MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 12, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2500 - CASE MANAGEMENT

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2500 are being proposed to clarify that qualified providers who are employees or contractors of the State may provide Targeted Case Management (TCM) services to the Seriously Mentally Ill (SMI) population. This will be done in accordance with State Plan Section, Supplement to Attachment 3.1-A.

These changes are effective March 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 04/15 CHAPTER 2500 - CASE MANAGEMENT	MTL 18/14 CHAPTER 2500 - CASE MANAGEMENT

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2503.1A.4c.	**Target Group-Adults with a Serious Mental Illness (SMI)**	Added clarification that in accordance with State Plan Section, Supplement to Attachment 3.1-A the DHCFP will allow qualified providers who are employees or contractors of the State to provide Targeted Case Management (TCM) services to the Seriously Mentally Ill (SMI) population.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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CASE MANAGEMENT

2500 INTRODUCTION

Case Management is an optional Medicaid service pursuant to federal regulations. It may be provided without the use of a waiver and the state may limit the provision of services to a specific target group or defined location in the state. States are allowed to limit the providers of case management services available for individuals with development disabilities or chronic mental illness to ensure that these recipients receive needed services. The receipt of case management services does not alter an individual's eligibility to receive other services under the State Plan and recipients must have free choice of any qualified Medicaid provider. A recipient cannot be compelled to receive case management services, services cannot be a condition of receipt of other Medicaid services and other covered services cannot be a condition to receive case management services. Case management services provided in accordance with Section 1915(g) of the Social Security Act (SSA) will not duplicate payments made to public agencies or private entities under State Plan and other program authorities. Case managers cannot authorize, approve or deny the provision of services.

The intent of case management services is to assist recipients eligible under the State Plan in gaining access to needed medical, social, educational, and other support services including housing and transportation needs. Case management services do not include the direct delivery of medical, clinical or other direct services. Components of the service include assessment, care planning, referral/linkage and monitoring/follow-up. Case management services are provided to eligible recipients who are residing in a community setting or transitioning to a community setting following an institutional stay.

There are eight target groups eligible to receive this service. These groups are: (1) children and adolescents who are Non-Severely Emotionally Disturbed (Non-SED) with a mental illness; (2) children and adolescents who are Severely Emotionally Disturbed (SED); (3) adults who are Non-Seriously Mentally Ill (Non-SMI) with a mental illness; (4) adults who are Seriously Mentally Ill (SMI); (5) persons with intellectual disabilities or related conditions; (6) developmentally delayed infants and toddlers under age three; (7) Juvenile Probation Services (JPS), and (8) Child Protective Services (CPS).

All providers who participate in the Medicaid program must provide services in accordance with the rules and regulations of the Division of Health Care Financing and Policy (DHCFP), all policies and procedures described here in Medicaid Services Manual (MSM) Chapter 2500, as well as state and federal regulations and statutes.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and Nevada Check Up policies differ as documented in the Nevada Check Up Manual, Chapter 1000.

2501 AUTHORITY

A. In 1965, the 89th Congress added Title XIX of the Social Security Act (SSA) authorizing varying percentages of Federal Financial Participation (FFP) to states that elect to offer medical programs. The state must offer the 11 basic required medical services. FFP is also available, should states elect to cover some optional services. One of these optional services is Case Management.

B. Authorities include:

- Section 190 5(a)(19) of the SSA
- Section 191 5(b) of the SSA
- Section 191 5(c) of the SSA
- Section 191 5(g)(2) of the SSA
- 42 Code of Federal Regulations (CFR) Parts 431, 440, and 441
- 42 CFR 483.430
- Section 60 52 of the Deficit Reduction Act of 200
- The Supplemental Appropriations Act 2008

2502 TARGET GROUP DEFINITIONS

2502.1 LEAD CASE MANAGER

The Lead Case Manager is only used if a recipient is included in more than one target group at a given time. The Lead Case Manager is a case manager, and represents Severely Emotionally Disturbed (SED) children and adolescents or Seriously Mentally Ill (SMI) adults. The Lead Case Manager coordinates the recipient's care and services with another case manager. The Lead Case Manager is responsible for coordinating the additional case management services, whether or not, chronologically, the Lead Case Manager was the original or the subsequent case manager.

2502.2 TARGET GROUP — CHILD PROTECTIVE SERVICES (CPS)

Child Protective Services are:

a. Provided to children and young adults who are Medicaid recipients and abused or neglected or suspected to be at risk thereof as evidenced by being in the care of the Division of Child and Family Services (DCFS), Clark County Department of Family Youth Services or Washoe County Department of Social Services.

b. Provided to families who are abused or neglected or suspected to be at risk thereof as evidenced by being in the care of DCFS, Clark County Department of Family Services or Washoe County Department of Social Services.

2502.3 TARGET GROUP - DEVELOPMENTALLY DELAYED INFANTS AND TODDLERS UNDER AGE THREE

A. Developmentally delayed infants and toddlers are children ages birth through two years determined eligible for early intervention services through the identification of a "developmental delay," a term which means:

1. A child exhibits a minimum of 50% delay of the child's chronological age in any one of the areas listed below or a minimum of 25% delay of the child's chronological age in any two of the areas listed below. Delays for infants less than 36 weeks gestation shall be calculated according to their adjusted age.

2. The delay(s) must be defined in one or more of the following areas:

a. Cognitive development;

b. Physical development, including vision and hearing;

c. Communication development;

d. Social or emotional development; or

e. Adaptive development.

3. Children also are eligible who have a diagnosed physical or mental condition which has a high probability of resulting in developmental delays.

4. Informed clinical opinion must be used in determining eligibility for services as a result of a development delay.

2502.4 TARGET GROUP — JUVENILE PROBATION SERVICES (JPS)

A. Juvenile Probation Services are:

1. Covered services provided to juveniles on probation (referred or under the supervision of juvenile caseworkers) for Washoe County JPS and Clark County Department of Juvenile Justice Services.

2. Covered services provided to family member(s) who are Medicaid eligible whose children are on probation.

2502. 5 TARGET GROUP — PERSONS WITH INTELLECTUAL DISABILITIES OR RELATED CONDITIONS

Persons with intellectual disabilities or related conditions are persons who:

a. Are significantly sub-average in general intellectual functioning (intelligence quotient (IQ) of 70 or below) with concurrent related limitations in two or more adaptive skill areas, such as communication, self-care, social skills, community use, self-direction, health and safety, functional academics, leisure and work activities.

Persons with related conditions are individuals who have a severe chronic disability. It is manifested before the person reaches age 22 and is likely to continue indefinitely. The disability can be attributable to cerebral palsy, epilepsy or any other condition, other than mental illness, found to be closely related to intellectual disabilities because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of an intellectually disabled person and requires treatment or services similar to those required by these persons.

The related condition results in substantial functional limitations in three or more of the following areas of major life activity:

1. Self care.

2. Understanding and use of language.

3. Learning.

4. Mobility.

5. Self-direction.

6. Capacity for independent living.

2502.6 TARGET GROUP — NON-SERIOUSLY MENTALLY ILL (NON-SMI) ADULTS

Adults, who are Non-SMI, excluding dementia and intellectual disabilities, are recipients 18 years of age and older with significant life stressors and have:

a. A Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) Axis I diagnosis, including V-codes, that does not meet SMI criteria.

b. A Level of Care Utilization System (LOCUS) score of Level I or II.

2502.7 TARGET GROUP — SERIOUS MENTAL ILLNESS (SMI) ADULTS

Adults with an SMI are persons:

a. 18 years of age and older;

b. Who currently, or at any time during the past year (continuous 12 month period);

1. Have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified within the DSM-IV (excluding substance abuse or addictive disorders, irreversible dementias as well as intellectual disabilities, unless they co-occur with another SMI that meets DSM-IV criteria);

2. That resulted in functional impairment which substantially interferes with or limits one or more major life activities;

c. Have a functional impairment addressing the ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health illness and is viewed from the individual's perspective within the environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety.

2502.8 TARGET GROUP — NON-SEVERELY EMOTIONALLY DISTURBED (NON-SED) CHILDREN AND ADOLESCENTS

Children and adolescents, who are Non-SED, excluding dementia and intellectual disabilities, are recipients with significant life stressors and have:

a. A DSM-IV Axis I diagnosis that does not meet SED criteria.

b. V-code DSM-IV diagnosis that does not meet SED criteria.

c. Child and Adolescent Services Intensity Instrument (CASII) Level of 0, 1, 2, or above.

d. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3) Axis I diagnosis or DC:0-3 Axis II Parent-Infancy Relationship Global Assessment Scale (PIR-GAS) score of 40 or less.

2502.9 TARGET GROUP — SEVERE EMOTIONAL DISTURBANCE (SED)

Children from birth through 48 months who currently or at any time during the past year (continuous 12 month period) have a:

a. DC:0-3 Axis I diagnostic category in place of a DSM-IV Axis I diagnostic category; or

b. DC:0-3 Axis II PIR-GAS score of 40 or less (the label for a PIR-GAS score of 40 is "Disturbed"); or

Children with a SED are persons age four to age 18 who currently or at any time during the past year (continuous 12-month period) have a:

a. Diagnosable mental, behavioral or diagnostic criteria that meet the coding and definition criteria specified in the DSM-IV. This excludes substance abuse or addictive disorders, irreversible dementias, as well as mental retardation/intellectual disabilities and V codes, unless they co-occur with another SMI that meets DSM-IV criteria that results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities, and

b. These disorders include any mental disorder (including those of biological etiology) listed in DSM-IV or their International Classification of Diseases (ICD)-9-Clinical Modification (CM) equivalent (and subsequent revisions), with the exception of DSM-IV "V" codes, substance use and developmental disorders, which are excluded unless they co-occur with another diagnosable SED. All of these disorders have episodic, recurrent, or persistent features; however they vary in terms of severity and disabling effects; and

c. Have a functional impairment defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

2502.10 CASE MANAGEMENT SERVICES

Case management services are services which assist an individual in gaining access to needed medical, social, educational, and other supportive services and must include the following components:

a. Assessment of the eligible individual to determine service needs.

b. Development of a person-centered care plan.

c. Referral and related activities to help the individual obtain needed services.

d. Monitoring and follow-up.

Case management services involve the following activities to assist the eligible recipient in obtaining needed services:

a. Assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. The assessment activities include the following:

1. Taking client history.

2. Identifying the needs of the individual and completing related documentation.

3. Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible recipient.

b. Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:

1. Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible recipient.

2. Includes activities such as ensuring the active participation of the eligible recipient and working with the recipient (or the individual's authorized health care decision maker) and others to develop those goals.

3. Identifies a course of action to respond to the assessed needs of the eligible recipient.

c. Referral and related activities (such as scheduling appointments for the recipient) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

d. Monitoring and follow-up; activities include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and may be with the individual, family members, service provider or other entities or individuals. The monitoring should be conducted as frequently as necessary, and include at least one annual monitoring, to help determine whether the following conditions are met:

1. Services are being furnished in accordance with the individual's care plan.

2. Services in the care plan are adequate.

3. There are changes in the needs or status of the eligible recipient.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. Monitoring may involve either face-to-face or telephone contact, at least annually.

2502.10A CASE RECORD DOCUMENTATION

A case record documentation shall be maintained for each recipient and shall contain the following items:

1. The name of the individual receiving services, the dates of case management services, the name of the provider agency and person chosen by the recipient to provide services.

2. The nature, content, and units of case management services received. Units, for documentation purposes, are further defined as actual case management activities performed.

a. If paid per unit, document date, time, number of units and activities completed.

b. If paid per monthly cap rate, document date, time and activities completed.

3. Whether the goals specified in the care plan have been achieved.

4. If an individual declines services listed in the care plan, this must be documented in the individual's case record.

5. Timelines for providing services and reassessment.

6. The need for and occurrences of coordination with case managers of other programs.

The case manager shall make available to Nevada Medicaid or Medicaid's Quality Improvement Organization (QIO-like vendor), upon request, copies of the medical record, progress notes, care plan, case record or summary documents which reflect the ongoing need for case management services and support any additional services requested.

2503 POLICY

2503.1 CASE MANAGEMENT SERVICES POLICY

2503.1A COVERAGE AND LIMITATIONS

A maximum of 30 hours per target group, per calendar month, per recipient, is allowed for case management services. (Maximum hours do not apply to providers who are paid a capitated, per member/per month rate).

1. Case management services are reimbursable when:

   a. Provided to Medicaid eligible recipients, on a one-to-one (telephone or face-to-face) basis.

   b. Medically necessary.

   c. Provided by a qualified provider enrolled to serve the target group in which the recipient belongs.

   d. Provided by the recipient's chosen provider.

   e. Contacts by the case manager with individuals who are not eligible for Medicaid when the purpose of the contact is directly related to the management of the eligible recipient's care.

   f. There are no third parties liable to pay for these services, including as reimbursement under a medical, social, educational or other federally funded program. Third party insurance payments for case management services must be pursued for all recipients.

      The provider must determine whether the recipient has other health insurance. Providers may survey health care insurance companies to determine whether case management is a covered benefit. Exception: This is not necessary for Medicare since it is not a covered service. If the health care provider covers case management, it must be billed for all recipients for services provided. For Medicaid recipients, the health care insurance company must be billed before Medicaid is billed. Once payment is received, if the other company did not pay the entire cost of services, Medicaid may be billed. If the health care insurance company will not pay for case management services, documentation of this must be maintained in the recipient’s case record.

   g. The service is not an integral component or administrative service of another covered Medicaid service.

2. Case management services not reimbursable under the Nevada Medicaid Program include, but are not limited to:

   a. The actual or direct provision of medical services or treatment. Examples include, but are not limited to:

      1. Training in daily living skills;

      2. Training in work skills and social skills;

      3. Grooming and other personal services;

      4. Training in housekeeping, laundry, cooking;

      5. Transportation services;

      6. Individual, group or family therapy services;

      7. Crisis intervention services; and/or

      8. Diagnostic testing and assessments.

   b. Services which go beyond assisting individuals in gaining access to needed services. Examples include, but are not limited to:

      1. Paying bills and/or balancing the recipient's checkbook;

      2. Completing application forms, paper work, evaluations and reports including applying for Medicaid eligibility;

      3. Escorting or transporting recipients to scheduled medical appointments; and/or

      4. Providing child care so the recipient can access services.

   c. Traveling to and from appointments with recipients.

   d. Traveling to and from appointments (without recipients).

   e. Case management services provided to recipients between 22 and 64 years of age who are in an Institution for Mental Disease (IMD).

   f. Using case management codes for billing, when the recipient does not meet the criteria for the target group.

g. Recipient Outreach – Outreach activities in which a state agency or other provider attempts to contact potential recipients of a service do not constitute case management services.

h. The direct delivery of foster care services and therapeutic foster care services. The following activities are not considered to qualify as components of Medicaid case management services:

1. Research gathering and completion of documentation required by the foster care program.

2. Assessing adoption placements.

3. Recruiting or interviewing potential foster care parents.

4. Serving legal papers and attendance at court appearances.

5. Home investigations.

6. Providing transportation.

7. Administering foster care subsidies.

8. Making placement arrangements.

9. Training, supervision, compensation for foster care parents.

i. If the case manager also provides other services under the plan, the State must ensure that a conflict of interest does not exist that will result in the case manager making self-referrals. Individuals must be free to choose their case management provider from among those that have qualified to participate in Medicaid and are willing to provide the service.

j. Services provided as “administrative case management”, including Medicaid eligibility determination, intake processing, preadmission screening for inpatient care, utilization review and prior authorization for Medicaid services are not reimbursable.

k. Administrative functions for recipients under the Individuals with Disabilities Education Act (IDEA) such as the development of an Individual Education Plan and the implementation and development of an Individual Family Service Plan for Early Intervention Services are not reimbursable as case management services.

3. Target Group – Non-Seriously Mentally Ill (NON-SMI) Adults

a. Service Eligibility:

The determination for adults with a NON-SMI is made by a licensed, qualified mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), or Master's degree psychiatric nurse).

b. Provider Qualifications:

Minimum qualification of a case manager providing services for NON-SMI adults are a service coordinator with a bachelor's degree in a health-related field, Registered Nurse (RN), Master's level professional (LSCW or LMFT), Advanced Practice Registered Nurse (APRN) in mental health, psychologist, or mental health professional who works under the direct supervision of a person listed above.

c. Service Criteria:

Admission Criteria includes:

1. Diagnostic and Statistical manual of Mental Disorders (DSM-IV), Axis I diagnosis, including V-codes (including dementia, intellectual disabilities or primary diagnosis of a substance abuse disorder, unless these co-occur with another mental illness that meets DSM-IV criteria).

2. Recipients require assistance in obtaining and coordinating medical, social, educational and other support services.

d. Continuing Stay Criteria:

1. Continues to meet admission criteria.

2. Individualized care plan identifies all medical, social, educational and other support services currently being provided, as well as unmet needs of the recipient.

3. Documentation supports progress towards specific case management goals identified in the established care plan with barriers identified and addressed.

e. Discharge/Exclusionary Criteria:

1. No longer meets NON-SMI determination.

2. No longer meets the admission and continuing stay criteria.

3. Recipient or family chooses not to participate in the program or is non-compliant.

4. Recipient requires inpatient psychiatric hospitalization, Institution for Mental Diseases (IMD), or Nursing Facility (NF) placement.

5. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute admission.

4. Targeted Group – Adult with a Serious Mental Illness (SMI)

a. Reference definition under Section 2502.6.

b. Service Eligibility Determination

The determination for adults with a SMI is made by a licensed mental health professional (psychiatrist, psychologist, LCSW, LMFT, or Master's degree psychiatric nurse).

c. Provider Qualifications

Minimum qualifications of a case manager providing services for SMI adults (which can only be provided by a state agency and its employees or contractors or an organization affiliated with the University of Nevada School of Medicine) are a case manager with a Bachelor's degree in a health-related field, Registered Nurse (RN), Master's level professional (LCSW or LMFT), APRN in mental health, psychologist, or mental health professional who works under the direct supervision of a person listed above.

d. Service Criteria

1. Admission Criteria:

Must meet of all the following:

a. DSM-IV, AXIS I or II, diagnosis (excluding V-codes, dementia, intellectual disabilities or a primary diagnosis of a substance abuse disorder, unless these co-occur with another mental illness that meets DMS-IV criteria).

b. Recipient requires assistance in obtaining and coordinating medical, social, educational and other support services.

2. Continuing Stay Criteria:

Must meet all of the following:

a. Continues to meet admission criteria.

b. Individualized care plan identifies all medical, social, educational and other support services currently being provided, as well as unmet needs of the recipient.

c. Documentation supports progress towards specific case management goals identified in the case management care plan, and barriers have been identified and addressed.

d. Treatment plan and goals must be established.

3. Discharge Criteria:

Must meet at least one of the following:

a. No longer meets SMI determination.

b. No longer meets the admission and continuing stay criteria.

c. Admission into a psychiatric hospital, IMD or NF.

d. Recipient or family chooses not to participate in the program or is non-compliant.

e. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute treatment.

4. Exclusionary Criteria:

Must meet at least one of the following:

a. No longer meets SMI determination.

b. No longer meets the admission and continuing stay criteria.

c. Admission into a psychiatric hospital, NF or IMD.

d. Recipient chooses not to participate in the program or is non-compliant.

e. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute treatment.

5. Target Group – Non-Severely Emotionally Disturbed (NON-SED) Children and Adolescents

a. Service Eligibility Determination

The determination for children and adolescents with a NON-SED is made by a qualified mental health professional (psychiatrist, psychologist, LCSW, LMFT, or Master's degree psychiatric nurse).

b. Provider Qualifications

The minimum qualifications of a case manager providing services for a NON-SED child are a case manager with a Bachelor's degree in a health related field, Doctorate degree and license in psychology, RN, Master's level professional (LCSW or LMFT) APRN in mental health, or a mental health professional who works under the direct supervision of a person listed above, and LCSW or LMFT interns that are supervised within the scope of their license.

6. Target Group – Children and Adolescents with a Severe Emotional Disturbance (SED)

a. Reference definition under Section 2502.8.

b. Service Eligibility Determination

The determination for children and adolescents with a SED is made by a licensed mental health professional (psychiatrist, psychologist, LCSW, LMFT or Master's degree psychiatric nurse).

c. Provider Qualifications

Minimum qualifications of a case manager providing services for SED children and adolescents (which can only be provided by a state agency or organization affiliated with the University of Nevada School of Medicine) are a case manager with a Bachelor's degree in a health-related field, RN, Master's level professional (LCSW or LMFT), APRN in mental health, psychologist, or mental health professional who works under the direct supervision of a person listed above.

d. Service Criteria

1. Admission

Must meet all of the following:

a. DSM-IV, AXIS I or II, diagnosis (excluding V-codes, dementia, intellectual disability or a primary diagnosis of a substance abuse disorder, unless they co-occur with another mental illness that meets DSM-IV criteria).

b. Recipient requires assistance in obtaining and coordinating medical, social, educational and other support services.

2. Continuing Stay Criteria:

Must meet all of the following:

a. Continues to meet admission criteria.

b. Individualized care plan identifies all medical, social, educational and other support services currently being provided, as well as unmet needs of the recipient.

c. Documentation supports progress towards specific case management goals identified in the case management care plan, and barriers have been identified and addressed. Treatment plan and goals must be established.

3. Discharge Criteria:

Must meet one of the following:

a. No longer meets SED determination.

b. No longer meets the admission and continuing stay criteria.

c. Recipient or family chooses not to participate in the program or is non-compliant.

d. Requires inpatient psychiatric hospitalization, NF or Residential Treatment Center (RTC) placement.

e. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute admissions.

4. Exclusionary Criteria:

a. No longer meets SED determination.

b. No longer meets the admission and continuing stay criteria.

c. Requires inpatient psychiatric, NF or RTC hospitalization.

d. Recipient or family chooses not to participate in the program.

e. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

a. Transitional Targeted Case Management services are provided 14 days prior to discharge for an institutional stay.

b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

7. Target Group – Persons with Intellectual Disabilities or Related Conditions

a. Reference definition under Section 2502.4.

b. Service Eligibility Determination

The determination is made by a Qualified Mental Retardation Professional (QMRP) as defined in 42 Code of Federal Regulations (CFR) 483.430.

c. Provider Qualifications

1. Employee or contractor of the Division of Mental Health and Development Services (MHDS) or the Division of Child and Family Services (DCFS); and

a. Bachelor's level social worker licensed to practice in Nevada.

b. RN licensed in Nevada to practice professional nursing.

c. Disabilities specialist with at least a Bachelor's degree in human sciences.

d. Psychologist licensed to practice in Nevada.

e. Child development specialist and psychology, nursing, or social work caseworker who works under the direct supervision of a person in classes (a) through (d) above.

d. Service Criteria

1. Admission Criteria:

Meets admission criteria as addressed in Section 2502.4.A.

2. Continuing Stay Criteria:

Continues to meet admission criteria.

3. Discharge Criteria:

a. Does not meet admission criteria.

b. Recipient or family chooses not to participate in program or is non-compliant.

c. Admission into a hospital, NF, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

d. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute admissions.

4. Exclusionary Criteria:

a. Does not meet admission criteria.

b. Recipient is hospitalized or resides in an ICF/IID.

c. Admission into a hospital, NF or CFR/IID.

e. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

    a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.

    b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

8. Target Group – Developmentally Delayed Infants and Toddlers Under Age Three

    a. Reference definition under Section 2502.2.

    b. Service Eligibility Determination

    Eligibility is determined by a multidisciplinary team consisting of two early intervention professionals and the parent. Eligibility determination must include the following:

    1. Be conducted by personnel trained to utilize appropriate methods and procedures;

    2. Be based on informed clinical opinions; and

    3. Include the following:

        a. Review of pertinent records related to the child's current health status and medical history.

        b. An evaluation of the child's level of functioning in each of the following developmental areas:

            1. Cognitive development.

            2. Physical development, including vision and hearing.

            3. Communication development.

            4. Social or emotional development.

            5. Adaptive development.

c. An assessment of the unique needs of the child including the identification of services appropriate to meet those needs.

c. Provider Qualifications

Qualifications of a case manager providing services to an infant or toddler with developmental delays in an employee or contractor of the Department of Health and Human Services (DHHS) or one of its qualified Divisions; and

1. An individual with a Master's degree from an accredited college or university in early childhood special education, childhood human growth and development, psychology, counseling, social work, or a closely related field; or

2. An individual with a Bachelor's degree from an accredited college or university with major work in early childhood growth and development, early childhood special education, psychology, counseling, social work or a closely related field, and one year of full-time professional experience in an early integrated preschool program, mental health facility, or a clinical setting providing developmental or special education or treatment-oriented services to preschool or school age children with physical or mental disabilities, or emotional or behavioral disorders.

d. Service Criteria

1. Admission Criteria:

a. Medicaid eligible.

b. Meets criteria addressed in Section 2502.1.A.

2. Continuing Stay Criteria:

Continues to meet admission criteria.

3. Discharge Criteria:

a. Does not meet admission criteria.

b. Child has demonstrated age appropriate skills for six consecutive months.

c. Child turns age three.

d. Meets criteria for admission to an inpatient facility.

e. Family chooses not to participate in the program or is non-compliant.

f. Has sufficient support system to sustain stability, not requiring unnecessary or frequent acute admissions.

4. Exclusionary Criteria:

a. Does not meet admission criteria.

b. Child is age three or older.

c. Meets criteria for admission to an inpatient facility.

d. Family chooses not to participate in the program or is non-compliant.

e. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.

b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

9. Target Group – Juvenile Probation Services

a. Reference definition under Section 2502.3.

b. Provider Qualifications

The organization providing case management services for JPS must meet the following requirements:

1. A minimum of five years experience of working successfully with children and families in the target population, including a demonstrated capacity to provide all components of case management.

2. A minimum of five years experience in responding successfully to the needs of children and families in the target population on a countywide 24 hours, seven days a week basis.

3. A minimum of five years case management experience in coordinating and linking community medical, social, educational, or other resources needed by the target population on a countywide basis.

4. A minimum of five years working with the target population.

5. A minimum of five years experience in documenting and maintaining individual case records that is in accordance with all applicable state and federal requirements.

6. A minimum of five years experience of demonstrated capacity in meeting the case management service needs of the target population.

7. Demonstrated capacity to provide training and supervision to individual case managers, including training pertaining to Medicaid-covered services.

8. Qualifications of individual case managers:

   a. Bachelor's degree in a related field; or equivalent college and field experience; and

   b. Ability to work in and with legal systems, including the court system; and

   c. Ability to learn state and federal rules, laws, and guidelines relating to the target population and to gain knowledge about community resources.

c. Eligibility Determination

Medicaid eligible recipient's status is determined by the County Department of JPS.

d. Service Criteria

Medicaid eligible recipient is under the care of the County Department of JPS. Scope of coverage services must be in accordance with federal regulations.

e. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.

b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

10. Target Group – Child Protective Services (CPS)

a. Reference definition under Section 2502.1.

b. Provider Qualifications

The organization providing case management services for CPS must meet the following requirements:

1. A minimum of five years experience of working successfully with children and families in the target population, including a demonstrated capacity to provide all components of case management.

2. A minimum of five years experience in responding successfully to the needs of children and families in the target population on a countywide 24 hours, seven days a week basis.

3. A minimum of five years case management experience in accordance and linking community medical, social, educational, or other resources needed by the target population on a countywide basis.

4. A minimum of five years working with the target population.

5. A minimum of five years experience in documenting and maintaining individual case records that is in accordance with all applicable state and federal requirements.

6. A minimum of five years experience of demonstrated capacity in meeting the case management service needs of the target population.

7. Demonstrated capacity to provide training and supervision to individual case managers, including training pertaining to Medicaid-covered services.

8. Qualifications of individual case managers:

   a. Bachelor's degree in a related field; or equivalent college and field experience; and

   b. Ability to work in and with legal systems, including the court system; and

   c. Ability to learn state and federal rules, laws, and guidelines relating to the target population and to gain knowledge about community resources.

c. Eligibility Determination

Medicaid eligible recipient's status is determined by the County's Department of Social Services CPS.

d. Service Criteria

Medicaid eligible recipient is under the care of the County's Department of Social Services CPS. Scope of services must be in accordance with federal regulations.

e. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

   a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.

   b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

2503.1B RECIPIENT RESPONSIBILITIES

1. Medicaid recipients, their families, or legal guardians are required to provide a valid Medicaid eligibility card to their case management service providers.

2. Medicaid recipients, their families, or legal guardians are expected to comply with the recipient's treatment and care plans.

2503.1C AUTHORIZATION PROCESS

Medicaid recipients are entitled to receive a maximum of 30 hours of case management services per target group, per calendar month, per recipient. (Maximum hours do not apply to providers who are paid a capitated, per member/per month rate).

If the recipient requires more than 30 hours per month, the case manager must thoroughly document in the recipient's case record the justification for the additional hours and submit a prior authorization request to the QIO-like vendor.

2504 HEARINGS

Please reference Medicaid Services Manual (MSM) Chapter 3100, Hearings, for hearings procedures.

2505 RESERVED FOR FUTURE USE