# South Carolina
# Department of Disabilities and Special Needs

# Case Management Standards
## [Medicaid Targeted Case Management (MTCM)
## And
## State-Funded Case Management (SFCM)]

**Effective July 1, 2014**

**Revised July 1, 2019**

***NOTE: These Standards do <u>not</u> apply to Home and Community Based Services (HCBS) Waiver participants. Please see the DDSN Waiver Case Management Standards for the requirements for HCBS Waiver participants.***

| STANDARDS | GUIDANCE |
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| **I. STAFF QUALIFICATIONS AND PROVIDER REQUIREMENTS** | |
| A. Case Management (CM) services shall be rendered by qualified staff.<br><br>1. Case Management Supervisors (CMSs) must possess a bachelor's degree from an accredited college or university[1], or licensure from the South Carolina Labor Licensing and Regulation Board as a Registered Nurse and have two (2) years of supervisory experience and two (2) years of case management experience.<br><br>2. Case Managers (CMs) must possess a bachelor's or graduate degree from an accredited college or university[1], or licensure from the South Carolina Labor, Licensing and Regulation Board as a Registered Nurse, and at least one (1) year of experience working with the target population.<br><br>***[1]The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.*** | Case Management activities or activities, functions of Case Management Supervisors and Case Managers who do not meet qualifications are NOT reportable. No exceptions can be made.<br><br>Case Managers must have at least one (1) year of experience working with the target population for which they are providing case management (i.e., ID/RD, HASCI).<br><br>A Case Manager may not provide Case Management services to a family member. |
| B. Each Case Manager or Case Management Supervisor must be an employee of DDSN, a DSN Board, or a DDSN qualified Case Management provider. | |
| C. Each Case Management provider shall maintain:<br><br>1. a current list of staff members<br><br>2. a signature sheet for Case Managers and Case Management supervisors which includes all signatures and initial variations used by those staff<br><br>3. a credentials folder for each staff member which includes:<br><br>a. Resume'/Equivalent Application;<br><br>b. Official copies of transcripts from an accredited university or college;<br><br>c. Training records;<br><br>d. Job description; | The signature sheet must include each way a Case Manager has abbreviated his or her name in the record, as well as his/her professional title and the user identification (ID) for electronic files. |

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| e. Criminal Checks (including SLED Background checks and/or FBI Checks);<br><br>f. Child Abuse and Neglect Registry Checks;<br><br>g. Registry for Centers for Medicare and Medicaid Services (CMS) List of Excluded Individuals/ Entities (LEIE);<br><br>h. Nurse Registry, if applicable;<br><br>i. Sex Offender Registry;<br><br>j. Proof of current licensure as a Registered Nurse, if applicable;<br><br>k. TB Test results;<br><br>l. Department of Motor Vehicles Driving Record, if applicable; | |
| D. Prior to delivering Case Management services, Case Management staff must be provided training in the following topic areas:<br><br>a. DDSN Case Management Standards including, but not limited to Assessment, Care Planning, Referral and Linkage, Monitoring and Follow Up, and reportable and non-reportable activities and case note documentation;<br><br>b. Basic Case Management skills;<br><br>c. DDSN policies and procedures applicable to Case Management;<br><br>d. Rights of people;<br><br>e. Local, state, and national resources that comprise the system of care for DDSN's target populations;<br><br>f. Access to and use of CDSS/STS;<br><br>g. Nature of Developmental and Intellectual Disabilities, Autism, Traumatic Brain Injury, Spinal Cord Injury and Similar Disability (as appropriate); | Case Management staff must be trained.<br><br>Documentation must be available and reflect that information presented in training is understood by the Case Manager.<br><br>In order to ensure competency, training in excess of the minimum requirements is encouraged.<br><br>Training in a classroom setting is not required. Other venues for training may be used such as:<br><br>• Shadowing an experienced Case Manager or other professional staff<br><br>• One on one instruction (not routine supervision) by a supervisor or other designated staff<br><br>• Site visits to disability programs and services of other community service providers for the purpose of understanding the disability community and its service provider network.<br><br>• Reference:<br>DDSN Directive 534-02-DD<br>DDSN Directive 167-06-DD |

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| h. Abuse and Neglect;<br><br>i. Confidentiality.<br><br>2. Annually, Case Management staff must receive training on:<br>• Procedures for Reporting Abuse, Neglect or Exploitation of People (DDSN Directive 534-02-DD), and<br>• Confidentiality of Personal Information (DDSN Directive 167-06-DD).<br><br>3. As needed, Case Management staff must be provided training on programmatic changes and/or updates. | |
| E. Case Management providers must be accessible to people served and must have a system in place which allows people served to receive assistance with any crisis situation 24 hours a day, 7 days a week. | A back-up on-call system may be implemented which will allow immediate accessibility for people receiving services. People receiving services and providers should be encouraged to call 911 in the event of a medical or police emergency; however, Case Management providers must still be accessible to provide assistance as needed. It is acceptable to have a general on-call number (beyond working hours) provided there is a response to crisis calls within two hours. |

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| **II. REQUESTING ACTIVE CASE MANAGEMENT** | **PROCEDURES** |
| A. DDSN approval for active Case Management services must be reflected by an active precertification date range in CDSS. | Before Case Management services are delivered, the person must be approved by DDSN for active Case Management services.<br><br>Those needing active Case Management services may be identified by:<br><br>• A Case Management provider;<br><br>• An Intake provider; or<br><br>• DDSN.<br><br>When the need for Case Management services is identified by a Case Management provider or an Intake provider a request for approval of active Case Management services should be initiated by sending a Therap S-Comm to "DDSN, CM Referral" that includes the following information:<br><br>• The name of the person;<br><br>• Social Security Number (SSN);<br><br>• Date of birth (DOB);<br><br>• A description of the need for the services;<br><br>• An indication of whether the person is receiving MTCM from another provider; and<br><br>• An indication of whether the person is enrolled in an HCB Waiver operated by SCDHHS.<br><br>Response to the requests will be returned via Therap S-Comm within two (2) business days.<br><br>If the request is approved, the precertification date range in CDSS will be updated to reflect the appropriate case management type and the approved period. Case Management providers are not required to keep copies of the approvals as the pre-certification date range will serve as DDSN's official approval.<br><br>If the request is denied, the decision may be appealed in accordance with DDSN Directive 535-11-DD: Appeal and |

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| | Reconsideration Policy and Procedures (https://www.ddsn.sc.gov/sites/default/files/Documents/Quality%20Management/Current%20Directives/535-11-DD%20-%20Revised%20%28091015%29.pdf).<br><br>When the need for active Case Management services is identified by DDSN:<br><br>DDSN will offer the choice of provider from among the DDSN qualified providers serving the county in which the person resides.<br><br>• DDSN will make a referral to the chosen provider via Therap S-Comm to Case Management Supervisor(s).<br><br>• Providers will have four (4) business days to accept the referral.<br><br>• If the provider accepts the referral, the precertification date range in CDSS will be updated to reflect the appropriate case management type and the approved period.<br><br>If needed, the person's record will be transferred to the chosen provider on CDSS within two (2) business days. |
| B. | The person receiving Case Management services or his/her representative must verify the choice of the Case Management provider. The choice can be documented in the case notes or on an Acknowledgement of Choice form. |

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| **III. SERVICE DESCRIPTION** | |
| A. Case Management services will be provided in accordance with all applicable DDSN policies and procedures. | Please refer to: https://www.ddsn.sc.gov/providers/directives-and-standards |
| B. ASSESSMENT<br><br>Either the "Case Management Annual Assessment" or the "Abbreviated Case Management Assessment" must initially be completed:<br><br>• Within 45 days of the approval date[1] of active case management,<br><br>• Prior to the initiation of the Case Management Support Plan, and<br><br>• In conjunction with a face-to-face visit in the person's residence during which information is gathered.<br><br>The assessment must be re-completed at least annually in conjunction with a face-to-face visit in the person's residence. | Case Managers have the choice of completing either the "Case Management Annual Assessment" or the "Abbreviated Case Management Assessment."<br><br>While either assessment may be used, if services are being provided to someone who is projected to receive a DDSN Waiver slot within the next year, the use of the "Case Management Annual Assessment" is strongly recommended. If the "Abbreviated Case Management Assessment" is completed, upon Waiver enrollment and prior to receipt of Waiver services, the "Case Management Annual Assessment" must be completed.<br><br>Assessment and periodic reassessment is conducted to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services must be completed. Such assessment activities include the following:<br><br>• Taking individual history;<br><br>• Identifying the needs of the person supported and completing related documentation;<br><br>• Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment.<br><br>Both the assessment and the Case Management Support Plan can be completed on the same day.<br><br>A face-to-face contact in the person's natural environment is permissible in lieu of the visit in the person's residence under the following circumstances:<br><br>• The person is homeless.<br><br>• The person or homeowner refuses to allow access to the home. |

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| | • There is documented evidence of criminal activity, violence, or isolation in the residence that places the Case Manager in danger.<br><br>When these circumstances exist, the assessment and the Plan should address safety issues or housing concerns for the person.<br><br>***[1]The approval date for active case management is the precertification date range begin date in CDSS.*** |
| C. CARE PLANNING<br><br>The Case Management Support Plan (the Plan) must be completed within 45 calendar days of authorization for case management services.<br><br>The Plan must be re-completed annually (within 365 calendar days of the previous plan).<br><br>The Plan must include:<br><br>• Statement(s) of need(s);<br><br>• The case management action(s) to address the need(s);<br><br>• The name or type of provider to which the person will be referred; and<br><br>• A projected completion date.<br><br>The Plan must be signed, titled and dated by a qualified Case Manager.<br><br>The Plan must be signed by the person or his/her representative indicating agreement with the Plan.<br><br>The Plan must be provided, by copy, to the person or his/her representative.<br><br>The Plan must be updated as needed and be current at all times. | Care planning includes the development and periodic revision of a specific care plan (Case Management Support Plan) based on the information collected through the assessment, that includes the following:<br><br>• Specific goals and actions to address the medical, social, educational, and other services needed by the person.<br><br>• Activities such as ensuring the active participation of the person and working with the person or his /her representative and others to develop such goals.<br><br>• A course of action to respond to the assessed needs of the person.<br><br>The Plan must be signed, titled, and dated by a qualified Case Manager; this signature, title, and date are generated electronically in Therap.<br><br>The Plan must be signed by the person or his/her representative. This signature can be obtained on a separate form (attestation) rather than on the Plan itself.<br><br>If a plan is not signed by the person or his/her representative at the time of plan completion, the Case Manager must document why the signature could not be obtained and must have the Plan (or separate form) signed at the next face-to-face contact.<br><br>A copy of the completed plan must be provided to the person or his/her representative and documented in the case notes.<br><br>The Case Manager must document that the person or his/her representative participated in the planning process. Evidence of participation may be in the form of a plan meeting sign-in sheet when |

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| | the person was present and/or a specific description of participation documented in case notes. Documentation, in case notes, that the completed plan was provided to the person, or his/her representative is also indicative of participation in planning, as is documentation of participation in completion of the Assessment.<br><br>Payment for any Case Management services delivered in the absence of a current/valid Plan may be subject to sanctions/recoupment when identified through quality assurance reviews, Medicaid audits, or other means. |
| D. REFERRAL AND LINKAGE<br><br>Following the completion or re-completion of the Plan, the Case Manager will implement/follow the Plan.<br><br>Prior to referring/linking to planned services, the Case Manager must offer the person or his/her representative choice of available providers. The offering of choice must be documented.<br><br>Annually, written information about abuse, neglect and exploitation and how to report it is provided to the person or his/her representative. | Regarding Referral and Linkage, referral includes making actual referrals and activities related to making referrals (such as scheduling appointments) to help the person obtain needed services. Linkage includes activities that help link the person with medical, social, or education providers and/or other programs and services that could provide services to address identified needs and achieve goals specified in the Plan.<br><br>CHOICE OF PROVIDERS – The person receiving services or his/her representative must be given a choice of all qualified providers of services and supports to which the person will be referred or linked.<br><br>In addition to the initial choice offered when a service begins, choice should minimally be offered:<br><br>• Annually during plan development, and<br><br>• Any time the person receiving services or representative requests a change in services or providers.<br><br>The offering of choice must be documented in case notes along with the choice made by the person or his/her representative. If only one potential provider is available, the person or his/her representative must be informed and the Case Manager must document this discussion in a case note.<br><br>Case Managers should be responsive to preferences of the person or his/her representative by promptly responding to a request for a change in <u>any</u> service provider. |

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| E. MONITORING OR FOLLOW UP<br><br>Face-to-face, email or telephone contact must occur with the person, his/her representative, or the service provider at least every 60 calendar days.<br><br>The assessment must be monitored/reviewed at least every 180 days <u>in conjunction with a face–to-face visit</u> with the person to determine if the assessment information remains current.<br><br>The Plan must be monitored/reviewed in consultation with the person or his/her representative:<br><br>• At least every 180 days;<br><br>• To determine if the actions included in the Plan should continue, be updated or be discontinued. | Monitoring and follow-up includes activities, contacts, and reviews that are necessary to ensure the Plan is effectively implemented and adequately addresses the needs of the person. Monitoring and follow-up may be conducted with the person, his/her family members or representative, service providers, or other people or entities.<br><br>Case Management "contact" is defined as a communication exchange with the person, his or her family, authorized representative, representative or the provider when a component of case management (assessment, planning, referral or monitoring) is rendered.<br><br>Contact may occur as frequently as necessary but must occur at least every 60 days in order to determine if:<br><br>• Services are being furnished in accordance with Case Management Support Plan, and<br><br>• Services in the Case Management Support Plan are adequate to meet the needs of the person, and<br><br>• There have been changes in the person's needs or status. If there have been changes, monitoring and follow-up activities include making necessary adjustments in the Plan and/or service arrangements with providers.<br><br>Monitoring and follow-up includes reviewing the most recent assessment completed for the person. The assessment must be reviewed at least every 180 days and be completed in conjunction with a face-to-face visit with the person.<br><br>Monitoring and follow-up includes reviewing the person's current Plan. The Plan must be reviewed at least every 180 days in consultation with the person or his/her representative. "In consultation" means that a face-to-face contact is made with the person in his/her natural environment. The outcome of reviewing the Plan is to determine if the actions included in the Plan should continue, be updated or be discontinued. |

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| **IV. RECORD KEEPING AND DOCUMENTATION** | |
| A. A primary case record will be maintained for each person receiving services. | Case records (paper files and electronic records) maintained by the Case Manager are considered to be the person's primary case record with DDSN. |
| B. The primary case record must be organized in accordance with a File Index determined by the provider agency. | Primary case records should be logically and consistently organized such that the identification of needs, referrals, follow-up, plan development and monitoring can be easily and clearly reviewed, copied, and audited. Case Management providers will have the flexibility to use the filing system of their choice (i.e., six-section divided files, three-ring binders, etc.). |
| C. The primary case record must identify records or documents that are maintained electronically. | |
| D. As appropriate records will include, but are not limited to, the following:<br>1. Assessment Information.<br>2. Current Plan and previous year's plan in paper or electronic format as applicable. The paper file will identify records that are maintained electronically.<br>3. Initial Social History Assessment (CIS) and updates (If applicable).<br>4. Medical information as applicable and when available.<br>5. Psychological Assessment, if applicable.<br>6. IEPs, IFSPs, FSPs, if applicable by age.<br>7. Eligibility Letter (after 1988).<br>8. HIPAA Acknowledgement.<br>9. Correspondence, including emails, and any other documentation intended to support Medicaid reimbursement for Case Management.<br>10. Legal records determining competency or determining a change in representativeship or documenting a legal name change, if applicable. | Case notes should provide a clear/concise description of the circumstances being recorded. The contents should be current, complete, timely, and meet documentation requirements. Documentation and record organization should also permit someone unfamiliar with the person receiving services to quickly acquire knowledge sufficient to provide Case Management, or to review the records to assure compliance with contracts, policies, standards and procedures.<br><br>Purged record contents should also be maintained according to the provider agency's File Index and in close proximity to the primary case record. Closed records and backup records will also be retained according to the provider's primary case record index. Closed case records must be retained for a period of no less than six (6) years after the end of the annual contract period. If any litigation, claims or other actions involving the records are initiated prior to the expiration of the six (6) year period, the records must be retained until completion of the actions and resolution of all issues which arise from it, or until the end of the required period whichever is later. (For more detailed information regarding record retention, please refer to DDSN Directive 368-01-DD: Individual Service Delivery Records Management). |

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| 11. Information from other service agencies providing services to the person.<br><br>12. Other documents which from time to time may be deemed essential by DDSN or the State Medicaid agency. | |
| E. The primary case record including the electronic assessment, planning, monitoring and case note system will be kept secure according to DDSN and HIPAA security, confidentiality and privacy policies. | Refer to DDSN Directives:<br><br>• 167-06-DD: Confidentiality of Personal Information.<br><br>• 368-01-DD: Individual Service Delivery Records Management<br><br>• 367-12-DD: Computer Data Security |
| F. Case notes must document all Case Management activity delivered on behalf of the specific person represented by the primary case record and, upon review, must justify the need for Case Management. | Multiple actions which support the same activity and which occurred on the same day may be incorporated into a single case note provided all necessary information is included and is clear to any other readers or reviewers. |
| G. Case notes will include the following if a reportable activity is being documented:<br><br>• Type of activity and type of contact;<br><br>• Place of contact or activity;<br><br>• Person with whom the contact occurred and relationship to the person receiving Case Management services;<br><br>• Purpose of the contact or activity;<br><br>• Description of the Case Management intervention delivered;<br><br>• Outcome(s) of the contact or activity, and, if applicable, next step(s) or follow-up to be completed;<br><br>• Each case management activity performed and the case management component being provided;<br><br>• Be authored, signed, titled and signature dated by the qualified Case Manager who rendered the case management activity;<br><br>• Be filed or entered in the beneficiary's record within seven calendar days of delivery of the activity. | In order to determine the rate paid for the activity, each case note must indicate the type of Case Management activity as:<br><br>• Office Visit; or<br><br>• Home/Residential.<br><br>"Office Visit" is defined as the completion of a component of case management that did not include travel away from the office.<br><br>"Home/Residential" is defined as a planned, in-person contact requiring travel away from the office to meet with the person, parent, guardian, or provider.<br><br>"Case management component" refers to the core functions of Case Management services which are assessment, planning, referral/linkage and monitoring/follow-up. |

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| H. All case notes must:<br>1. Be entered within seven (7) calendar days of the activity/event being documented.<br>2. Be completed on the correct case note template in Therap so that activities may be reported to DDSN for billing.<br>3. Be completed by a qualified Case Manager. | It is strongly recommended and considered a best practice to complete case notes on the day the service or activity is rendered.<br>Case notes in Therap are the electronic documentation of core functions and other activities performed by the Case Manager. The Case Note module of Therap conforms to the Uniform Electronic Transactions Act (S.C. Code § 26-6-10 et seq.)<br>When a case note for a core function or other activity is completed ("Submit" not "Save" is chosen) in Therap it is automatically transmitted to DDSN for possible billing.<br>When a case note is "Saved" ("Submit" not chosen) in Therap, the note is still in progress (not completed) and will not be automatically transmitted to DDSN for possible billing.<br>Case notes completed on Therap do not have to be printed and placed in the primary case record. |
| I. All manual case notes must be typed or handwritten in black or dark blue ink. | Electronic case notes can only be typed and printed in black. |
| J. All case notes must be legible and kept in chronological order according to the date of entry. | All case notes should be entered into Therap. |
| K. All manual and electronic case notes must be dated and legibly signed with the Case Manager's name or initials, professional title, and dated. | Non-electronic case notes must be manually signed by a Case Manager. |
| L. A list of any abbreviations or symbols used in the records must be maintained. | This list must be clear as to the meaning of each abbreviation or symbol, and only abbreviations and symbols on this approved list may be used. |
| M. Any person(s) referenced in case notes or any supporting correspondences must be identified in each entry. | Identify person(s) in case notes by their full name and title or relationship to the person. References in case notes must be done at least one time for each entry/case note. |
| N. Errors in case notes must be corrected appropriately. | When an error is made in a Therap case note, the Case Manager will edit the case note. Therap will retain the history of the note and changes made to the note. |
| O. Case notes must be individualized to the specific person represented by the primary case record. | A single identical case note cannot be used to document activity about two or more people. |

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| **V. SERVICE REPORTING** | |
| Electronic case notes intended to document Case Management activities must be sufficient in content to support billing to Medicaid. | Reportable Case Management activities must represent at least one (1) of the four (4) Case Management activities (assessment, care planning, referral and linkage, monitoring and follow up).<br><br>Case notes must correspond to reporting in type of activity, length of activity, units of service, and date of delivery.<br><br>INITIAL REPORTING<br><br>No Case Management activity is reportable unless a Pre-certification date range is available in CDSS (Refer to Section II-Requesting Active Case Management) regardless of the number of case notes or the type of activity described.<br><br>SUPPORT PLAN<br><br>Case Management activity may be reported only when a current Support Plan is in place or when a plan is in process according to established timeframes. If a plan is not in place or not in process within established time frames, the activity must be documented as non-reportable.<br><br>PERSON/APPLICANT NOT LOCATED<br><br>If a DDSN applicant or DDSN eligible person is missing and his/her whereabouts cannot be determined within 30 calendar days, Case Management activity must not be reported until that person is located. Reporting must be discontinued after 30 calendar days from the date the Case Manager is made aware the person is missing, not the actual date the person went missing. After 30 calendar days, all Case Management activity is not reportable until such time as the person is located and documented by a case note. As mentioned previously, Case Management activities and non-reportable electronic case notes may be entered at any time.<br><br>**EXAMPLES OF REPORTABLE ACTIVITIES:**<br><br>• Assessing needs, access to services or client functioning. |

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| | • Assessing the medical and/or mental needs through review of evaluations completed by other providers of services.<br><br>• Assessing of physical needs, such as food and clothing.<br><br>• Assessing of social and/or emotional status.<br><br>• Assessing for housing, financial and/or physical environmental needs.<br><br>• Assessing for familial and/or social support system.<br><br>• Assessing for vocational and/or educational needs.<br><br>• Assessing for independent living skills and/or abilities.<br><br>• Ensuring the active participation of the person supported or his/her representative.<br><br>• Working with those supported and others to develop goals.<br><br>• Identifying a course of action to respond to the assessed needs of the person supported.<br><br>• Linking the person with medical, social, educational, and/or other providers, programs, and services that are capable of providing the assessed needed services.<br><br>• Ensuring the Plan is implemented effectively and is adequately addressing the needs of the person.<br><br>• Contacting the person, family members, outside service providers, or other entities to ensure services are being furnished In accordance with person's Plan.<br><br>• Ensuring the adequacy of the services in the Plan, and changes in the needs or status of the person.<br><br>• Assisting in obtaining required educational, treatment, residential, medical, social, or other |

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| | support services by accessing available services or advocating for service provision.<br><br>• Contacting social, health, and rehabilitation service providers, either via telephone or face-to-face, in order to promote access to and appropriate use of services. Additionally, services by multiple providers may be coordinated.<br><br>• Monitoring the progress through the services and performing periodic reviews and reassessment of treatment needs. When an assessment indicates the need for medical treatment, referrals or arrangements for such treatment may be included as case management services, but the actual treatment must not be included.<br><br>• Arranging and monitoring the person's access to primary healthcare providers including written correspondence sent to a primary health care provider, which gives a synopsis of the treatment the individual is receiving.<br><br>• Coordinating and monitoring other health care needs by arranging appointments for medical services with follow-up and documentation.<br><br>• Staffing's related to receiving consultation and supervision on a specific case to facilitate optimal case management. This includes recommending and facilitating movement from one program to another or from one agency to another.<br><br>• Contacting the person to deal with specific and identifiable problems of service access and requiring the case manager to guide or advice his or her in the resolution of the problem.<br><br>• Contacting the family, representatives of human service agencies, and other service providers to form a multidisciplinary team to develop a comprehensive and individualized Plan. The individualized Plan describes the problems, corresponding needs, and details services to be accessed or procured to meet the person's needs. |

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| | • Preparing a written report that details a psychiatric and/or functional status, history, treatment, or progress (other than for legal or consultative purposes) for physicians, other service providers, or agencies<br><br>**EXAMPLES OF <u>NON-REPORTABLE</u> ACTIVITIES**<br><br>• Attempting but not completing a contact whether in person or by telephone.<br><br>• Reviewing case management record (of own agency files).<br><br>• Referring and monitoring of one's own activities.<br><br>• Completing special requested information regarding the people supported or the provider, public agencies or other private entities for administration purposes.<br><br>• Participating in recreation or socialization activities with the person supported or his or her family.<br><br>• Rendering case management to individuals in institutional placements [i.e., Intermediate Care Facilities (ICFs) or ICF-IIDs (Intellectual Disabilities), nursing homes, etc.], except during the last 180 days of the stay for the purpose of transition and/or discharge planning.******<br><br>• Rendering services while incarcerated, an evaluation center (formerly known as reception and evaluation centers), a local jail and/or prison, or a detention center.******<br><br>• Documenting Case Notes.<br><br>• Performing administrative duties such as copying, filing, mailing of reports, etc.<br><br>• Rendering activities (SC Family Court, General Sessions or Federal Court), which are convened to address custody, criminal charges, or other judicial matter by the individual or others.****** |

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| | • Rendering services on behalf of a person supported after Death.<br><br>• Rendering services as Case Management components that are mandated functions required by another payer source (*i.e.*, an assessment that has been completed as a program intake requirement). A treatment plan that covers court mandated services only should not be the basis for MTCM services.<br><br>• Rendering services provided as administrative case management including Medicaid eligibility determination, intake processing, and preadmission screening for inpatient care.******<br><br>• Performing utilization review and prior authorization for Medicaid.<br><br>• Rendering the actual or direct provision of medical services or treatment:<br><br>➢ Training in daily living skills;<br><br>➢ Training in work skills and social skills;<br><br>➢ Grooming and other personal services;<br><br>➢ Training in housekeeping, laundry, cooking;<br><br>➢ Individual, group or family therapy services;<br><br>➢ Crisis intervention services;<br><br>➢ Diagnostic testing and assessments;<br><br>• Rendering services which go beyond assisting individuals in gaining access to needed services:<br><br>➢ Paying bills and/or balancing the person's checkbook;<br><br>➢ Completing application forms, paperwork, evaluations and reports including applying for Medicaid; |

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| | ➢ Escorting or transporting person to scheduled medical appointments;<br>➢ Providing childcare so the person can access services;<br>➢ Shopping or running errands for the person;<br>➢ Delivering groceries, medications, gifts;<br>➢ Reading the mail for the person;<br>➢ Setting up the person's medication;<br>➢ Traveling to and from appointments on behalf of the person.<br>• Performing 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.<br>• Rendering Case Management services when there is no Plan in place except during the first 45 days while a Plan is being developed.<br>****** ***For those who are approved for State Funded Case Management (active precertification date range with DHHS N), these activities may be entered as reportable as long as a component of case management was rendered.*** |

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| **VI. Case Transfers** | |
| When a new Case Management provider who is a DDSN qualified provider is chosen by the person and transfer is requested, within ten (10) business days of the request for transfer, the sending provider must:<br><br>• Update CDSS to transfer to the newly chosen provider; and<br><br>• Send the original paper/hardcopy record to the newly chosen provider. | To prevent any disruption in services, the sending Case Management provider should contact the chosen provider by email or phone or fax to determine if the provider will accept the case.<br><br>Please note, if the person independently contacts/chooses another provider or if any circumstances prohibit the sending provider from doing so, the receiving chosen provider can contact the sending provider to initiate the transfer.<br><br>If the case is accepted, both Case Management providers should discuss the logistics of transferring, discuss current services and providers, and set a date (within 10 business days) for mailing the case record and transfer on CDSS.<br><br>Within 10 business days of the transfer on CDSS the sending provider must:<br><br>• Update/change CDSS as needed.<br><br>• Review case record with Case Management Supervisor.<br><br>• Copy the case record and maintain a copy of all records of service according to DDSN Directive 368-01-DD: Individual Service Delivery Records Management.<br><br>• Send originals of the paper case record to the receiving Case Management provider. Records may be sent via US Mail, a package shipping company, or otherwise delivered. Regardless of the method used for sending, documentation of the sending of the records should be maintained.<br><br>The receiving Case Management provider should:<br><br>• Ensure that the Financial Manager on the CDSS (county to county transfers only) is correct.<br><br>• Contact chosen providers and refer for services if necessary.<br><br>• Update existing plan or complete a new plan as necessary.<br><br>• Organize all case record information and insert into a file. |