I am happy you are helping me.”

(4) Staff Signature (& Credentials): Dawn Talton, CM (5) 12345XYZ
# Medicare's 8 Minute Rule

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<th>Units</th>
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<td>12 units</td>
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Helpful Links

ODMHSAS and OHCA
OHCA

- OHCA requirements for reimbursable behavioral health case management, including documentation requirements, can be located in OHCA Policy/Rules:
  - Part 67 Behavioral Health Case Management Services

ODMHSAS

ODMHSAS requirements for reimbursable behavioral health case management, including documentation requirements, can be located in the ODMHSAS Services Manual:

www.odmhsas.org/arc.htm
This website contains helpful information for both ODMHSAS and OHCA contractors, including but not limited to:

- Prior Authorization (PA) Manual (which includes the CDC Manual)
- PA Groups
- Rates and Codes