SECTION 10
CASE MANAGEMENT

Case management is an activity under which responsibility for locating, coordinating and monitoring a group of necessary services for a MO HealthNet participant rests with a designated person or organization in order to promote the effective and efficient access to necessary comprehensive health services. Case management seeks to promote the good health of participants and includes referral to various agencies for other needed services, such as Women, Infant and Children (WIC).

CASE MANAGEMENT ENROLLMENT CRITERIA

To provide and bill for case management services, a local health department must be approved and enrolled as a case management provider with MO HealthNet. Upon approval, a specialty code of 90, Case Management, or A7, Targeted Case Management - Children EPSDT, is added to the existing provider enrollment file. In order to be eligible for participation as a MO HealthNet case management provider, the local health department must:

- have at least two years experience in the development and implementation of coordinated individual maternal and child health plans;
- be able to demonstrate the ability to assure that every pregnant woman and infant/child being case managed has access to comprehensive health services;
- have a minimum of one year experience in the delivery of public health or community health care services including home visiting.
- employ licensed registered nurses (R.N.); licensed clinical social workers with a minimum of 1 year experience as medical social work, certified nurse practitioners or licensed physicians (M.D. or D.O.) case managers who have knowledge of:
    - federal, state and local entitlement and categorical programs related to children and pregnant women such as Title V, WIC, Prevention of Mental Retardation, Children With Special Health Care Needs, etc.;
    - individual health care plan development and evaluation;
    - community health care systems and resources; and
    - perinatal and child health care standards (ACOG, AAP, etc.)

and the ability to:

- interpret medical findings;
- develop an individual case management plan based on an assessment of client health, nutritional status and psycho/social status and personal and community resources;
- reinforce client responsibility for independent compliance;
- establish linkages among service providers;
- coordinate multiple entity services to the benefit of the client;

- evaluate client progress in accessing appropriate medical care and other needed services; and,
- educate clients regarding their health conditions and implications of risk factors.

HCY case management services may not duplicate any targeted case management services provided by the Department of Mental Health, the Jackson County Foster Care Alternative Care Medical Plan, or case management provided under a waiver, e.g., AIDS Waiver.

CASE MANAGEMENT FOR PREGNANT WOMEN

Case management services are available for MO HealthNet eligible pregnant women who are "at risk" of poor pregnancy outcomes and are intended to reduce infant mortality and low birth weight by encouraging adequate prenatal care and adherence to the recommendations of the prenatal caregiver.

Risk Appraisal

A risk appraisal is a set of criteria to be used in identifying pregnant women who are at risk of poor pregnancy outcomes, and children who have or are at risk of developing, physical, psychosocial and/or developmental problems.

All appropriate MO HealthNet participating providers, including local health departments, are urged to perform risk appraisals on pregnant women during the initial visit and as changes in the patient's medical condition indicate. Completion of the *Risk Appraisal for Pregnant Women* is mandatory in order to establish the "at risk" status of the patient and to bill the global prenatal or global delivery procedure code. No additional payment is made for performing the risk appraisal as it is included in the global reimbursement for prenatal care or delivery. The *Risk Appraisal for Pregnant Women* form must be sent to the Department of Health and Senior Services and a copy filed in the patient's medical record.

Any eligible pregnant woman who meets any one of the identified risk factors, as determined by the administration of the *Risk Appraisal for Pregnant Women*, is eligible for prenatal case management services and a referral should be made to a MO HealthNet participating prenatal case management provider. The medical care provider should inform "at risk" pregnant women of prenatal case management benefits available to her and her unborn child.

Only MO HealthNet participating providers, including local health departments, who meet the prenatal case management criteria, as established by the MO HealthNet Division, are eligible for reimbursement of prenatal case management services for participants considered "at risk" as a result of the appraisal.

Providers who are interested in becoming case managers should contact the Provider Enrollment Unit for more information at:

MO HealthNet Division
Provider Enrollment Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

Procedure Code for Risk Appraisal

The following procedure code should be used when billing the *Risk Appraisal for Pregnant Women* when it is provided separately and apart from a global prenatal service.

Procedure Code	Description
H1000	Risk Appraisal, Pregnant Women

The *Risk Appraisal for Pregnant Women* is included in the following CPT procedure codes and may not be billed separately:

59400	59510	59610	59618	59425	59426
99204	99204EP	99205	99205EP	99214	99214EP
99215	99215EP				

Procedure Codes for Case Management for Pregnant Women

Procedure Code	Description
H1001TS	Prenatal care, at risk enhanced service; antepartum management; follow up service
H1001	Prenatal care, at risk enhanced service; antepartum management
H1004	Prenatal care, at risk enhanced service; follow-up home visit
H1001TS52	Prenatal care, at risk enhanced service; antepartum management; follow-up, reduced service
G9012	Other specified case management service *not* elsewhere classified

The date of the last menstrual period (LMP) must be shown on the professional claim when billing a code for initial case management for pregnant women.

Case management services are exempt from cost sharing.

*The initial visit must be provided prior to the date of delivery.

HEALTHY CHILDREN AND YOUTH (HCY) CASE MANAGEMENT

Medically necessary case management services under Section 1905(a) of the Social Security Act are covered for persons under the age of 21 through the Healthy Children and Youth (HCY) Program. (Refer to Section 9 of the *MO HealthNet Provider Manual* for information about the HCY Program.)

Healthy Children and Youth (HCY) case management is an activity under which responsibility for locating, coordinating and monitoring necessary and appropriate

services for a participant rests with a specific individual or organization. It centers on the process of collecting information on the health needs of the child, making (and following up on) referrals as needed, maintaining a health history and activating the examination/diagnosis/ treatment "loop."

HCY case management may be used to reach out beyond the bounds of the MO HealthNet Program to coordinate access to a broad range of services, regardless of the source of funding for the services to which access is gained. The services to which access is gained *must* be found by the MO HealthNet Program to be medically necessary for the child. HCY case management services are intended to assist MO HealthNet eligible individuals in gaining access to needed medical, social, educational and other services. However, MO HealthNet cannot pay for social, educational and other services that are not medical in nature even though the case management service that assists the individual in accessing these services is covered.

Health care providers should be aware of this service so that patients who have a medical need for such services can be referred to a case management entity. HCY Case Management services require prior authorization, unless otherwise stated and are limited as follows:

Initial Month—HCY Case Management

A separate procedure code and reimbursement have been established for the first month that HCY case management services are provided. This includes the assessment and development of the care plan, and a face-to-face encounter that includes an educational component.

Procedure Code	Description	Restrictions
T1016EP	Case Management, Child, Month with initial visit	Prior authorization required and limited to one per child per provider

Subsequent Months—HCY Case Management

Subsequent months of case management should be billed using the following procedure code.

Procedure Code	Description	Restrictions
T1016EPTS	Case Management, HCY	Prior authorization required

Procedure Code T1016EPTS *cannot* be billed during the same month as the initial case management visit.

Prior Authorization Process for HCY Case Management

Prior Authorization Requests for HCY case management are processed by the Department of Health and Senior Services, Bureau of Special Health Care Needs (BSHCN). The *Prior Authorization Request* should be submitted on the yellow *Prior Authorization Request* form and mailed to:

Department of Health and Senior Services
The Bureau of Special Health Care Needs
P.O. Box 570
Jefferson City, MO 65102-0570.

Emergency requests may be faxed or telephoned to the Bureau of Special Health Care Needs.

FAX Number: (573) 751-6010
Telephone Number: (573) 751-6246

The *Prior Authorization Request* must be initiated by the provider who will be performing the HCY case management services.

More information on proper completion of the Prior Authorization Request from is found in Section 8 of the *MO HealthNet Provider Manual*.

HCY Case Management Assessment and Care Plan

The individual's need for case management services *must* be assessed and a care plan must be developed. The plan *must* indicate the date of the full/partial/interperiodic screen that resulted in the establishment of the medically necessary case management services and the date of the most recent full HCY screen. *If the child has not received a full screen, the case management provider must make arrangements for a full screen and follow up that the screen was obtained, including all age-appropriate immunizations and lead screening if indicated.* The plan *must* contain the type of interventions, frequency of visits, if home visits are necessary, and an end date. The care plan *must* be maintained in the patient's medical record. All HCY case management services must be documented in the patient's record. Maintenance of a condition-specific protocol by the case management entity is *not* accepted instead of individual client records.

Contact the MO HealthNet Provider Communications Unit at (573) 751-2896 for more information.

LEAD CASE MANAGEMENT FOR CHILDREN SERVICES

Children with one blood lead level of 20 µg/dL or greater, or who have had two venous tests at least three months apart with elevations of 15 µg/dL or greater *must* be referred for case management services through the HCY Program. In order to be reimbursed for these services, the lead case management agency *must* be an enrolled provider with the MO HealthNet Division. The following procedure codes have been established for billing lead case management. Prior authorization is not required:

Procedure Code	Description
T1016UA	Lead Case Management, with Initial Visit
T1016UATS	Lead Case Management, Subsequent Months

Procedure Code	Description
T1016UA	Lead Case Management, with Initial Visit For admission to case management within two weeks of receiving confirmatory blood-lead level. This includes client/family assessment, establishes a Plan of Care and reinforces education provided by health care providers. The client/family is provided the case manager's name and telephone number. (The higher the blood lead level, the more timely the initial visit should occur.)
T1016UATS	Lead Case Management, Subsequent Months Three month encounter following initial encounter to assess progress of affected child and review and reinforce client/family education and medical regime. and At six to seven months after initial encounter which includes discharge counseling regarding lead status and ongoing nutrition and environmental maintenance. Discharge is contingent upon the following three conditions being met: • Blood lead level remains less than 15 µg/dL for at least six months • Lead hazards have been removed; and • There are no new exposures Other reasons for discharge may include: • Blood lead level remains below 20 µg/dL for one year. This closure reason is intended for use in cases where all efforts to reduce a child's blood lead level have been made (i.e, hazards in the home environment have been reduced, personal hygiene, nutritional, and housekeeping behaviors have been appropriately modified, etc.), yet the child's body burden of lead causes the child's blood lead level to consistently remain between 15-20 µg/dL. • Refusal of service • The child is older than 72 months of age • Unable to locate • A minimum of three client/family case management encounters, all face-to face, are mandatory. If more than three case management fees are billed per participant, documentation of medical necessity and copies of progress notes are required for the additional visits and must be submitted with the claim. These encounters *must* be at two to three month intervals, all being face-to-face.

Documentation of Lead Case Management Services

The following information *must* be included in the client record:

- Admission progress notes made to include blood-lead level, assessment of client/family, Plan of Care and any interventions by the case manager.
- Follow-up visit (second visit) to include lab results, client status, any interventions by case manager and progress to goals.
- Exit discharge contact documentation to include reason for discharge, lab results, client status, exit counseling, and the status of goal completion (to include telephone number for questions and assistance).

Additional Lead Case Management Services

- Case management of children with elevated blood levels greater than 20 µg/dL may be continued beyond the minimum of three encounters until two acceptable blood-lead levels are documented.
- Encounters must be at two- to three-month intervals, all being face to face.
- Documentation must be attached to the claim to include validation of the blood-lead level and significant interaction. Procedure code T1016UATS should be billed.

If a case management provider cannot be located for the child, contact the area Bureau of Special Health Care Needs office for case management services.