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MENTAL HEALTH CASE MANAGEMENT (H0023)

Population Definitions

The following Department of Behavioral Health and Developmental Services (DBHDS) definitions are referred to in the discussion of the appropriate populations for Mental Health Case Management services.

1. Serious Mental Illness

Adults, 18 years of age or older, who have severe and persistent mental or emotional disorders that seriously impair their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance use disorder or developmental disability are included. The population is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

a. Diagnosis

There must be a major mental disorder diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). These disorders are: schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability. A diagnosis of adjustment disorder or a V Code diagnosis cannot be used to satisfy these criteria.

b. Level of Disability

There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis:

1) Is unemployed; is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.
2) Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
3) Has difficulty establishing or maintaining a personal social support system.
4) Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
5) Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

c. Duration of Illness

The individual is expected to require services of an extended duration, or the individual's treatment history meets at least one of the following criteria:

1) The individual has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization).
2) The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

2. Serious Emotional Disturbance

Serious emotional disturbance in children ages birth through 17 is defined as a serious mental health problem that can be diagnosed under the DSM, or the child must exhibit all of the following:

a. Problems in personality development and social functioning that have been exhibited over at least one year's time; and
b. Problems that are significantly disabling based upon the social functioning of most children that age; and
c. Problems that have become more disabling over time; and
d. Service needs that require significant intervention by more than one agency.

Children diagnosed with Serious Emotional Disturbance and a co-occurring substance use disorder or developmental disability diagnosis are also eligible for Case Management for Serious Emotional Disturbance.

3. At Risk of Serious Emotional Disturbance

Children aged birth through seven are considered at risk of developing serious emotional disturbances if they meet at least one of the following criteria:

a. The child exhibits behavior or maturity that is significantly different from most children of that age and which is not primarily the result of developmental disabilities; or
b. Parents, or persons responsible for the child's care, have predisposing factors themselves that could result in the child developing serious emotional or behavioral problems (e.g., inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, etc.); or

c. The child has experienced physical or psychological stressors that have put him or her at risk for serious emotional or behavioral problems (e.g., living in poverty, parental neglect, physical or emotional abuse, etc.).

MHCM Level of Care Guidelines	
Service Definition Critical Features & Service Components	Mental health case management is defined as a service to assist individuals, eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational, and other services. Case management does not include the provision of direct clinical or treatment services. If an individual has co-occurring mental health and substance use disorders, the case manager may include activities to address both the mental health and substance use disorders, as long as the treatment for the substance use disorder is intended to positively impact the mental health condition. The impact of the substance use disorder on the mental health condition must be documented in the assessment, the ISP, and the progress notes.
Required Activities	The following services and activities must be provided: • Assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment, but does include referral for such). An assessment must be completed by a qualified mental health case manager to determine the need for services or included as a recommended service on a Comprehensive Needs Assessment conducted by a LMHP, LMHP-R, LMHP-RP or LMHP-S. If completed by a qualified case management who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S, the assessment is conducted as part of the first month of case management service. Case Management assessments and intakes must be provided in accordance with the provider requirements defined in DBHDS licensing rules for case management services. The assessment serves as the basis for the ISP. • The ISP must document the need for case management and be fully completed within 30 calendar days of initiation of the service, and the case manager shall review the ISP every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month

following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review. The ISP shall be updated at least annually.

- Mandatory monthly case management contact, activity, or communication relevant to the ISP. Written plan development, review, or other written work is excluded.
- Linking the individual to needed services and supports specified in the ISP.
- Provide services in accordance with the ISP.
- Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;
- Coordinating services and service planning with other agencies and providers involved with the individual.
- Enhancing community integration by contacting other entities to arrange community access and involvement including opportunities to learn community living skills, and use vocational, civic, and recreational services.
- Making collateral contacts, which are non-therapy contacts, with significant others to promote implementation of the service plan and community adjustment.
- Following up and monitoring to assess ongoing progress and ensuring services are delivered.
- Monitoring service delivery as needed through contacts with service providers as well as periodic site visits and home visits.
- Education and counseling, which guide the individual and develop a supportive relationship that promotes the service plan. Counseling, in this context, is not psychological counseling,

examination, or therapy. The case management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community. These activities must be linked to the goals and objectives on the Case Management ISP.

Educational activities do not include group activities that provide general information and that do not provide opportunities for individualized application to specific individuals. For example, group sessions on stress management, the nature of serious mental illness, or family coping skills are not case management activities.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of CMHRS services, specifically mental health case management.

- A face-to-face contact must be made at least once every 90 calendar day period. The purpose of the face-to-face contact is for the case manager to observe the individual's condition, to verify that services which the case manager is monitoring are in fact being provided, to assess the individual's satisfaction with services, to determine any unmet needs, and to generally evaluate the member's status.

Case Management services are intended to be an individualized client-specific activity between the case manager and the member. There are some appropriate instances where the case manager could offer case management to more than one individual at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more individuals was consumer-specific. For example, the case manager needs to work with two individuals, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both individuals simultaneously for the purpose of helping each individual obtain a financial entitlement and subsequently follow-up with each individual to ensure he or she has proceeded correctly.

Case Management Agency Requirements

1. The assessment and subsequent re-assessments of the individual's medical, mental, and social status must be reflected with appropriate documentation. The initial assessment must

also include current documentation of a medical examination, a psychological/psychiatric evaluation, and a social assessment.

2. All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer. The individual or legal representative and any relevant family members or friends involved in the development of the ISP must sign the ISP.

3. There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when appropriate) sign a document verifying freedom of choice of providers was offered and this provider was chosen.

4. A release form must be completed and signed by the individual for the release of any information.

5. There must be an ISP from each provider rendering services to the individual. The ISP is the service plan developed by the individual service provider related solely to the specific tasks required of that service provider and the desired outcomes. ISPs help to determine the overall ISP for the individual. The ISPs must state long-term service goals and specified short-term objectives in measurable terms. For case management services, specific objectives for monitoring, linking, and coordinating must be included.

6. Case management records must include the individual's name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual declined services, and a timeline for reevaluation of the plan. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

Monitoring and Re-Evaluation of the Service Need by the Case Manager

The case manager must continuously monitor the appropriateness of the individual's ISP and make revisions as indicated by the changing support needs of the individual. At a minimum, the case manager shall review the ISP every three months to determine whether service goals and objectives are

	being met, satisfaction with the program, and whether any modifications to the ISP are necessary. Providers must coordinate reviews of the ISP with the case manager every three months. This quarterly re-evaluation must be documented in the case manager's file. The case manager must have monthly activity regarding the individual and a face-to-face contact with the individual at least once every 90 calendar days. The case manager must revise the ISP whenever the amount, type, or frequency of services rendered by the individual service providers change. When such a change occurs, the case manager must involve the individual in the discussion of the need for the change.
MHCM Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	The Medicaid eligible individual shall meet the DBHDS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance. • There must be documentation of the presence of serious mental illness for an adult individual or of serious emotional disturbance or a risk of serious emotional disturbance for a child or adolescent. • The individual must require case management as documented on the ISP, which is developed by a qualified mental health case manager and based on an appropriate assessment and supporting documentation. • To receive case management services, the individual must be an "active client," which means that the individual has an ISP in effect which requires regular direct or client-related contacts and communication or activity with the client, family, service providers, significant others, and others, including a minimum of one face-to-face contact every 90 calendar days.
Exclusions and Service Limitations	• No other type of case management, from any funding source, may be billed concurrently with targeted case management. • Limited services are available to individuals in institutions (see billing requirements section)

MHCM Provider Participation Requirements	
Provider Qualifications	The mental health case management provider must be a Community Services Board member and licensed by DBHDS. To qualify as a provider of services through DMAS for Mental Health Case Management for adults with serious mental illness and children and adolescents with serious emotional disturbance, the provider must meet the following criteria: • The provider must have the administrative and financial management capacity to meet state and federal requirements; • The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements; • The services shall be in accordance with the Virginia Comprehensive State Plan for Behavioral Health and Developmental Services; and • The provider must be licensed as a provider of Case Management Services by DBHDS.
Staff Requirements	Providers may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers. Persons providing case management services must have knowledge of: • Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, developmental disability, and substance abuse treatment programs; • The nature of serious mental illness, developmental disability, and substance abuse depending on the population served, including clinical and developmental issues;

	• Different types of assessments, including functional assessments, and their uses in service planning; • Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination; • The service planning process and major components of a service plan; • The use of medications in the care or treatment of the population served; and All applicable federal and state laws, regulations, and local ordinances. Persons providing case management services must have skills in: • Identifying and documenting an individual's needs for resources, services, and other supports; • Using information from assessments, evaluations, observation, and interviews to develop Individual Service Plans; • Identifying services and resources within the community and establishing service systems to meet the individual's needs and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal habilitative, rehabilitative, and life goals; and • Coordinating the provision of services by public and private providers. Persons providing case management services must have abilities to: • Work with team members, maintaining effective inter- and intra-agency working relationships; • Work independently, performing position duties under general supervision; and • Engage and sustain ongoing relationships with individuals receiving services.

	The provider must be a DBHDS-licensed case management provider, and case management must be provided by a qualified mental health case manager as defined above. The individual providing case management services is not required to be a member of an organizational unit that provides only case management. The case manager who is not a member of an organized case management unit must possess a job description that describes case management activities as job duties, must provide services as defined for case management, and must comply with service expectations and documentation requirements as required for organized case management units.
MHCM Service Authorization and Utilization Review	
Service Authorization	While service authorization for this service is not required, registration of this service with the FFS contractor or the MCO is required. If the individual qualifies for case management through a different population definition ('at risk', SED, or SMI) a new registration is required. Providers may contact the FFS contractor or the MCO directly for more information.
Documentation and Utilization Review	Refer to Chapter VI of this manual for all documentation and utilization review requirements.
MHCM Billing Requirements	

- A billing unit is one calendar month.
- Billing can be submitted for case management only for months in which direct or client-related contacts, activity, or communications occur. These activities must be documented in the clinical record. The provider should bill for the specific date of the face to face visit, or the date the monthly summary note has been documented, or a specific date service was provided. In order to support the 1 billing unit per calendar month, the face to face visit must be performed on the date billed or the specific date the monthly summary note is completed, AND there must be contacts made and documented within that same month. Providers are NOT to span the month for Case Management services.
- Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or activity or communication with the client or families, significant others, service

providers, and others including a minimum of one face-to-face client contact within a 90 calendar day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

- Federal regulation 42CFR441.18 prohibits providers from using case management services to restrict access to other services. An individual cannot be compelled to receive case management if he or she is receiving another service, nor can an individual be required to receive another service if they are receiving case management. For example, a provider cannot require that an individual receive case management if the individual also receives medication management services.

- In accordance to 42 CFR 441.18(a)(8)(vii), reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in institutions of mental diseases (IMDs) and individuals of any age who are inmates of public institutions. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds..

- Services rendered during the same month as the admission to the IMD is reimbursable for individuals ages 22 - 64 as long as the service was rendered prior to the date of the admission.

- Two conditions must be met to bill for Case Management services for individuals that are in an acute care psychiatric units or who are in institutions and who do not meet the exclusions noted above. The services may not duplicate the services of the facility discharge planner or other services provided by the institution, and the community case management services provided to the individual are limited to one month of service, 30 calendar days prior to discharge from the facility. Case management for hospitalized individuals may be billed for no more than two non-consecutive pre-discharge periods in 12 months.

- Case Management services for the same individual must be billed by only ONE type of Case Management provider. See Chapter V for billing instructions.

Providers must follow the requirements for the provision of telemedicine described in the "Telehealth Services Supplement" including the use of the GT modifier for units billed for services provided through telemedicine. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Treatment Foster Care - Case Management (T1016)

TFC-CM Level of Care Guidelines	
Service Definition Critical Features & Service Components	Treatment Foster Care - Case Management (TFC-CM) is a service that assists Medicaid eligible individuals in gaining and coordinating access to necessary care and services appropriate to their needs. Case management services will coordinate service to minimize fragmentation of care, reduce barriers, and link children with appropriate services to ensure comprehensive, continuous access to needed medical, social education, and other services appropriate to the needs of the child. TFC-CM is directed toward children or youth with a behavioral disorder or emotional disturbance referred to Treatment Foster Care by the Family Assessment and Planning Team (FAPT) of the Comprehensive Services Act (CSA) for Youth and Families or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.2-5208 of the Code of Virginia. "Child" or "youth" means any Medicaid-eligible child under age 21 years of age who is otherwise eligible for CSA services. Each individual must be assessed by a Family Assessment and Planning Team (FAPT) or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.2-5209 of the Code of Virginia. The team must assess the individual's immediate and long- range therapeutic needs, developmental priorities, personal strengths and liabilities, the potential for reunification with the individual's family, set treatment objectives, and prescribe therapeutic modalities to achieve the plan's objectives. The assessment must include the dated signatures of a majority (at least three) of the FAPT members. The FAPT shall refer the individuals needing TFC-CM to a qualified participating treatment foster care case manager. TFC-CM is a component of treatment foster care through which a treatment foster care case manager provides treatment planning, monitors the care plan, and links the individual to other community resources as necessary to address the special identified needs of the individual. Services to the individuals shall be delivered primarily by treatment foster parents who are trained, supervised, and supported by professional child-placing agency staff. TFC-CM focuses on a continuity of services that is goal-directed and results-oriented. Services shall not include room and board. The following activities are considered covered services related to TFC-CM services:

	1. Care planning, monitoring of the plan of care, and discharge planning; 2. Case management; and 3. Evaluation of the effectiveness of the individual's plan of care.
Required Activities	Duties of a TFC Case Manager are to: • Perform a periodic assessment to determine the individual's needs for psychosocial, nutritional, medical, and educational services; • Develop individualized treatment and service plans to describe the services and resources needed to meet the needs of the individual and to help access those services and resources. Such service planning shall not include performing medical and psychiatric assessment but shall include referrals for such assessments. The case manager shall collaborate closely with the FAPT and other involved parties in preparation of all case plans; • Coordinate services and service planning with other agencies and providers involved with the individual including the FAPT; • Refer the individual to services and support specified in the individualized treatment and service plans; • Directly assist the child to locate or obtain needed services and resources; and • Follow up and monitoring by assessing ongoing progress in each case to ensure services are delivered. The case manager shall continually evaluate and review each child's plan of care. The case manager shall collaborate with the FAPT and other involved parties on review and coordination of services to youth and families; Treatment Teams in TFC-CM

The TFC-CM provider shall assure that a professional staff person provides leadership to the treatment team, which includes managing team decision-making regarding the care and treatment of the individual and services to the individual's treatment foster care family. The provider must provide information and training to the treatment team members as necessary. The provider must involve the individual and the individual's treatment foster care family in treatment team meetings, plans, and decisions and keep them informed of the individual's progress whenever possible. Treatment team members shall consult as often as necessary, but no less than quarterly.

Initial Plan of Care

The initial plan of care delineates the services that are to be provided to the individual at admission. This document must be completed within 14 calendar days of the placement or be subject to retraction until completed.

Treatment and Service Plans in TFC-CM

The TFC-CM provider shall prepare and implement an individualized comprehensive plan for each individual in its care. When available, the birth parents shall be consulted unless parental rights have been terminated. If birth parents cannot be consulted, the agency shall document the reason in the individual's record.

When the treatment foster care case management provider holds custody of the child, a service plan shall be filed with the court within 60 calendar days after the agency receives custody unless the court grants an additional 60 calendar days, or the child is returned home or placed for adoption within 60 calendar days. Providers with legal custody of the child shall follow the requirements of § 16.1-281 and 16.1-282 of the Code of Virginia. The permanency planning goals and the requirements and procedures in the Department of Social Services Service Programs Manual, Volume VII, Section III, Chapter B, "Preparing the Initial Service Plan" may be consulted.

Comprehensive Treatment and Service Plan in TFC-CM

The treatment foster care (TFC) case manager and other designated child-placing agency staff shall develop and implement for each individual in care an individualized comprehensive treatment plan within the first 45 calendar days of placement that shall include:

1. A comprehensive assessment of the individual's emotional, behavioral, educational, and medical needs;

2. The treatment goals and objectives, including the individual's specific problems, behaviors, and skills to be addressed, the criteria for achievement, and target dates for each goal and objective;

3. The TFC-CM provider's program of therapies, activities, and services, including the specific methods of program of therapies, activities, and services, the specific methods of intervention and strategies designed to meet the above goals and objectives, and describing how the provider is working with related community resources to ensure a continuity of care with the individual's family, school and community;

4. The discharge plan and the target date for discharge from the program;

5. The discharge goals and objectives, services to be provided for their achievement, and plans for reunification of the child and the child's family, where appropriate. Unless specifically prohibited by court order, foster children shall have access to regular contact with their families.

6. For individuals age 16 and over, a description of the programs and services that will help the individual transition from foster care to independent living; and

7. The plan shall be signed and dated by the treatment foster care case manager. It shall indicate all members of the treatment team who participated in its development.

The TFC case manager shall include and work with the individual, the custodial agency, the treatment foster care parents, and the birth parents, where appropriate, in the development of the treatment plan, and a copy shall be provided to the custodial agency. A copy shall be provided to the treatment foster parents as long as confidential information about the individual's birth family is not revealed. A copy shall be provided to the parents, if appropriate, as long as confidential information about the treatment foster parents is not revealed. If any of these parties do not participate in the development of the treatment and service plan, the TFC case manager shall document the reasons in the individual's record.

The TFC case manager shall provide supervision, training, support, and guidance to foster families in implementing the treatment plan for the individual.

Progress Reports and Ongoing Services Plans in TFC-CM

The TFC case manager shall complete written progress reports beginning 90 calendar days after the date of the individual's placement and every 90 calendar days thereafter. The progress report shall specify the time period covered and include:

1. Progress on the individual's specific problems and behaviors and any changes in the methods of intervention and strategies to be implemented, including:

    a. A description of the treatment goals and objectives met, goals and objectives to be continued or added, the criteria for achievement, and target dates for each goal and objective;

    b. A description of the therapies, activities, and services provided during the previous 90 calendar days toward the treatment goals and objectives; and

    c. Any changes needed for the next 90 calendar days.

2. Services provided during the last 90 calendar days toward the discharge goals, including plans for reunification of the individual and birth family or placement with relatives, any changes in these goals, and services to be provided during the next 90 calendar days, including:

    a. The individual's assessment of his or her progress and his or her description of services needed, where appropriate;

    b. Contacts between the individual and the individual's birth family, where appropriate;

    c. Medical needs, specifying medical treatment provided and still needed and medications provided;

    d. An update to the discharge plans including the projected discharge date; and

    e. A description of the programs and services provided to

individuals 16 and older to help the individual transition from foster care to independent living, where appropriate.

Annually, the progress report shall address the above requirements as well as evaluate and update the comprehensive treatment and service plan for the upcoming year. The case manager shall date and sign each progress report. The dated signature indicates the effective date of the report.

The case manager shall include each child who has the ability to understand in the preparation of the child's treatment and service plans and progress reports or document the reasons this was not possible. The child's comments shall be recorded in the report. The case manager shall include and work with the child, the treatment foster parents, the custodial agency, and the birth parents, where appropriate, in the development of the progress report. A copy shall be provided to the placing agency worker and, if appropriate, to the treatment foster parents.

Contacts with the Child in TFC-CM

1. There shall be face-to-face contact between the TFC case manager and the individual, based upon the individual's treatment and service plan and as often as necessary, to ensure that the individual is receiving safe and effective services.

2. Face-to-face contacts shall be no less than twice a month, one of which shall be with the individual in the treatment foster care home. One of the contacts shall include the individual and at least one treatment foster parent and shall assess the relationship between the individual and the treatment foster parents. The two required face-to-face contacts cannot occur on the same day.

3. The contacts shall assess the individual's progress and provide guidance to the treatment foster parents, monitor service delivery, and allow the individual to communicate concerns.

4. A description of all contacts shall be documented in the narrative.

5. Individuals who are able to communicate shall be interviewed privately at least once a month.

6. The TFC case manager shall record all medications prescribed for each individual and all reported side effects or adverse reactions.

	Unless specifically prohibited by a court or the custodial agency, foster children shall have access to regular contact with their birth families as described in the treatment and service plan. The TFC case manager shall work actively to support and enhance the family relationships and work directly with the individual's birth family toward reunification as specified in the treatment and service plan. Professional Clinical or Consultative Services in TFC-CM In consultation with the custodial agency, the TFC case manager shall provide or arrange for an individual to receive psychiatric, psychological, and other clinical services as recommended or identified in the treatment service plan. Case management (CM) services by any source other than the TFC agency is considered a duplication of services. Medicaid reimbursed targeted case management, including Mental Health CM, Intellectual Disability CM cannot be billed when the child is receiving TFC- CM. Duplication of services is subject to retraction.
TFC-CM Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	TFC Medical Necessity Criteria TFC case management will serve children under age 21 in treatment foster care who are seriously emotionally disturbed or children with a behavioral disorder who in the absence of such programs would be at risk for placement into more restrictive residential setting such as psychiatric hospitals, correctional facilities, residential treatment programs or group home. The individual must have a documented moderate to severe impairment and moderate to severe risk factors as recorded on the CANS. The individual's condition must meet one of the three levels described below: a. **Level I:** Moderate impairment with one or more of the following moderate risk factors as documented on the CANS: (1) Needs intensive supervision to prevent harmful consequences; (2) Moderate/frequent disruptive or non-compliant behaviors in home setting that increase the risk to self or others; or (3) Needs assistance of trained professionals as caregivers. b. **Level II:** The individual must display a significant impairment with

	problems with authority, impulsivity, and caregiver issues as documented on the CANS. For example, the individual must: (1) Be unable to handle the emotional demands of family living; (2) Need 24-hour immediate response to crisis behaviors; or (3) Have severe disruptive peer and authority interactions that increase risk and impede growth c. **Level III:** The individual must display a significant impairment with severe risk factors as documented on the CANS. The individual must demonstrate risk behaviors that create significant risk of harm to self or others.
Exclusions and Service Limitations	No other type of case management may be billed concurrently with treatment foster care case management.
TFC-CM Provider Participation Requirements	
Provider Qualifications	Treatment Foster Care Case Management shall be provided by child placing agencies with treatment foster care programs that are licensed or certified by the Virginia Department of Social Services (DSS) to be in compliance with DMAS and meet the provider qualifications for treatment foster care set forth in this manual, the FFS contractor provider contract and policies, and state and federal regulations. Providers may bill Medicaid for case management for individuals in treatment foster care only when the services are provided by qualified treatment foster care case managers. The treatment foster care case manager must meet, at a minimum, the qualifications specified by DMAS. Minimum Standards for Treatment Foster Care Case Managers A Ph.D. or master's degree in social work from a college or university accredited by the Council on Social Work Education or in a field related to social work such as sociology, psychology, education, or counseling, with a student placement in providing casework services to children and families. One year of experience in providing casework services to children and families may be substituted for a student placement; or A baccalaureate degree in social work or a field related to social work including sociology, psychology, education, or counseling and one year of experience in providing casework services to children and families; or A baccalaureate degree in any field plus two years' experience in providing

	casework services to children and families.
Staff Requirements	Providers may bill Medicaid for case management for individuals in treatment foster care only when the services are provided by qualified treatment foster care case managers. The treatment foster care case manager must meet, at a minimum, the qualifications specified by DMAS. Minimum Standards for Treatment Foster Care Case Managers A Ph.D. or master's degree in social work from a college or university accredited by the Council on Social Work Education or in a field related to social work such as sociology, psychology, education, or counseling, with a student placement in providing casework services to children and families. One year of experience in providing casework services to children and families may be substituted for a student placement; or A baccalaureate degree in social work or a field related to social work including sociology, psychology, education, or counseling and one year of experience in providing casework services to children and families; or A baccalaureate degree in any field plus two years' experience in providing casework services to children and families. **Caseload Size**: The TFC Case Manager shall have a maximum of 12 individuals in his/her caseload for a full-time professional staff person. The caseload shall be adjusted downward if: 1. The TFC-Case Manager's job responsibilities exceed those listed in the agency's job description for a caseworker, as determined by the supervisor. 2. The difficulty of the client population served requires more intensive supervision and training of the treatment foster parents. 3. Exception: A TFC- Case Manger may have a maximum caseload of 15 individuals as long as no more than 10 of the individuals are in TFC and the above criteria for adjusting the caseload downward do not apply.

	4. There shall be a maximum of six individuals in the caseload for a beginning trainee that may be increased to nine by the end of the first year and to 12 by the end of the second year. 5. There shall be a maximum of three individuals in a caseload for a student intern, if any work in the agency.
TFC-CM Service Authorization and Utilization Review	
Service Authorization	Treatment Foster Care Case Management requires service authorization within business 10 days of admission. Providers can submit service authorization requests up to 30 days prior to the requested start date. For additional information on submitting requests for Service Authorization, refer to Appendix C of this manual. For an initial review request, the provider will need to submit demographic information, as well as the following information: • The 3-digit locality code is required (The locality code will reflect the locality that has fiscal responsibility for the Medicaid individual and should be submitted to the provider by the referral source.); • DSM Diagnosis; • Confirmation of the timely completion of the FAPT assessment; • A description of the child's behaviors immediately prior to admission that correlate to the state recognized uniform assessment instrument scores, and; • The state uniform assessment instrument, which is the Child and Adolescent Needs and Strengths (CANS) instrument, scores a completion date. The completion date for CANS must be current within 90 calendar days prior to submission of the service authorization request. For a continued stay review request, the provider will need to submit demographic information, as well as the following: • Locality code confirmation; • DSM Diagnosis; • Confirmation that the Comprehensive Treatment and Service Plan is completed timely; • Confirmation that continued TFC-CM is needed to meet the child's needs; • Confirmation on face-to-face visits; • A description of the individual's behaviors that both support the need for this level of care and correlate to the CANS scores, and; • The CANS scores and completion date. The completion date for the CANS must be current within 90 calendar days.

	If the individual has been in placement for more than 45 calendar days, the information required to be submitted will include both the initial review and continued stay review information noted above. An authorization for TFC-CM will be for a single unit for each month. Only one provider is eligible for authorization and payment for each month. If an individual is discharged during an authorized period, notify the FFS contractor of the discharge date. If an approval is for a full month, but the discharge date is mid-month, the FFS contractor will not change the authorization for that month, only for subsequent months, since only one unit is authorized for each month, and only one provider can bill for that unit. If a new provider begins service mid-month, and the previous provider already has authorization for the month, the new provider's authorization will begin on the first of the next month. A notice of discharge must be sent to the FFS contractor within one week of the discharge date.
Documentation and Utilization Review	Record Documentation in TFC-CM **Entries in Case Records**: All entries shall include the dated signature of the staff person who performed the service. If a TFC-CM provider has offices in more than one location, the record shall identify the office that provided the service. Each individual's record shall contain documentation that verifies the services rendered for billing. **Narratives in the Individual's Record**: Narratives shall be in chronological order and current within 30 days. Narratives shall include areas specified in these regulations and shall cover: treatment and services provided; all contacts related to the individual; visitation between the individual and the individual's birth family; and other significant events. Each contact with the individual, his or her birth family, treatment foster care family, or other individuals in the course of providing case management services must be documented in the individual's record. Narratives must include the dated signature of the TFC case manager. **Plans of Care**: Copies of all assessments and Plans of Care must be filed in the individual's case record. **Timeliness:** The dated signature of the service provider on required documentation indicates the completion date of the document. Discharge from Care

	A discharge summary shall be developed for each child and placed in the child's record within 30 days of discharge. It shall include the date and reason for discharge, the name of the person with whom the child was placed or to whom he was discharged, and a description of the services provided to the child and progress made while the child was in care. Written recommendation for aftercare shall be made for each child prior to the child's discharge. Such recommendation shall specify the nature, frequency, and duration of aftercare services to be provided to the child and the child's family. The discharge summary shall also include an evaluation of the progress made toward the child's treatment goals. Discharge planning shall be developed with the treatment team and the child, the child's parents or guardian, and the custodial agency. Children in the custody of a local department of social services or private child-placing agency shall not be discharged without the knowledge, consultation, and notification of the custodial agency. Refer also to Chapter VI of this manual for documentation and utilization review requirements.

TFC-CM Billing Requirements

- A billing unit is one calendar month.
- If an individual is temporarily out of the home, documentation of active treatment foster care case management services is required to bill for the time the individual is out of the home in the following situations:
  - Placement for inpatient services, in cooperation with the facility, to assist in discharge planning for transition back to the home;
  - Runaway – if the treatment foster care case manager is actively involved in finding the individual to be returned to the home; and
  - Detention – refer to the Chapter III discussion on "inmate" and verify Medicaid eligibility.