

Cathy Cooper  
Authorized Signature

**Number:** SPD-AR-09-018  
**Issue Date:** 6/30/2009

**Topic:** Developmental Disabilities

**Due Date:**

**Subject:** Targeted Case Management Encounters: Guidelines

**Applies to (check all that apply):**

- All DHS employees
- Area Agencies on Aging
- Children, Adults and Families
- County DD Program Managers
- County Mental Health Directors
- Health Services
- Seniors and People with Disabilities
- Other (please specify): DD Children's residential services; SPD/DD central office staff

**Action Required:** Review; Replace existing guidelines with new guidelines, effective immediately.

**Reason for Action:** Allowable TCM activities have been revised based on DD system and CMS changes.

**Field/Stakeholder review:**  Yes  No

**If yes, reviewed by:**

*If you have any questions about this action request, contact:*

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**Service Coordinator**  
**Targeted Case Management Services**  
**IMPORTANT THINGS TO REMEMBER:**

**1. Service Coordinators:**

- Bill for services that are identified as Targeted Case management activities. Targeted Case Management (TCM) is described in Oregon's State Plan for Medicaid Services as case management activities "to access, coordinate and assure the delivery of services and supports required by individuals with developmental disabilities."
- A Service Coordinator may report encounters for TCM activities provided on a daily basis for individuals served. A corresponding progress note must be entered into the individual's case file and must adequately describe the qualifying TCM activity. Progress notes should clearly document the date the service was provided. That service date must also correspond with the service date of the encounter reported.

**2. To qualify as a Targeted Case Management service:**

- the individual for whom an encounter is being reported, **must be enrolled in case management services**
- the activities in which the **Service Coordinator is engaged are for the purpose of assisting individuals to gain access to needed care and services** that are appropriate to the individual. This can include phone contact, written information and email as long as it is a **means of delivering a service related to the documented needs of the individual (not simply providing information)**
- there must be documentation in the person's case file with enough information to describe the activity undertaken and how the action relates to the individuals needs.

**3. Some services cannot be reported as an encounter by Services Coordinators. These include:**

- The provision of **direct services**, such as money management, budgeting, etc.
- Any **duplicated service**. As stated in the State Plan for Medicaid Services, "Targeted case management services will not duplicate any other Medicaid service provided under the State plan or under a waiver."
- **Intake**, because an individual must be enrolled in case management to bill for services.
- **Determination of eligibility for DD services**
- **Enrollment, termination and/or encounter reporting** in CPMS or eXPRS – these are not case management services.
- **General outreach**, such as mass mailings and non-individualized information sharing.
- **Certification and/or licensing** specific activities.

## Targeted Case Management Billable Services

This follows Oregon’s Administrative Rule 411-320-0010 through 411-320-0200 for Community Developmental Disability Services; specifically section 411-320-0090(4) Minimum standards for Case Management services.

<b>Plans and Annual Summaries</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Attending the annual plan meeting and participating in the development of the plan for an individual enrolled in comprehensive services.</i></li> <li>➤ <i>Assuring that the level of care information identified in the Title XIX waiver form is addressed and supported by the Individual Support Plan.</i></li> <li>➤ <i>Participating in any ISP associated tasks such as the Personal Focus Worksheet, Risk Tracking Record, Financial Management Plan or development of Protocols.</i></li> <li>➤ <i>Assisting an individual to obtain services identified in their services plan.</i></li> <li>➤ <i>Developing the annual plan for a child who is receiving family support services, in coordination with the child and family.</i></li> <li>➤ <i>Completing an annual summary for an individual enrolled in only case management services. This must include contact with the individual or other significant party who can provide updated information.</i></li> <li>➤ <i>Assisting in developing service plans for children living at home, adults in In- Home Comprehensive Services and adults on waiting lists who are not served by a Support Service Brokerage.</i></li> </ul>

<b>Service Authorization</b>	
<i>Examples:</i>	<ul style="list-style-type: none"> <li>➤ <i>Signing an ISP for someone in Comprehensive services. This includes assuring that the ISP was based on a person centered planning process; that what is important to and for an individual is documented as a part of the plan development and that the supports necessary to address issues of health, behavior, safety and financial supports are documented and included in the action plan(s).</i></li> <li>➤ <i>Signing a plan developed for a child in family support services or an Adult in In Home Comprehensive Support services and assuring that plans meet Administrative Rule requirements.</i></li> <li>➤ <i>Authorizing Personal Care for people in case management only services.</i></li> </ul>

<b>Monitoring</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Service monitoring of an individual in a comprehensive service (adult or child), or a child served in family support.</i></li> <li>➤ <i>Monitoring of personal funds for those in 24 hour homes and foster care.</i></li> <li>➤ <i>Following up on an incident report or SERT, with an individual or provider, that results in the facilitation or provision of service (other than those individuals in Support Services).</i></li> <li>➤ <i>Following up with an individual, their family or provider as a result of a SERT incident, monitoring the health and safety of the individual.</i></li> <li>➤ <i>Attending a SERT meeting when individual issues are discussed and Service Coordinator action is required.</i></li> <li>➤ <i>Following up with a person in case management only services, after the development of the annual summary, to respond to a change in individual circumstances or to take action as a result of reviewing the plan.</i></li> </ul>

<b>Entry, Exit or Transfer</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Making referral for an entry, exit or transfer into: department funded programs for people with developmental disabilities; children's residential services; children's proctor care; children's intensive in-home supports; state operated community programs; and state training center.</i></li> <li>➤ <i>Participating in entry, exit or transfer meeting for any of the above.</i></li> <li>➤ <i>Assuring the appropriate referral to a support service brokerage, and participating in the entry of an individual into a brokerage.</i></li> </ul>

<b>Crisis Services</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Assessing an individual crisis situation, determining eligibility for crisis services, investigating any alternative resources which might be available, and referring for crisis services.</i></li> <li>➤ <i>Participating in planning meetings to address individual crisis needs, discuss options and develop an action plan.</i></li> <li>➤ <i>Assessing whether the individual's crisis is being mitigated, and providing follow up when appropriate (coordinating with regional crisis coordinator). This should be done through contact with the individual, any service providers and the family.</i></li> <li>➤ <i>Coordinating with service providers or other support team members to evaluate the impact of crisis service upon the individuals, and assuring that needed changes are recommended to the individuals' support team.</i></li> <li>➤ <i>Monitoring crisis services by reviewing reports and on-site visits. When monitoring, consider: a review of the frequency, duration and cost of goods and services being provided; outcome of the service; and whether the need for crisis services continues.</i></li> </ul>

<b>Protective Services</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Assessing the need for protective services which may include: determining the ability of the adult to understand the nature of the protective service and his or her willingness to accept services; coordinating evaluations to determine or verify the adult's physical and mental status.</i></li> <li>➤ <i>Assisting in, and arranging for appropriate services and alternative living arrangements.</i></li> <li>➤ <i>Assisting in or arranging the medical, legal or other necessary services to prevent further abuse.</i></li> <li>➤ <i>Providing advocacy to assure the adult's rights and entitlements are protected.</i></li> <li>➤ <i>Processing the information, developing conclusions as a result of the investigation, making recommendations, and adjusting the individual plan if necessary to support recommendations.</i></li> <li>➤ <i>Monitoring for the implementation of the report recommendations.</i></li> </ul>

<b>Civil Commitment</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Investigating and evaluating whether alternatives to commitment are available.</i></li> <li>➤ <i>Preparing information for the court</i></li> <li>➤ <i>Being present and available at the commitment hearing.</i></li> </ul>

<b>Information and Referral</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Communicating with individuals and their families, in a timely manner, information relevant to specific needs, which are available within the county, and documenting such in a case note.</i></li> <li>➤ <i>Providing information and timely referral for services available from other agencies or organizations within the county.</i></li> <li>➤ <b><i>IMPORTANT:</i></b> <i>Encounters for which a claim can be made are those <b>activities which assist individuals gain access to needed care and services</b> that are <u>appropriate</u> to the individual. <u>Sending a flyer regarding general upcoming community activities is not billable.</u> However, if the information is specific to an interest identified by the individual (preferably documented in his/her ISP), and the Services Coordinator provides follow up contact to further facilitate access to the information shared, then the activity can be claimed as a TCM encounter..</i></li> <li>➤ <i>Contacting family members or significant others to assess an individuals needs, coordinate and/or access services and provide information and referral (with the consent of the adult individual).</i></li> </ul>

<b>Access</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Assisting individuals to access services and resources. This could include :</i> <ul style="list-style-type: none"> <li>➤ <i>Discussing with family and individuals their particular needs and interests (are there resources through other social service entities that would be beneficial?)</i></li> <li>➤ <i>Assisting in the development and disbursement of referral information,</i></li> <li>➤ <i>Coordinating with other agencies, the individual and the family to assure an appropriate referral for the services being requested.</i></li> <li>➤ <i>Facilitating access to financial assistance, e.g. Social Security benefits, Food stamps, Section 8 Housing, etc.</i></li> <li>➤ <i>Assisting an individual to access legal services.</i></li> <li>➤ <i>Assisting an individual to obtain transportation to appointments.</i></li> <li>➤ <i>Informing and assisting an individual or their family to obtain guardianship services.</i></li> </ul> </li> </ul>

<b>Coordination with Child Welfare Activities</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Coordinating services with the Child Welfare case worker, to ensure the provision of required supports from the CDDP in conjunction with the supports provided through Child Welfare.</i></li> </ul>

<b>Children in School</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Attending and contributing to the IEP planning meeting for a child, to discuss relevant supports outside of the supports provided through the school system, when invited by the family or guardian.</i></li> <li>➤ <i>Assisting the family in accessing <b>critical non educational services</b> that a child or family may need.</i></li> <li>➤ <i>Participating in transition planning by attending the IEP meeting of students 16 years or older to discuss transition to adult living and work situations.</i></li> </ul>

<b>Nursing Home Services</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Facilitating a referral to a nursing home when appropriate. This may include working with the local SDA to request that a Pre-Admission Screening occur.</i></li> <li>➤ <i>Participating in an entry meeting, and providing all related health care and support needs.</i></li> <li>➤ <i>Participating in transitional planning for an individual's discharge from the Nursing Home, within six months of the actual discharge date.</i></li> </ul>

<b>Specialized Services in Nursing Facilities</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Referring an individuals for PASSR-2 assessment to determine if they meet the OAR eligibility criteria for Specialized Services;</i></li> <li>➤ <i>Coordinating with the SPD Program Specialist regarding access and enrollment into available Specialized Services;</i></li> <li>➤ <i>Coordinating with the individual, his or her legal guardian, the staff of the nursing facility and other service providers, as appropriate, to provide or arrange for specialized services.</i></li> <li>➤ <i>Monitoring the individual's Specialized Services plan; and authorization of annual Specialized Services plans.</i></li> </ul>

<b>Adult Case Management Only</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>For individuals who are not enrolled in any other services besides case management, an annual summary must be completed, and must include contact with the individual or other significant party who can provide updated information.</i></li> <li>➤ <i>Referral to a Support Services brokerage, particularly for those individuals who require more than occasional services, or who could benefit from services offered through a brokerage.</i></li> </ul>

<b>Serious Events</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Reviewing Incident Reports to determine whether the report rises to the level of a SERT</i></li> <li>➤ <i>Participating in a SERT meeting <u>when</u> individual issues are discussed and action is required.</i></li> <li>➤ <i>Review and follow-up of serious event reports as part of the SERT process, as it relates to an individual.</i></li> </ul>

<b>Medicaid Waivers</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Completing a Title XIX Waiver form which includes the individual's level of care.</i></li> <li>➤ <i>Assuring that the ISP is consistent with the needs identified through the level of care assessment on the Title XIX waiver form.</i></li> <li>➤ <i>Offering Medicaid eligible individuals the choice of home and community based waiver services (except for children being served by CIIS or in a Department direct contracted 24 hour residential home).</i></li> <li>➤ <i>Assuring that Medicaid eligible individuals are provided a notice of fair hearing rights.</i></li> <li>➤ <i>Reviewing the Title XIX Waiver form for people served through the comprehensive waiver, on an annual basis, or whenever there is a significant change.</i></li> </ul>

<b>Health Care Representative</b>	
<i>Examples:</i>	<ul style="list-style-type: none"> <li>➤ <i>Participating in the assessment with the ISP team, for capacity of an individual to appoint a health care representative.</i></li> <li>➤ <i>Efforts on the part of a service coordinator to facilitate the appointment of a health care representative.</i></li> </ul>
<b>Interagency Coordination</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Coordinating with other state, public and private agencies regarding services to individuals with developmental disabilities.</i></li> <li>➤ <i>Facilitating access to financial assistance such Social Security benefits, Veterans, etc.</i></li> </ul>
<b>In Home Services</b>	
<i>Examples</i>	<ul style="list-style-type: none"> <li>➤ <i>Assisting in determining the needs of the individual, and developing a service plan.</i></li> <li>➤ <i>Assisting in finding and arranging resources and supports for the individual.</i></li> <li>➤ <i>Identifying technical assistance supports for the individual regarding directing support providers and employers.</i></li> <li>➤ <i>Providing information and referral to fiscal intermediary services.</i></li> <li>➤ <i>Assisting with monitoring and improving the quality of supports.</i></li> </ul>