



COMMONWEALTH OF PENNSYLVANIA

OCT 25 2010

Dear County Administrators and Behavioral Health Managed Care Organizations:

In 2009, The Department of Health and Human Services Office of Inspector General (OIG) conducted a review of Pennsylvania's Medicaid Targeted Case Management (TCM) program for calendar years 2003 through 2005. The purpose was to determine whether the Pennsylvania Department of Public Welfare (DPW) claims process for TCM services complied with federal and state requirements.

During the audit, the OIG found that the providers of TCM did not always comply with federal and state requirements. Based upon a review of claims, a portion of the claims were deemed unallowable because the services were unsupported by case records or insufficiently documented. The unallowable claims included: billing for services when a person was not at home; not providing specific documentation of the necessity, circumstances and recipient of services; not documenting the nature and extent of the service as compensable under Pennsylvania state plan; illegible case notes and the absence of case records all together. This resulted in a return of funds to the federal government.

The OIG recommended that DPW ensure that future TCM services claimed under the Medicaid program are properly documented in accordance with federal and state requirements. To that end, OMHSAS is re-issuing existing guidance to providers as it pertains to billing and payment for TCM (includes Intensive Case Management, Resource Coordination, and Blended Case Management) services. The guidance provided is derived from various regulations, bulletins, and policy clarifications identified in the ensuing paragraphs of this letter.

Documentation/Recordkeeping

The providers of TCM must ensure that the following documentation requirements are adhered to:

- Verification of eligibility to receive TCM, such as past treatment records, behavioral health assessments, psychiatric or psychological evaluation, letter summarizing treatment history, Individual Education Plan (IEP), and the like.
- The record shall contain a preliminary working diagnosis as well as a final diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- Treatments/services provided to the individual as well as the treatment/service plan shall be entered in the record.

DEPUTY SECRETARY FOR MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

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- The record shall indicate the progress at each visit, change in diagnosis, change in treatment and response to treatment.
- The disposition of the case shall be entered in the record. The record shall contain documentation of the medical necessity of a rendered, ordered or prescribed service.
- Case notes shall:
 - Be legible.
 - Verify the necessity for the contact and reflect the goals and objectives of the targeted case management service plan.
 - Include the date, time and circumstance of contacts, regardless of whether or not a billable service was provided.
 - Identify the consumer by name or case number on both sides of each page on which there is writing on both sides. The consumer's name and case number should appear together earlier in the file.
 - Be dated and signed by the individual providing the service.
- Records shall be retained for 7 years. Note: Although ICM regulation indicates that records need to be retained only for 4 years, the federal standards stipulate 7 years of record retention. In order to meet the federal requirement, OMHSAS is asking that all records be maintained for 7 years. Please also note that the requirement in the Blended Case Management bulletin OMHSAS-10-03 is already consistent with the federal standards for record retention (7 years).
- Providers shall make those records readily available for review and copying by state and federal officials or their authorized agents. Readily available means that the records shall be made available at the provider's place of business or, upon written request, shall be forwarded, without charge, to the Department.

Billable/Non-Billable Services

- Provider staff meetings, trainings, recordkeeping activities and other non-direct services are not Medicaid reimbursable. The costs for these activities are already built into the overall rate structure.
- The unit of service for billing purposes shall be 1/4 hour of service (15 minutes) in which the targeted case manager or targeted case manager supervisor is in face-to-face or telephone contact with the consumer, the consumer's family or friends, service providers or other essential persons for the purpose of assisting the consumer in meeting his needs. Multiple contacts can not be combined to claim as a unit of service (example: three distinct contacts, each lasting 5 minutes can not be combined to bill as one unit of service). Additionally, time spent on activities that do not constitute actual contacts are not Medicaid reimbursable (example: leaving a voice mail message or just waiting for consumer).

- During a 1/4 hour period, if one or more targeted case management staff (who are providing services together) makes service contact with a consumer (or a consumer's family member if the consumer is a child), then the maximum number of units that may be billed shall equal the number of staff persons involved or the number individuals being served, whichever is smaller.
- The Department will participate in 100% of the approved expenditures for the following components of targeted case management:
 - Assessment and understanding of the consumer's history and present life situation; service planning, based on the consumer's strengths and desires, to include activities necessary to enable the consumer to function as an integral part of the community.
 - Informal support network building.
 - Use of community resources, to include assistance to consumers or the consumers' parents, if the consumer is a child, in identifying, accessing and learning to use community resources.
 - Linking with resources.
 - Monitoring of service delivery.
 - Aggressive and creative attempts to help the consumer gain access to resources and required services identified in the treatment plan.
 - Life support and problem resolution, to include direct, active efforts to assist the consumer in gaining access to needed services and entitlements.
- TCM services provided to individuals in inpatient settings are reimbursable only under certain conditions as outlined in the Policy Clarifications ICM-04 RC-01 FBMHS-09, and TCM-01 (please contact your OMHSAS Field Office if you do not have copies of these policy clarifications)

The items listed above represent the minimum standard. The following links have been provided for additional clarification;

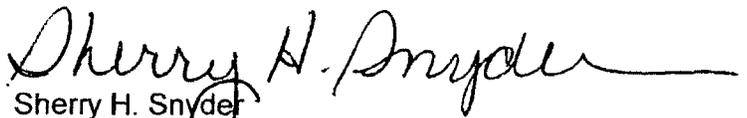
- * **ICM Regulation:**
<http://www.pacode.com/secure/data/055/chapter5221/chap5221toc.html>
- * **Resource Coordination Bulletin:**
<http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003673169.aspx?BulletinId=1006>
- * **Blended Case Management Bulletin:**
<http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003673169.aspx?BulletinDetailId=4566>

Counties, BH-MCOs and TCM providers must ensure that TCM staff are trained and supervised to ensure compliance with appropriate recordkeeping and documentation procedures; therefore we ask that you share this information with your TCM staff, if applicable, and with your contracted provider(s) to ensure compliance with the federal and state requirements. In addition, I encourage your periodic review of services and documentation.

Additionally, OMHSAS has partnered with Western Psychiatric Institute and Clinic (WPIC), Drexel and Behavioral Health Training and Education Network (BH-TEN) to develop a more comprehensive training curriculum to ensure that future TCM staff have a thorough grounding on Medicaid documentation, recordkeeping/retention and billing requirements.

I trust you can appreciate the importance of this request. Thank you for your support and cooperation. If you have any questions or concerns, please contact Amanda Pearson at apearson@state.pa.us.

Sincerely


Sherry H. Snyder
Acting Deputy Secretary

	Mental Health and Substance Abuse Services Bulletin COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE		
	Date of Issue: July 30, 1993	Effective Date: April 1, 1993	Number: OMH-93-09
Subject Resource Coordination: Implementation	By  Ford S. Thompson Deputy Secretary for Mental Health		

SCOPE:

County MH/MR Administrators

PURPOSE:

The Department of Public Welfare, Office of Mental Health, is establishing Resource Coordination as a new service under the MH/MR Act of 1966, which will be eligible for Medicaid reimbursement and 100% state financial participation effective April 1, 1993. Since Resource Coordination is being implemented prior to the publication of final regulations which will govern the service, this bulletin transmits the information necessary for the provision and reimbursement of services until final regulations are published and codified.

BACKGROUND:

In March, 1989, the Department established intensive case management as a new service under the MH/MR Act of 1966, targeted to assist adults with serious mental illnesses and children with serious mental illnesses or serious emotional disturbance to gain access to needed resources and services. Within two years of implementation the service was available statewide. Caseloads were limited to a maximum of 30; however, they have averaged much lower in order for intensive case managers to meet the complex needs of persons being served. Intensive case management has grown to a \$26 million program, employing approximately 930 intensive case managers and supervisors, and serving more than 8,600 children and adults.

Service management has been the only other case management option for persons in the mental health system. Caseloads for service management average more than 300, allowing for minimal direct, proactive intervention. Although many persons who are eligible for intensive case management do not need the frequency and intensity of the service, they do need more support than service management can provide. Also, the lack of a less intensive, but supportive level of case management has impeded some recipients of intensive case management from moving onto greater independence with continued support. These consumers could benefit from another level of care, freeing intensive case management to serve persons with greater need.

Creating additional levels of case management is included as an implementation strategy for Objective 1.1 in the Pennsylvania State Mental Health Plan. In February, 1992, a workgroup which included representatives of consumers, family members, county administrators, and provider organizations, was convened by the Office of Mental Health to help guide the development and implementation of a less intensive level of case management. The workgroup recommended standards for the new service, named Resource Coordination. In order to maximize funding available to implement this new level, the Department applied for and received approval to include Resource Coordination under our Medicaid State Plan Amendment covering targeted case management services.

Proposed regulations for Resource Coordination services have been drafted and will be entered into the regulatory approval process during the next several weeks. Publication of the proposed regulations in the Pennsylvania Bulletin is anticipated by late 1993. Final regulations should be published and effective in 1994. While Resource Coordination services are not required at this time, agencies identified as providers of Resource Coordination services will be required to meet the standards set forth in the final regulations upon publication. Until that time, the Department intends for identified providers of Resource Coordination services to adhere to the guidelines set forth in this bulletin.

There are three attachments to this bulletin: Attachment "A" describes fiscal issues associated with the provision of resource coordination services; Attachment "B" describes the procedures that will enable providers to enroll with Medicaid; and Attachment "C" provides service guidelines for the provision of Resource Coordination services until final regulations are promulgated. Providers identified in an approved 92-93 rebudget that meet the guidelines set forth in Attachment "C" may bill for Resource Coordination services retroactively to April 1, 1993. Providers identified in an approved 93-94 budget or rebudget that meet the guidelines may bill for Resource Coordination services effective the date of approval by the Area Office of Mental Health.

ATTACHMENT A FISCAL ISSUES

The Office of Mental Health (OMH) will reimburse Resource Coordination Services using a county negotiated, cost-based, Departmentally approved, fee-for-service method of payment. To do this, the OMH has developed a rate setting package to be completed by each agency identified in a county rebudget/mental health plan as a provider of Resource Coordination Services. A separate rate will be negotiated for each provider of service. Rates may be based on a 67% productivity level for each resource coordinator during the first fiscal year of employment, and must be based on a 75% productivity level during subsequent fiscal years. Rate setting information will be completed by the provider and reviewed by the county office as a prudent buyer of service. Rates endorsed by the county will then be forwarded to the Area OMH for final approval.

Information on the conditions for payment can be found in Attachment C, Guidelines. Billing for Resource Coordination Services will occur using the standard invoice for Medical Assistance (refer to the MA Handbook for Resource Coordination services for further details). State dollars required to match federal Medicaid revenues and to reimburse services not eligible for MA reimbursement will be administered by the MH/MR County Program. Administrative Costs may be claimed in accordance with procedures set forth in Mental Health Bulletin OMH-93-07.

ATTACHMENT B ENROLLMENT

With the implementation of Resource Coordination (RC) as a Medicaid reimbursable service, counties have been asked to identify their providers of RC services through the rebudget process. Identification of service providers begins the provider enrollment process. That process is outlined as follows:

1. Counties identify provider (s) of RC services and outline a plan of service in the rebudget. Guidelines for the '92-'93 rebudget were distributed in January, 1993. Guidelines for FY '93-'94 were included with the Tentative Allocations.
2. The Area OMH reviews the county rebudget to determine acceptability.
3. The OMH distributes rate setting packages to each county.
4. The Area OMH distributes an MA enrollment package to each provider agency identified in the county's rebudget after it has been accepted.
5. The provider agency submits a completed rate setting package to the county for approval.
6. The county reviews the rate submitted and verifies that costs are in line with other services provided in the geographic area, acknowledges its ability to provide the match necessary to support the proposed budget, and forwards the rate to the Area OMH for final review and approval by the Area Director.
7. The provider completes the MA enrollment package and returns it to the Area Office.
8. The Area Office schedules a site visit to review and approve the Resource Coordination program.
9. The Area Director approves the rate.
10. The Area Office submits the approved rate setting package, completed enrollment package and a copy of the letter approving the agency to provide resource coordination services to the Central Office.
11. The Central Office receives the rate setting and enrollment information and approval letter and enrolls the provider.
12. The Central Office notifies the provider and/or county administrator of the enrollment, approved rate and effective date of billing, and forwards the provider handbook and related materials.
13. Providers may begin billing for services retroactively to the effective date of enrollment in accordance with the instructions outlined in the provider handbook.

ATTACHMENT C GUIDELINES

These guidelines establish standards for the provision of Mental Health Resource Coordination Services under provisions of the approved Medicaid State Plan. The guidelines are intended to enhance consistency and uniformity of application of statutory authority. It is the intent of the Department that providers adhere to the guidelines in providing resource coordination services. However, individual circumstances may warrant flexibility in application of the standards as long as provisions of the approved Medicaid State Plan Amendment are met. Any deviation from the guidelines must be approved by the Director of the appropriate Area Office of Mental Health. Providers may bill under procedures set forth in this bulletin until final regulations are promulgated.

GENERAL PROVISIONS

Service Description - Resource coordination services are targeted to adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who do not need the intensity and frequency of contacts provided through intensive case management, but who do need assistance in accessing, and

coordination and monitoring of, resources and services. Services are provided to assess individual's strengths and needs, and to assist them in accessing resources and services that build upon strengths and meet needs in order to achieve stability in the community. Resource coordination is similar to intensive case management in that the activities are the same. However, since resource coordination is targeted for persons with less complex needs, caseload limits are larger and there is no requirement for 24-hour service availability. Resource coordination is established as an additional level of case management, and is not intended to replace intensive case management. The implementation of Resource Coordination services is optional at this time.

Organization - The Resource Coordination Program must be organized or identified as a separate service within the organization of the agency. A director shall be identified to provide supervision of the Resource Coordination Program. There shall be a full-time supervisor to provide individual supervision for every 10 resource coordinators. If a full-time supervisor is not required, a supervisor may have other duties but must devote 1/10th of available hours per week to supervising each resource coordinator. The caseload size for adults is a minimum of 30 and a maximum of 75. The caseload size for children and adolescents is a minimum of 20 and a maximum of 40. Resource coordinators are required to work full-time in the program unless an exception is granted by the OMH Area Director.

ELIGIBILITY

Provider Participation - Providers must be identified in a county mental health plan or rebudget which has been accepted by the Department, and must meet all other applicable standards. Providers must be enrolled as specified in Chapter 1101, relating to Medical Assistance General Provisions, to receive the Federal share of Medical Assistance reimbursements. Providers must meet the conditions of these guidelines, and receive on-sight approval to provide resource coordination prior to billing for services. When in conflict, these guidelines shall prevail over requirements established in other regulations.

Consumer Eligibility - Services under these guidelines are reimbursable when provided to an adult, or child or adolescent and his/her family, who meet the following criteria:

- A. Adults who have a serious mental illness as defined by meeting the criteria for Diagnosis, Treatment History **and** Functioning Level:
 1. **Diagnosis**
Diagnosis within DSM III R (or succeeding revisions thereafter), excluding those with a principal diagnosis of mental retardation, psychoactive substance abuse, organic brain syndrome or a V-Code.
 2. **Treatment History**
Shall be established when **one** of the following criteria are met:
 - a. Six or more days of psychiatric inpatient treatment in the past twelve months; or
 - b. Met standards for involuntary treatment within the past twelve months; or
 - c. Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, etc.; or
 - d. At least 3 missed community mental health service appointments, or two or more face-to-face encounters with crisis intervention/emergency services personnel within the past twelve months, or documentation that the consumer has not maintained his/her medication regimen for a period of at least 30 days.
 3. **Functioning Level**
Global Assessment of Functioning Scale (DSM III R, Pages 12 and 20) ratings of 60 and below.
- B. Adults who were receiving resource coordination services as children and were recommended by the provider and approved by the County Administrator as needing resource coordination services beyond the date of transition from child to adult.
- C. Children who have a mental illness or serious emotional disturbance as defined by meeting the criteria for Diagnosis, Treatment History and Functioning Level:
 1. **Diagnosis**
Diagnosis within DSM III R (or succeeding revisions thereafter) excluding those with a principal diagnosis of mental retardation, psychoactive substance abuse, organic brain syndrome or a V-Code.
 2. **Treatment History**
Shall be established when one of the following criteria are met:
 - a. Six or more days of psychiatric inpatient treatment in the past twelve months; or
 - b. Without resource coordination services would result in placement in a community inpatient unit, state mental hospital or other out-of-home placement, including foster homes or juvenile court placements;
 - c. Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems such as Education, Child Welfare, Juvenile Justice, etc.
 3. **Functioning Level**
Global Assessment of Functioning Scale (DSM III R, Pages 12 and 20) rating of 70 and below.
- D. An adult, child or adolescent who currently receives intensive case management services.
An adult, child or adolescent who needs to receive resource coordination services but who does not meet the requirements identified above may be eligible for resource coordination upon review and recommendation by the County Administrator and written approval by the Department's Area Office of Mental Health.

RESPONSIBILITIES

Responsibilities of County Administrators - County Mental Health Administrators are responsible for identifying the need for

resource coordination services and for developing a program and fiscal plan to address that need. County Administrators are required to monitor the compliance of resource coordination providers under their jurisdiction with provisions of these guidelines as well as to provide fiscal and program reports to the Department. Administrators must certify that state funds are available for matching Medicaid compensable services and must ensure that sufficient state funds are available for non-Medicaid compensable services.

Responsibilities of Providers - Providers must adhere to requirements set forth in these guidelines and submit reports as required by the Department and the County Administrator. Providers must assist consumers or the parents, if the consumer is a child, in accessing appropriate mental health services and in obtaining and maintaining culturally appropriate basic living needs and skills. Services must be provided within the context of the consumer's and the family's culture. Providers must provide services in accordance with a written, consumer-specific, service plan which is goal and outcome oriented. The initial plan must be developed within 30 days of admission to resource coordination, and must be reviewed and updated at least every 12 months. Outcomes shall be reported to the Department on an annual basis via the Consolidated Community Reporting System. Providers must deliver services as needed in the place where the consumer resides or needs the service. Services may also be provided at the Resource Coordinator's office when off-site interventions would not be more appropriate. Providers must contact the consumer or the parents, if the consumer is a child or adolescent, at least once a month. Face-to-face contact with a child or adolescent consumer shall be made **at least** once a month. Face-to-face contact with an adult consumer shall be made at least every two months. If the consumer cannot be contacted face-to-face, the attempt to contact shall be documented. The provider must establish protocols to ensure that resource coordination staff attend orientation and ongoing training sessions. Providers must ensure that the principles established by the Pennsylvania Child and Adolescent Service System Program (CASSP), to include Cultural Competence, are followed in providing services for consumers who are children or adolescents and their families, and that Community Support Program (CSP) principles are followed in providing services for adult consumers. See Appendix A.

REQUIREMENTS

Staff Requirements - In accordance with educational and experiential standards recently approved by the Health Care Finance Administration, the following minimal requirements must be met by supervisors of resource coordination services:

- A. A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, nursing, other related social sciences, criminal justice, theology, counseling, or education, and have two years mental health direct care experience; or
- B. A registered nurse with three years mental health direct care experience.

A resource coordination staff person must meet one of the following criteria;

- A. A bachelor's degree with major course work in sociology, social welfare, psychology, gerontology, anthropology, other related social sciences, criminal justice, theology, nursing, counseling, or education; or
- B. A registered nurse; or
- C. A high school diploma and 12 semester credit hours in sociology, social welfare, psychology, gerontology, or other social science and two years experience in direct contact with mental health consumers; or
- D. A high school diploma and five years of mental health direct care experience in public or private human services with employment as a case management staff person prior to April 1, 1989.

Mental health direct care experience is working directly with mental health service consumers (adults, children or adolescents) providing services involving casework or case management, individual or group therapy, crisis intervention, early intervention, vocational training, residential care, or social rehabilitation in a mental health facility or in a facility or program that is publicly funded to provide services to mental health consumers, or in a nursing home, a juvenile justice agency, or a children and adolescent service agency.

Recordkeeping - Records must be maintained which verify compliance with the requirements of these guidelines. Consistent with regulations at 55 PA Code 1101.51(e) (Medical Assistance General Provisions) records must be kept for a minimum of four years. Site survey reports, employee schedules, payroll records, job descriptions, documents verifying employee qualifications and training, policies and protocols, fees or charges, records of supervision and training, letters of agreement with referral sources and service agencies and a grievance and appeals process are examples of records that must be kept to verify compliance with these guidelines.

Case Records - Each recipient of resource coordination services shall have a case record which is identified and maintained apart from other service records, and which contains at a minimum:

- A. Intake information which identifies the reason for referral to the service and that the consumer is eligible for the service.
- B. Written assessments and evaluations identifying medical, psychiatric and social strengths, needs and interests, on which to base the service plan.
- C. An individualized service plan which is developed within 30 days of admission to resource coordination based upon the intake and assessment information, and which is updated at least every 12 months thereafter. The plan must be signed by the consumer, the family if the consumer is a child, the resource coordinator and others as determined appropriate by the consumer and the resource coordinator.
- D. Documentation of each contact indicating the date and time (beginning and end) of service, purpose of the contact, staff person(s) involved, service(s) provided and the outcome(s) of the contact.

- E. Termination summary, to be completed within 30 days of discharge from the program. The summary must identify the services provided, the goals attained through involvement with resource coordination, goals not completed and why, the reason for closure, and a recommended after-care plan. The summary must be signed by the consumer, the family if the consumer is a child or adolescent, and involved others, if obtainable.

Quality Assurance and Utilization Review - The quality and appropriateness of services must be monitored at the agency and county levels. Monitoring must occur according to an annual quality assurance/utilization review plan, to be developed by each provider of resource coordination services, and to be reviewed and approved by the County MH/MR Administrator or designee. The plan shall address the implementation of concurrent utilization review, peer review, consumer and family member satisfaction surveys, and self-evaluation of compliance with standards set forth in this chapter. Services are subject to reviews by federal and state authorities as provided in Medical Assistance General Provisions, Sections 1101.71-75 (relating to utilization control, invoice adjustment, provider misutilization and abuse, provider fraud and provider prohibited acts) and by agents of the county.

Conflict of Interest - Providers of resource coordination services must assure consumers the freedom to choose among any available providers of needed services and resources. The resource coordinator must also assist the consumer in accessing these services.

CONSUMER RIGHTS

Consumer Participation - Consumers have a right to terminate services without prejudice to other mental health services or future services. Consumers must receive assurances of nondiscrimination, right of appeal and individual civil rights. The Mental Health Procedures Act, 50 P.S. §7101 et seq., provides for an adolescent's right to seek or reject services. Parents must be involved in service planning for a child, and should be involved in service planning for adolescents over 14 unless the adolescent objects. Consumers cannot be terminated from services for non-compliant or non-participatory behavior that results from a mental illness or emotional disorder.

Notice of Confidentiality - There must be an assurance of confidentiality to individuals receiving resource coordination services as provided by Departmental regulations at 55 PA Code 5100.31-39. The right to confidentiality shall serve to protect the consumer's dignity and well-being, and not to create a barrier to appropriate treatment and services.

PAYMENT

Payment - These guidelines establish criteria for payment for resource coordination services under provisions of 55 PA Code 4300 (the County MH/MR Fiscal Manual). When conditions of these guidelines are met, services paid from county mental health allocations are eligible for 100% State financial participation. Providers must bill the Medical Assistance Program for eligible services provided to eligible recipients. Payment for a quarter-hour, or major portion thereof, unit of service will be made at a county negotiated, Departmentally approved, cost-based fee-for-service rate. Non-direct services (such as staff meetings, completing paperwork and attending training) are not billable, with the exception of staff time spent in necessary travel which results in billable resource coordination services. The maximum number of units that may be billed during a quarter-hour period shall equal the number of staff persons involved or the number of consumers being served, whichever is smaller. Payment will be made for assessment service planning informal support network building, assistance in gaining access to needed services and resources, linking, monitoring, and life support and problem resolution activities. See Appendix A for activity descriptions.

APPENDIX A

RESOURCE COORDINATION ACTIVITIES

Resource coordination is a service for adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disorders and their families, who do not need the intensity and frequency of contacts provided through intensive case management, but who do need assistance in accessing, and coordination and monitoring of, resources and services. Services are provided to assess individual's strengths and needs, and to assist them in accessing resources and services that build upon strengths and meet needs in order to achieve stability in the community. Activities undertaken by staff providing resource coordination services shall include:

Assessment - A review of clinical information and a general discussion with the consumer and the family, if the consumer is a child, to understand the consumer's history and present life situation.

Service Planning - The development of goals and objectives with the consumer and the family, if the consumer is a child, based on strengths and desires identified through the assessment, to include any activities necessary to enable the consumer to live as an integral part of the community.

Linking with Services - Assisting the consumer and the family, if the consumer is a child, in locating and obtaining services specified in the treatment/services plan including arranging for the consumer to be established with the appropriate service provider.

Gaining Access to Services - Aggressive and creative attempts to help the consumer and the family, if the consumer is a child, obtain resources and services identified in the treatment/service plan. This may include home and community visits and

other efforts, as needed. Home and community shall be defined broadly to include but not be limited to field contacts which may take place on the street, in the person's residence, at school or place of work, and in psychiatric treatment facilities, rehabilitation programs and other agencies where support or entitlements are available to the recipient. (Refer to the special conditions under which Medicaid can be billed for case management services to persons in inpatient settings. Medicaid cannot be billed for persons in jail.)

Monitoring of Service Delivery - Ongoing review of the person's receipt of, and participation in, services. Contact with the consumer and the family, if the consumer is a child, must be made on a regular basis to determine his or her opinion on progress, satisfaction with the service or provider, and any needed revisions to the treatment/service plan. Contact with provider/program staff must be made on a regular basis to determine if the person is progressing on issues identified in the treatment/service plan and if specific services continue to be needed and appropriate. A process must be developed for resolution between staff members with levels of appeal to be pursued when there is clinical disagreement on the nature and extent of progress a particular consumer is making. Regular contacts must be made with other public agencies serving the consumer and with parents, if the consumer is a child.

Problem Resolution - Direct, active efforts in advocacy to assist the consumer and family, if the consumer is a child, in gaining access to needed services and entitlements. Staff shall have easy access to communicate with agency and county MH/MR administrators for the purpose of obtaining assistance in resolving issues which prevent a person from receiving needed treatment, rehabilitation and support services. On a systems level, this may include providing information to help plan modifications to existing services or implement new services to meet identified needs and providing information to help plan modifications for accessing resources.

Informal Support Network Building - Contact with the person's family (not family counseling or therapy) and friends (with the permission and cooperation of the adult consumer) to enhance the person's informal support network and alleviate dependency on the resource coordinator.

Use of Community Resources - Assistance to persons in identifying, accessing and **assessing their ability to use** community resources appropriately to meet daily living needs. This may include the use of public transportation, recreation facilities, stores, etc.



CHAPTER 5221. MENTAL HEALTH INTENSIVE CASE MANAGEMENT

GENERAL PROVISIONS

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Authority

The provisions of this Chapter 5221 issued under section 201(2) of the Mental Health and Mental Retardation Act of 1966 (50 P. S. § 4201(2)), unless otherwise noted.

Source

The provisions of this Chapter 5221 adopted December 21, 1990, effective December 22, 1990, and apply retroactively to March 4, 1989, 20 Pa.B. 6276, unless otherwise noted.

GENERAL PROVISIONS

§ 5221.1. Scope.

This chapter establishes minimum standards for the provision of intensive case management for targeted adults with serious and persistent mental illness and children with a serious mental illness or emotional disorder. It is applicable to county administrators and to providers approved by the Office of Mental Health to provide intensive case management services.

§ 5221.2. Objective.

Intensive case management is established as a primary, direct service to the targeted population. It is designed to insure access to community agencies, services and people whose functions are to provide the support, training and assistance required for a stable, safe and health community life. Services will be offered within the parameters imposed by funding and other resources.

§ 5221.3. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Case—A consumer and members of his family being served, if the consumer is a child.

Child—A person 17 years of age or younger or 21 years of age or younger if enrolled in special education.

Consumer—A person who receives intensive case management services. The term does not include a family member who receives services.

County administrator—The MH/MR administrator who has jurisdiction in the geographic

area.

County plan—A county plan and estimate of expenditures which describes how case management services will be made available, including the anticipated expenditures for the services. The plan is prepared and updated annually by the county administrator and the county MH/MR board and submitted for approval to the Department of Public Welfare, Office of Mental Health in accordance with this chapter.

Department—The Department of Public Welfare of the Commonwealth.

Emotional disturbance—A child's inability to function in the home, school or community and so the child requires multiple medical, social, educational or other supports.

Enrolled provider— A county MH/MR program or private agency specifically identified as a provider of intensive case management in the county human services plan which has been approved by the Department and enrolled by the Office of Mental Health and the Office of Medical Assistance Programs for claims processing.

Family—Parents, as defined in this section, siblings and other relatives living in the home.

Global assessment of functioning scale—A procedure for measuring the overall severity of psychiatric disturbance which is contained in DSM-III-R (*Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised), published by the American Psychiatric Association, 1987, Washington, D.C., and subsequent editions.

Intensive case manager— A staff person designated to provide intensive case management under § 5221.21 (relating to organizational requirements).

Intensive case management—The services described in this chapter which are designed to assist targeted adults with serious and persistent mental illness and targeted children with a serious mental illness or emotional disorder and their families, to gain access to needed resources, such as medical, social, educational and other services.

MH/MR—Mental Health/Mental Retardation.

Mental health direct care experience—Working directly with adult or children mental health service consumers, providing services involving casework or case management, individual or group therapy, crisis intervention, early intervention, vocational training, residential care or social rehabilitation in a mental health facility or in a facility or program that is publicly funded to provide services to mental health consumers, or in a nursing home, a juvenile justice agency, or a children and adolescent service agency.

Mental illness—The existence of a mental disability subject to DSM III-R diagnosis, excluding mental retardation or substance abuse as the primary diagnosis, rendered by a licensed physician or psychologist.

Parent— The biological or adoptive mother or father or the legal guardian of the child or a responsible relative or caretaker with whom the child regularly resides.

Supervisor—A person designated to supervise intensive case managers under § 5221.21.

Targeted population—Adults with serious and persistent mental illness and children with serious mental illness or emotional disorders who are deemed eligible to receive intensive case management as identified by the county administrator under this chapter.

GENERAL REQUIREMENTS

§ 5221.11. Provider participation.

- (a) County MH/MR programs and public and private agencies are eligible to enroll as intensive case management providers if they are specifically designated as providers in an approved county plan. The Department reserves the right to limit providers to those it considers best able to serve the targeted population.
- (b) County MH/MR programs and public and private agencies seeking to provide intensive case management shall apply to the county administrator to be included in the county plan.
- (c) Providers approved by the Department shall sign a provider agreement, as specified in Chapter 1101 (relating to general provisions), to participate as providers of intensive case management.
- (d) Enrolled providers shall complete a Multi-Category Enrollment Information Packet which will permit Federal share reimbursements through Medical Assistance.
- (e) Enrolled providers shall abide by Chapter 1101, to the extent that the compliance is consistent with compliance with this chapter.

§ 5221.12. Consumer eligibility.

- (a) Persons eligible for intensive case management are:
 - (1) Adults, 18 years of age or older, who have a serious and persistent mental illness. A person shall be considered to have a serious and persistent mental illness when two of the following criteria are met:
 - (i) *Diagnosis*--Schizophrenia or chronic major mood disorder (diagnosis codes 295 and 296 in the DSM III-R).
 - (ii) *Treatment history*-- One of the following:
 - (A) Admission to State mental hospitals totaling 60 days within the past 2 years.
 - (B) Two admissions to community inpatient psychiatric units totaling 20 or more days within the past 2 years.
 - (C) Five or more face-to-face encounters with emergency services personnel within the past 2 years.
 - (D) Three or more years of continuous attendance in a community mental health

service, at least one unit of service per quarter.

(E) History of sporadic course of treatment as evidenced by at least three missed appointments within the past 6 months, inability to or unwillingness to maintain medication regimen or involuntary commitment to outpatient treatment.

(iii) *Functioning level.* One of the following:

(A) Global Assessment of Functioning Scale (DSM-III-R, pages 12, and 20) ratings of 40 and below.

(B) A rating of 60 and below if the person is 35 years of age or younger or has a history of aggressive or violent behaviors.

(2) Adults who were receiving intensive case management services as children and were reviewed by the provider and approved by the county administrator as needing intensive case management services beyond the date of transition from child to adult.

(3) Children who are mentally ill or emotionally disturbed and who meet one of the criteria described as follows:

(i) Children, 6 years of age or younger, who are enrolled in, or require, early intervention services under section 671 of the Education of the Handicapped Act (20 U.S.C.A. § 1400).

(ii) Children who, with their families, are receiving services from three or more publicly funded programs such as, Medical Assistance, Aid to Families with Dependent Children and Special Education.

(iii) Children who are returning from State mental hospitals, community inpatient units or other out-of-home placements, including foster homes and juvenile court placements.

(iv) Children who are recommended as needing mental health services by a local interagency team which shall include county agency representatives.

(4) Families of eligible children who are receiving intensive case management services.

(b) *Exceptions.* An adult or child receiving, or who needs to receive, mental health services but who does not meet the requirements of this section is eligible for intensive case management upon review and recommendation by the county administrator and written approval by the Department's area office of mental health.

(c) *Termination.* Intensive case management may be terminated for one of the following reasons:

(1) Determination by the consumer or the parent of a child receiving the service that intensive case management is no longer needed or wanted.

(2) Determination by the intensive case manager in consultation with his supervisor or the director of intensive case management, and with written concurrence by the county

administrator that intensive case management is no longer necessary or appropriate for the adult or child receiving the services.

STRUCTURE AND ORGANIZATION

§ 5221.21. Organizational requirements.

Intensive case management providers shall ensure that the following organizational requirements are met:

(1) The intensive case management program shall be organized or identified as a separate unit within the organization of the enrolled provider.

(2) Overall supervision of the intensive case management unit, as well as individual supervision of intensive case managers, shall be carried out only by mental health professionals. To qualify as a mental health professional under this chapter, an individual shall have at least one of the following:

(i) A master's degree in social work, psychology, rehabilitation, activity therapies, counseling or education and 3 years mental health direct care experience.

(ii) A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, counseling, education, or be a registered nurse, and 5 years mental health direct care experience, 2 of which shall include supervisory experience.

(iii) A bachelor's degree in nursing and 3 years mental health direct care experience.

(3) Intensive case managers who are not mental health professionals shall:

(i) Have one of the following:

(A) A bachelor's degree with major course work in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, nursing, counseling or education.

(B) Be a registered nurse.

(C) A high school diploma and 12 semester credit hours in sociology, social welfare, psychology, gerontology or other social science and 2 years experience in public or private human services with 1 year in direct client contact.

(D) A high school diploma and 5 years of mental health direct care experience in public or private human services with employment as an intensive case management staff person prior to April 1, 1989.

(ii) Be supervised by a mental health professional. A record of supervision shall be on file.

Cross References

This section cited in 55 Pa. Code § 5221.3 (relating to definitions).

§ 5221.22. Relationship to other parts of the system.

(a) The intensive case manager shall work closely with the consumer's mental health therapist or psychiatrist and provide consultation in crisis situations as well as in the overall treatment and management of the consumer's mental illness, including discharge planning.

(b) The intensive case manager shall be involved in treatment planning for consumers on his caseload who are hospitalized.

(c) The intensive case manager or supervisor shall be present when an involuntary commitment of a consumer on his caseload is being considered to ensure that all appropriate alternatives to hospitalization are considered. When attendance is impossible because of road conditions, emergency situations or other causes, this shall be documented and an effort made to have other informed case managers present or to establish telephone contact.

(d) Enrolled providers shall establish formal and informal links with other service providers as needed to carry out intensive case management activities. Written agreements shall be made with frequently used contacts including the county MH/MR program, psychiatric inpatient facilities, partial hospitalization programs, psychiatric clinics, residential programs, drug and alcohol programs, social and vocational programs and other agencies as needed. For children and their families, linkages shall also be established with child welfare, education, juvenile justice and other child serving agencies.

§ 5221.23. Staffing patterns and limits.

(a) The provider shall have a written policy showing how 24-hour, 7-day per week coverage for intensive case management services is provided. This policy shall be made available to the Department upon request.

(b) The number of cases in a caseload shall be based on the intensity of the need for service but may not exceed 30.

(c) Team assignments to provide intensive case management services are not precluded as long as a single intensive case manager can be held accountable for the services provided to each case.

(d) A supervisor may supervise no more than seven intensive case managers. A supervisor shall maintain a minimum of three contacts one meeting per week with intensive case managers with additional supervision depending upon the performance of the case manager, the activity of the caseload and administrative judgment.

(e) If there are less than seven intensive case managers providing intensive case management, supervisory staff time shall be at least proportionate to the ratio of one full-time supervisor to seven intensive case managers.

(f) Intensive case managers shall be employed as full time staff unless an exception is

approved by the county administrator and the area office of mental health.

(1) When a part-time case manager has been approved, the case manager may not provide mental health service except intensive case management to a person on his caseload.

(2) When there is not a sufficient number of eligible persons to constitute a full-time caseload, part-time case management and supervisory staff shall be proportionate to the caseload and supervisory ratios stated in subsections (a), (d) and (e) and organized and operated in a manner that clearly records and identifies time spent on intensive case management.

(g) During the absence or illness of an intensive case manager, the provider shall temporarily designate another intensive case manager to be responsible for every adult or child on the absent intensive case manager's caseload.

(h) For recordkeeping and billing purposes, services to the child and family members shall be considered together as one case or caseload.

§ 5221.31. Responsibilities of providers.

Intensive case management providers are responsible for:

(1) Assisting the consumer in accessing appropriate mental health services.

(2) Assisting the consumer or the parents, if the consumer is a child, in obtaining and maintaining basic living needs and skills, such as housing, food, medical care, recreation, education and employment.

(3) Assuring the consumer or the parents, if the consumer is a child, continuous, 24-hour access to the intensive case management service.

(4) Providing the intensive case management service in accordance with a written, consumer-specific service plan which includes strengths as well as needs and which is goal and outcome oriented. The outcomes, which shall be measured and reviewed at least every 6 months on an individual and systems basis, are:

(i) Independence of living for the adult; or family integration, if the consumer is a child.

(ii) Vocational/educational participation.

(iii) Adequate social supports.

(iv) Reduced hospital lengths of stay or child out-of-home placements.

(5) Providing intensive case management services in the manner set forth in the approved county plan as it is updated.

(6) Providing intensive case management services as needed in the place where the consumer resides or needs the service. Reasonable attempts shall be made to contact the consumer or the parents, if the consumer is a child, at least every 2 weeks. The contact or

the attempt to contact shall be documented. If contact with the consumer or a parent cannot be made, then attempts to locate another member of the family, a relative or a friend shall be documented.

(7) Complying with reporting requirements as mandated by the Department using prescribed forms as required under Chapter 4300 (relating to county mental health and mental retardation fiscal manual).

(8) Documenting at least quarterly the functioning level of each consumer.

(9) Requiring county mental health crisis intervention services to contact the on-call intensive case manager when contacted by a consumer or a parent, if the consumer is a child receiving intensive case management services.

(10) Ensuring that intensive case management staff attend State mandated training sessions or make up training.

(11) Ensuring that the principles developed by the Pennsylvania Child and Adolescent Service System Program (CASSP) are followed in providing services for consumers who are children and their families. See Appendix A.

Cross References

This section cited in 55 Pa. Code § 5221.33 (relating to intensive case management records—statement of policy).

§ 5221.32. County administrator.

The county administrator shall:

(1) Regularly review and verify that intensive case management is provided under this chapter.

(2) Provide fiscal and program reports as required by the Department under § 4200.32 (relating to powers and duties).

(3) Certify that State matching funds are available for Medicaid compensable services.

§ 5221.33. Intensive case management records—statement of policy.

To satisfy the recordkeeping requirements in §§ 5221.31(4) and 5221.41 (relating to responsibilities of providers: and recordkeeping), intensive case management records should contain, at a minimum, the following:

(1) *Intake information.* The following shall be included:

(i) Identifying information to include the consumer's name, address, date of birth, social security number and third-party resources.

(ii) Referral Form, to include date, source and reason for referral to intensive case

management and DSM III-R, or subsequent revision, diagnosis.

(iii) Verification of eligibility to receive intensive case management, such as past treatment records, psychiatric or psychological evaluation, letter summarizing treatment history, Individual Education Plan (IEP), and the like.

(2) *Assessments and evaluations.*

(i) The following assessments and evaluations should be made:

(A) Medical history, taken within the past 12 months, or documentation of the intensive case manager's efforts to assist the consumer in obtaining a physical examination.

(B) Assessment of the consumer's strengths, needs and interests.

(C) Summaries of hospitalizations, incarcerations or other out-of-home placements while enrolled in intensive case management, including the place and date of admission, the reason for admission, length of stay and discharge plan.

(D) Children only: IEP, school testing-- for example, psychological evaluations-- guidance counselor reports, and the like, or documentation of the intensive case manager's efforts to obtain the information if not in the record.

(E) Outcome information required for annual Consolidated Community Reporting System reporting--that is, consumer level of functioning, independence of living and vocational/educational status.

(ii) The following applies to clauses (A), (C) and (D):

(A) If the intensive case management provider is part of a multiple service agency which maintains the assessments and evaluations in clauses (A), (C) and (D) in another file, the information other than that required to establish eligibility for intensive case management does not need to be duplicated for the intensive case management record.

(B) These reports are considered to be part of the intensive case management record, and shall be made available if the intensive case management record is requested.

(3) *Written service plan.* The initial plan shall:

(i) Be developed within 1 month of registration and reviewed at least every 6 months.

(ii) Reflect documented assessment of the consumer's strengths and needs.

(iii) Identify specific goals, objectives, responsible persons, time frames for completion and the intensive case manager's role in relating to the consumer and involved others.

(iv) Be signed by the consumer, the family if the consumer is a child, the intensive case manager, the intensive case management supervisor and others as determined appropriate by the consumer and the intensive case manager. If the signatures cannot be obtained, attempts to obtain them should be documented.

(4) *Documentation of services.* The following shall be included:

(i) Case notes. The case notes shall:

(A) Be legible.

(B) Verify the necessity for the contact and reflect the goals and objectives of the intensive case management service plan.

(C) Include the date, time and circumstance of contacts, regardless of whether or not a billable service was provided.

(D) Identify the consumer by name or case number on both sides of each page on which there is writing on both sides. The consumer's name and case number should appear together earlier in the file.

(E) Be dated and signed by the individual providing the service.

(ii) Documentation of referral for other services.

(iii) Encounter forms.

(5) *Discharge information.* The following shall be included:

(i) A termination summary, including a reason for admission to intensive case management, the services provided, the goals attained, the goals not completed and why and a reason for closure. The summary shall:

(A) Contain the signature of the consumer, the family if the consumer is a child, and involved others, if obtainable, to verify agreement of the termination.

(B) Contain the signature of the county administrator or designee if the consumer (or family, if the consumer is a child) does not consent to the termination.

(iii) A recommended after-care plan.

Source

The provisions of this § 5221.33 adopted September 10, 1993, effective upon publication and apply retroactively to August 31, 1993, 23 Pa.B. 4312.

RECORD AND PAYMENT REQUIREMENTS

§ 5221.41. Recordkeeping.

(a) Intensive case management records shall be identified and maintained apart from other service records using forms required by the Department.

(b) Records shall be maintained for a minimum of 4 years.

(c) Written procedures and records shall be kept in accordance with Chapters 1101 and 4300 (relating to general provisions; and county mental health and mental retardation fiscal manual).

(d) Changes in a consumer's progress, including admission and termination, shall be documented detailing cause and projected effect in the case record. For example, a meeting with a teacher shall indicate why the meeting was arranged and what the case manager hopes to accomplish in serving the consumer.

Cross References

This section cited in 55 Pa. Code § 5221.33 (relating to intensive case management records --statement of policy).

§ 5221.42. Payment.

(a) When conditions of this chapter are met and a county plan is approved by the Department, intensive case management paid from county mental health allocations is eligible for 100% State financial participation.

(b) If intensive case management is provided to an adult or child eligible for Medical Assistance coverage and the service qualifies for Federal financial participation, the provider shall bill the Medical Assistance Program in accordance with procedures established by the Department under Chapter 1101 (relating to general provisions).

(c) The non-Federal portion of the fee shall be met using the State portion of program funds as provided for under this chapter.

(d) No eligible adult or child may be denied needed intensive case management merely because the adult or child is ineligible for Federally-reimbursed services. In these circumstances, 100% State funds may be used to provide payment for the necessary service.

(e) Provider staff meetings, recordkeeping activities and other nondirect services are not billable as intensive case management.

(f) The unit of service for billing purposes shall be 1/4 hour of service or portion thereof in which the intensive case manager or intensive case manager supervisor is in face-to-face or telephone contact with the consumer, the consumer's family or friends, service providers or other essential persons for the purpose of assisting the consumer in meeting his needs.

(1) Staff time spent in necessary travel may be billed as units of services.

(2) When one or more intensive case management staff persons, acting together, make service contact with or for one or more consumers or family members, if the consumer is a child, during a 1/4-hour period, the maximum number of units that may be billed shall equal the number of staff persons involved or the number of cases being served, whichever is smaller.

(g) A fee-for service payment methodology as established in § 1150.62 (relating to payment levels) shall be used to reimburse intensive case management.

(h) The Department will participate in 100% of the approved expenditures for the following components of intensive case management provided under this chapter:

- (1) Assessment and understanding of the consumer's history and present life situation; service planning, based on the consumer's strengths and desires, to include activities necessary to enable the consumer to function as an integral part of the community.
- (2) Informal support network building.
- (3) Use of community resources, to include assistance to consumers or the consumers' parents, if the consumer is a child, in identifying, accessing and learning to use community resources.
- (4) Linking with resources.
- (5) Monitoring of service delivery.
- (6) Aggressive and creative attempts to help the consumer gain access to resources and required services identified in the treatment plan.
- (7) Life support and problem resolution, to include direct, active efforts to assist the consumer in gaining access to needed services and entitlements.

§ 5221.43. Quality assurance and utilization review.

The quality of intensive case management shall be ensured by written provider procedures which include periodic staff conferences, required attendance at training programs for staff members and other oversight. Services are subject to review by the Department and appropriate agencies in accordance with § § 1101.71--1101.75 and by authorized agents of the county government.

§ 5221.44. Conflict of interest.

When an agency that provides intensive case management also provides other mental health treatment, rehabilitation or support services, the responsible county administrator shall ensure that the provider agency:

- (1) Does not restrict the freedom of choice of the consumer, or parent, if the consumer is a child, of needed services and provider agencies when needed services, including case management, are available.
- (2) Fully discloses the fact that the agency is or may be performing other direct services which could be obtained at another agency if the consumer so desires.
- (3) Provides each consumer and parent, if the consumer is a child, a listing of mental health treatment, rehabilitation and support services available within a reasonable proximity to the consumer's home where needed services could be obtained and if the consumer or parent, if the consumer is a child, so desires, the case manager assists the consumer or parent in obtaining those services.

(4) Documents that the information in this section has been reviewed and understood by the consumer or parent, if the consumer is a child.

CONSUMER RIGHTS

§ 5221.51. Consumer participation and freedom of choice.

(a) A consumer or parent, if the consumer is a child, has the right to refuse to participate in intensive case management without prejudice to other parts of his treatment program.

(b) Case management staff shall be assigned with the participation of the person to be served or parents, if the person is a child. When a person needs intensive case management but the person or the parents, if the person is a child, does not wish to participate in the assignment process, the circumstances and efforts to gain participation shall be documented.

(c) Request for assignment or change of an intensive case manager by an adult or the parents of a child shall be made if possible. Requests of this nature and the outcome shall be documented.

(d) The intensive case manager shall continue to provide services to an assigned case unless the consumer or parent, if the consumer is a child, requests a change or the need for services ends.

(e) Consumers may not be terminated from service for nonattendance or noncompliant behavior that results from mental illness or emotional disorder.

(f) No service decisions may be made in violation of a consumer's civil rights.

(g) When it is necessary to terminate a consumer from intensive case management, the circumstances and rationale shall be fully documented and approved by the county administrator prior to termination.

(h) The parent with whom a child is living shall act on behalf of the child in service planning. The child shall be encouraged to participate in the process insofar as the child is able and insofar as participation is age and functionally appropriate.

(i) Persons readmitted to intensive case management shall be assigned to the intensive case manager who had previously assisted the person whenever possible, unless the consumer or parents, if the consumer is a child, object.

(j) A parent may act on behalf of the child in decisions relating to services and shall be involved in decisions involving the formation of, and change in, a service plan.

(k) A child 14 years of age or older may consent to treatment or discharge without the consent of the parent if the child substantially understands the nature of treatment and may sign and release records under section 201 of the Mental Health Procedures Act (50 P. S. § 7201).

(l) If the child 14 years of age or older acts independently, the parents shall be notified and

have a right to object.

§ 5221.52. Notice of confidentiality and nondiscrimination.

(a) Adults and children receiving intensive case management services are entitled to confidentiality of records and information as set forth in § 5100.31—5100.39 (relating to confidentiality of mental health records) and other applicable Federal and State requirements.

(b) Enrolled providers may not discriminate against staff or consumers on the basis of age, race, sex, religion, ethnic origin, economic status or sexual preference, and shall observe applicable State and Federal statutes and regulations.

§ 5221.53. Recipient right of appeal.

(a) Department actions for misutilization or abuse against a staff or consumer receiving intensive case management are subject to the right of appeal in accordance with Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings).

(b) Adults and children who have been terminated from intensive case management services over their objections, or the objection of a parent if the child is 13 years of age or younger, shall have the right to appeal the decision in accordance with procedures as outlined in Mental Retardation Bulletin Number 99-86-01 (a joint Mental Health/Mental Retardation Bulletin: Procedures for Review of Service Eligibility and Termination Decisions) effective January 17, 1986 and subsequent revisions of policy. Copies of the bulletin may be obtained from the county administrator.

APPENDIX A INTENSIVE CASE MANAGEMENT GUIDELINES

Case management is a service which will assist eligible individuals with mental illness, including children with a serious mental illness or emotional disorder, in gaining access to needed medical, social, educational and other services. Activities undertaken by staff providing case management services shall include:

Linking with services—Assisting the consumer in locating and obtaining services specified in the treatment or services plan, or both, including arranging for the consumer to be established with the appropriate service provider.

Monitoring of service delivery—There shall be an ongoing review and written record of the person's receipt of, and participation in, services. Contact with the consumer shall be made on a regular basis to determine his opinion on progress, satisfaction with the service or provider, and needed revisions to the treatment plan. Contact with the consumer's therapist shall be made on a regular basis to determine if the person is progressing on issues identified in the treatment plan and if specific services continue to be needed and

appropriate. A process shall be developed for resolution between staff members with levels of appeal to be pursued when there is clinical disagreement on the nature and extent of progress a particular consumer is making. Regular contacts shall be made with other public agencies serving the consumer and with parents, if the consumer is a child.

Gaining access to services---Aggressive and creative attempts are required to help the person gain resources and services identified in the treatment or service plan, or both. This may include home and community visits and other efforts as needed. It does not preclude the consumer's therapist from accompanying the case manager on these visits. Home and community shall be defined broadly to include field contacts which may take place on the street, at the person's residence or place of work, psychiatric treatment facilities, rehabilitation programs and other agencies where support or entitlements are available to the recipient. (Medicaid may not be billed for case management services provided to eligible persons in hospitals, SNF, ICF and ICF/MR facilities for which Medicaid is being billed for treatment nor for persons in jail.)

Assessment and service planning--A review of clinical assessment information and a general discussion with the consumer is required regarding unmet needs and plans for the future.

Problem resolution---Active efforts to assist the person in gaining access to needed services and entitlements. Staff shall have easy access to communicate with the county administrator for the purpose of obtaining assistance in resolving issues which prevent a person from receiving needed treatment, rehabilitation and support services. On a systems level, this may include providing information to help plan modifications to existing services or implement new services to meet identified needs and providing information to help plan modifications for accessing resources.

Informal support network building--Contact with the person's family, not family counseling or therapy, and friends, with the permission and cooperation of the adult person, to enhance the person's informal support network.

Use of community resources---Assistance to persons in identifying, accessing and learning to use community resources appropriately to meet his daily living needs shall be provided as needed. This may include the use of public transportation, the library, stores and the like. This will be done by making a referral to an appropriate service provider, creating such a resource if it does not already exist, in providing assistance directly to the consumer if no other resources are available to provide instruction.

PENNSYLVANIA CASE MANAGEMENT SERVICES FOR CHILDREN AND ADOLESCENTS WITH SEVERE EMOTIONAL DISTURBANCE AND THEIR FAMILIES

A. Core Values for the System of Care.

1. The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community-based, with the focus of services as well as management and decision-making responsibility resting at the community level.

B. Principles of Services for Children & Adolescents in Pennsylvania.

1. Children and adolescents deserve to live and grow in nurturing families.
2. Children and adolescents' needs for security and permanency in family relationships should pervade all planning.
3. The family setting should be the first focus for treatment for the child or adolescent. Out-of-home placement should be the last alternative. Young children should not need to be in a State hospital to receive appropriate mental health treatment.
4. Communities should develop a rich array of services for children and their families so that alternatives to out-of-home placement are available, such as home-based services, parent support groups, day treatment facilities, crisis centers and respite care.
5. Parents and the child should participate fully in service planning decisions.
6. The uniqueness and dignity of the child or adolescent and his family should govern service decisions. Individualized service plans should reflect the child or adolescent's developmental needs which include family, emotional, intellectual, physical and social factors. The older adolescent's right to risk should be considered. Children and adolescents should not need to be labeled in order to receive necessary services.
7. The community service systems which are involved with the child and family should participate and share placement, program, funding and discharge responsibilities.
8. The primary responsibility for the child or adolescent should remain with the family and community. Pre-placement planning should include a discharge plan.
9. Case management should be provided to each child and family to ensure that multiple services are delivered in a coordinated, time-limited and therapeutic manner which meet the needs of child and family.
10. Each child should have an advocate.

The Pennsylvania Child and Adolescent Service System Program (CASSP) guidelines which follow form the foundation for intensive case management services for children and their families:

1. The major thrust of the case management service shall be the commitment to permanency planning for each child and adolescent with severe emotional problems.
2. The relationship of the case manager with the family shall be one of a partnership, embodying the concept of "parents and professionals as partners."
3. The process of providing case management services to children and adolescents and their families shall be based on the developmental needs and phases of the children and

adolescents as they progress to adulthood.

4. The case manager will first utilize the normalizing community services as resources in serving the child and family rather than "specialty services."

5. The case management services shall be delivered in the context of a systems approach, recognizing that case management services shall be integrated with the other child-serving agencies and systems serving the child.

6. The case manager needs to view the family as the primary care giver and recognize the family as the primary resource in the care and treatment of their children.

7. The role of the case manager most often will be that of teacher and consultant to the family.

Cross References

This appendix cited in 55 Pa. Code § 5221.31 (relating to responsibilities of providers).

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