COLORADO
CHOICE TRANSITIONS
YOUR PATH TO INDEPENDENCE

Intensive Case Management Services Reimbursable Activities

Version 3.0

Introduction:

This technical assistance document provides guidance on billable activities for Colorado Choice Transitions (CCT) Intensive Case Management (ICM). This information should be used in conjunction with the "Services and Supports Desk Reference" and 10 CCR 2505-10, Section 8.555, Colorado Choice Transitions

Definitions:

Intensive Case Management means a service to assist clients' access to needed Home and Community-Based Services (HCBS), state plan, and non-Medicaid supports and services, including natural supports, to support the client's return to the community from placement in a qualified institution and to aid the client in attaining his/her transition goals. Up to 240 units can be requested initially, but if more units are required, an email with a detailed justification should be sent to Nicole.Storm@state.co.us requesting the additional units.

Intensive Case Manager means the person who is responsible for:

- Assessing/Identifying needs, risks, preferences and goals;
- Determining eligibility;
- Brokering, planning authorizing and coordinating services;
- Problem-solving client issues and mitigating risks to prevent critical incidents and re-institutionalization; and
- Monitoring services; health, welfare and safety of the client; and
- Promotion of client's self-advocacy and attainment of community living goals.

Direct contact means a primary activity that involves communication through direct contact with any individual including in-person meetings, telephone calls, e-mail, or other direct correspondence.

Indirect contact means a service that does not involve direct contact with an individual and includes a function that supports the primary activity including consultation, documentation, review of documents, distribution of records, etc.

Service Plan means a plan developed by Intensive Case Managers to communicate to the client, service providers and the Department the specific services that the client needs, is requesting or will be receiving.

BUS means the Benefits Utilization System and is the authorized electronic client record keeping system for ICM activities for all Colorado HCBS waivers.

ICM Rate means the reimbursement methodology based upon a unit of service equal to 15 minutes according to the State's approved fee schedule. An ICM unit is equal to $21.10 per 15 minutes.

Reimbursement for ICM Services

Apply the following guidelines when determining the number of units (unit = 15 minutes) to record for billing purposes:

- Activities performed that are less than 15 minutes are billed at 1 unit when the activity has a specifically defined and purposeful outcome, i.e., telephone contact with an individual for the purpose of scheduling a meeting.
- Activities that involve indirect contacts (e.g., documentation, mailing/distribution, BUS entry) are to be considered in the units appropriate to the primary case management activity whenever possible. For example, if 25 minutes (2 units) is spent to write a letter, but 5 minutes was spent to mail the letter on the following day, an additional unit is not billed. The entire activity is billed as 2 indirect contact units.
- Activities that include services to more than one individual (e.g., monthly ICM/Transition Coordination meetings where several different individuals may be discussed) should be estimated as time/unit per individual. For example, if 1 hour (4 units) is spent discussing 4 individuals during a meeting, 1 unit per person is billed. Typically, the total billed units should not exceed the total amount of time spent. In this example, 4 units for each of the 4 individuals will exceed the amount of time spent by that case manager by 3 hours.
- Typically, the number of units billed by a case manager in a given time period should not exceed the total amount of time worked. For example, an Intensive Case Manager who works 8 hours a day should not exceed 32 units of billable activities in that day.
- Since a Unit is defined as 1-15 minutes of ICM activity, there may be situations when the number of units billed exceeds the number of units worked per day or per activity. For example, an Intensive Case Manager may perform a monitoring visit at a group home for four individuals totaling 1 hour. Since the minimum unit that can be billed per individual is one unit, the case manager may bill one unit for each of the four individuals.
- The primary intent of an ICM service should always be related to the assessment of the client needs, preferences and goals or the development, implementation, amendment, coordination, or monitoring of the client's status and goal attainment and implementation of the Service Plan and Risk Mitigation Plan.
- Activities that take place while the client is in the nursing facility or Intermediate Care Facility can be retroactively billed ***after*** the client has transitioned.

Documenting ICM Services

In order to receive reimbursement for an ICM activity, the following steps must be taken:

- The ICM activity must be an allowable activity.
- The ICM activity must be recorded in the Benefits Utilization System (BUS) log notes.
  - Multiple related activities or activities performed within a single day may be entered into a single log note.
  - Case notes that are kept in other data systems or files are not sufficient to support ICM activities.
  - The maximum number of units per contact note for a single day is 32 units (i.e., 8 hours). If an ICM Service for one individual exceeds 32 units in a single day, then an additional log note must be created in order to bill additional units.
  - The number of units claimed for travel time must be in a log note that is separate and independent of the log note describing the case management activity performed. Mileage should not be included.
  - For BUS auto-generated log notes (e.g., completion of an 803), the Intensive Case Manager should identify the number of units associated with that specific activity.
  - The person providing ICM services must be identified by checking the appropriate box in the BUS (e.g., Intensive Case Manager, covering Intensive Case Manager, or Supervisor).
  - Any activity that is not entered into a BUS log note will be subject to disallowance and recovery of payment.

ICM Rate Methodology

The rate determined for Intensive Case Management reflects the anticipated expenditures given the number of clients that the service will be available for. The rate assumes the anticipated expenditures are met given the facility utilized, the staffing positions required, and administrative expenses. The following are considered in the rate methodology and cannot be billed separately as ICM activities:

- Personnel costs including hiring, training, payroll processing, benefits, vacation, sick leave, etc.
- Management oversight of intensive case managers.
- Program Support functions including those provided by program managers, associate program managers, program directors and program administrative assistants.
- Facility related costs includes rent/fees, maintenance, and utilities.
- Agency Management including executive staff time.

Intensive Case Manager Activities

The following is a description of typical activities performed by an Intensive Case Manager (ICM). This list is not exhaustive and other activities may also qualify. The activity must meet the definition of ICM service in order to be reimbursed.

General ICM Activities

- Contacts (telephone, email, correspondence, and face-to-face) with the individual receiving services, parent(s), guardian(s), caregivers, service providers, physicians or other medical professionals, state or county personnel (Colorado Department of Human Services, local Social Services, etc), other persons or agency personnel when necessary to ensure access or coordinate needed services. This includes providing or receiving voice mail messages for the purpose of exchanging information relating to an ICM service (i.e., beyond "returning your call, call me back"). Voice mails must be logged. Time to provide or listen and document voice mail messages cannot exceed one unit of service per voice mail.
- Consultation or coordination with a supervisor, agency staff, other providers, etc., when the purpose is to plan or coordinate needed services for an individual.
- Documentation of ICM activities in BUS log notes or other documentation required by 10 CCR 2505-10, Section 8.393.16 when completed as part of an individual case management activity.
- Documentation and review of documentation for the purpose of individual record management (e.g., transition options team meeting notes, Service Plan, and distribution of such documentation).
- Review and distribution of records for the purpose of planning, coordinating, assessing and referring services.
- Travel time when required in order to perform an intensive case management activity and when documented in a log note separate and independent of the case management activity.

Assessment

Comprehensive assessment and periodic reassessment of individual needs to determine the need for services. These assessment activities include:

- Taking an individual's history;
- Identifying the individual's community living goals, needs, preferences and risks in community living;
- Issuing new certification page and submitting to eligibility site;
- Confirming change of eligibility was made in Colorado Benefit Management System (CBMS) by County eligibility staff by day of discharge;
- Gathering information from other sources such as family members, medical providers, and/or social workers to form a complete assessment of the individual; and
- Completing related documentation.

Assessment - Sample Tasks

- Conduct initial screening for functional eligibility and inform Transition Coordinator of initial findings
- Conduct ULTC 100.2 to determine functional eligibility for HCBS and –identify needs related to ADL and IADL
- Participate in the transition assessment, transition and risk mitigation planning processes through Transition Options Team meetings
- Obtain and review any relevant and/or required assessment need for the development of the Service Plan
- Reassess based on new information, change in condition or the occurrence of a critical incident to adjust the service plan or the risk mitigation plan

Service Plan Development

Development (and periodic revision) of a Service Plan:

- Is based on the information collected through participants comprehensive assessment, including the ULTC 100.2, Minimum Data Set and/or the Transition Assessment and Plan;
- Addresses an individual's needs and community living goals in a person-centered way;
- Addresses all needs identified on the Professional Medical Information Page (PMIP) and Activities of Daily Living (ADL) identified in the ULTC 100.2 assessment;
- Addresses all needs identified in the Transition Assessment and Plan;
- Identifies all services the client needs to function in the community and to prevent institutionalization or other critical incident, including CCT Demonstration services as defined in the Services and Supports Desk Reference;
- Identifies a course of action to respond to the assessed needs of the individual;
- Identifies an emergency backup plan; and
- Identifies risks to the client's health, welfare, and safety and mitigation strategies to address these needs.

Service Plan Development - Sample Tasks

ICM activities related to Community Living Options Process:

- Meet with client to provide information about community-based services, transition service options, housing options, etc.
- Identify potential risks with the client living in the community and develop a risk mitigation plan for each identified risk
- Work with the Transition Options Team to develop an alternative plan to address that a need or desire If a provider is not available for a required service or support,
- Integrate Transition Plan components into Service Plan and complete in BUS
- Approve authorization and cost report within 10 business days and notify Transition Coordinator
- Complete emergency back-up plan and retain for records
- Complete service plan in BUS
    - SEPs – Enter summary of emergency back-up and risk mitigation plan in the contingency planning section in the BUS.

    - CCBs – Enter summary of emergency-back-up plan in the contingency section and complete the risk mitigation section in the BUS
- Arrange HCBS and State Plan services with client, transitions options team and support network
- Complete CCT Prior Authorization Request (PAR) and submit to Department for approval

Service and Support Coordination

Coordination of the services being provided as identified in the Service Plan and the Risk Mitigation Plan to ensure continuity of service provision.

Service and Support Coordination - Sample Tasks

Services and Supports are coordinated:

- Referrals are made to providers of HCBS State Plan services, including behavioral health services
- Communication with service providers regarding service delivery and concerns
- Inter-agency contact/coordination
- Coordination when individual is hospitalized or reinstitutionalized for 30 days or less
- Follow-up on billing issues
- Facilitating communication between agencies
- Coordinate transfers between programs, agencies and service areas (e.g., discharge to another service area and/or conclusion of 365 days of CCT participation).
- Respond and provide follow-up to complaints regarding emergency back-up services and help to provide resolution
- Ensure continuity of care by preparing client for transition to traditional HCBS and arrange other community resources as needed to maintain successful community living 90 days prior to CCT disenrollment.

Service Plan is reviewed to keep updated:

- Periodic utilization reviews to assure that services are adequate and being delivered in accordance with Service Plan
- Addendums to Service Plan
- Inter-disciplinary meetings to coordinate services and make changes as needed

Disputes and Appeals:

- LTC-803 notice, e.g., documentation, distribution, providing verbal explanation, information and answering questions.

For CCBs only

- Referrals (RFP) to providers, coordinating access to services
- Human Rights Committee (HRC) reviews (e.g., preparing documentation, reviewing HRC recommendations, attending reviews)

Monitoring and Remediation

Activities and contacts that are necessary to maintain the health and safety of the client, assure that the service plan is implemented and continues to adequately address the individual's needs and goals and necessary changes are made to address deficiencies.

- Identifying critical services and planning emergency back-up procedures if critical services are not delivered in accordance with service plan;
- Reporting of critical incidents; and
- Monitoring and remediation risks and problems to include interventions, ongoing communication and collaboration, risk mitigation plan development, ongoing assessment and documentation.

Monitoring and Remediation - Sample Tasks

Assure services and supports in the Service Plan are implemented and have intended effect:

- Conduct 48 hour check-in with client and performs weekly visits in first month post-discharge (joint visits with the TC are best practice)
- Monitor progress towards personal goals and increased independence
- Call or visit to service agency staff for the purpose
- Identify opportunities for quality improvement
- Conduct weekly face-to-face or phone contact with participant or guardian about goals and services identified in the Service Plan.
- Follow-up in response to monitoring activities (e.g., phone calls, documentation, coordination, etc.)
- On-going review of functional status
- Assessment of client's progress on necessary independent living skills
- Monitoring and revision of risk mitigation plans

Satisfaction and follow up:

- Communication (e.g., phone calls, face to face, etc.) regarding satisfaction with services and providers
- Follow up actions taken in response to expressed dissatisfaction

Health, welfare and safety needs are met:

- Communication and collaboration around risk preparedness
- Reporting of critical incidents in the BUS within 24 hours of notification (by client and/or provider)
- Follow-up of critical incidents with investigations of alleged mistreatment abuse, neglect, and exploitation
- Notification to other agencies and professionals concerning health and safety issues (e.g., Adult Protection Services, Child Protection Services, Division for Developmental Disabilities, etc.)
- Revision of the risk mitigation plan to include a strategy to prevent a future occurrence of a critical incident

Rights are respected, choice is given freely:

- Review of rights suspensions and due process
- Communication with participant/guardian about rights
- Communication with participant/guardian about provider choice and other daily choices
- Follow up to any identified concern related to rights and choice (e.g., phone calls, e-mail, etc.)

Other Tasks

Other Case Management Services:

- Advocate for services
- Provide resources and guidance
- Notification of intended actions
- Termination/transfer, etc.

Sample Other Tasks

Advocate for services identified in the Service Plan:

- Referrals to behavioral health services
- Referrals to Housing and Urban Development (HUD)
- Referrals to Division of Vocational Rehabilitation (DVR), (e.g., telephone contacts, documentations, etc.)
- Assistance with Low Income Energy Assistance (LEAP) applications

Providing notification and documentation of intended actions, transfers or terminations:

- Long Term Care-803 notice, (e.g., documentation, distribution, providing verbal explanation and answering questions.)

Provide counsel and support to the person receiving services and other appropriate parties as necessary to prepare them for entry, transfer or termination from a program:

- Discharge planning
- Coordination with Single Entry Point (SEP) or Community Centered Board (CCB) for enrollment to other HCBS-waiver programs
- Provide information on Medicaid State Plan benefits
- Transfers to new SEP or CCB service area

When a client transfers between counties

Clients may choose to move during their participation in the program.

Transferring Counties on day of discharge

- In the event that a client discharges to a different county from where they were a resident in a nursing facility, there will be a discharging ICM and a receiving ICM. The discharging ICM will have provided pre-transition services while the client was still in the nursing facility up to the date of discharge. The receiving ICM will assume intensive case management activities once the client has transitioned to the new county. Both agencies will bill for services on the same PAR submitted to the Department by the receiving ICM. The discharging ICM shall bill for all pre-

transition services on the date of discharge, the first day of the PAR span, and will communicate the number of units billed to the receiving ICM. The receiving ICM will bill for all remaining services beginning on the second day post-transition, the second day of the PAR span. Effective communication between ICMs is critical to ensure the well being of the client and successful transfer between agencies.

If a client moves while in the community

- In the event that a client choses to move to a new county at any time after they have transitioned to the community, the ICM that has been working with client will close the PAR on the day before the move. The new, receiving ICM will submit a new PAR to the Department beginning on the day the client moves.

Non-billable Activities

Activities that may be an Intensive Case Manager's responsibility, but are not billable as ICM activities. These activities are either paid through the SEP/CCB contract, personnel costs, non-direct costs, a component of another Medicaid service, a service to be paid by third party, or activities that are built into the rate structure for ICM. The list of activities below is not an exhaustive list.

Sample Non-billable Activities

- Intake and Screening
- Initial Developmental Disability Determination
- Case management activities related to pre-transition work including the ULTC 100.2 assessment if a potential CCT client does not transition
- Investigations of alleged Abuse, Neglect, Mistreatment, Exploitation
- Aggregation and analysis of Critical Incident Report data
- Aggregation and analysis of complaint logs and data
- Case management activities when an individual is terminated from an HCBS Waiver due to admission to a hospital, skilled nursing facility, or incarceration unless for the purposes of discharge prior to 30 days of institutionalization
- Case management activities when individual is incarcerated (i.e., in jail)
- Transition activities related to receiving/enrollment from another ICM agency e.g., enrollment from another CCB service area or SEP agency
- Case management staff meetings
- ICM training/professional development
- Assisting an individual with needs covered in room and board expense, e.g., minor home repairs.
- Recreational events e.g., agency functions when no ICM activity is performed
- Providing transportation to an individual, (e.g., medical dental, therapy appointments, etc.)
- Supports Intensity Scale Assessments and re-assessments
- Support Level calculations
- Fund raising activities of the agency
- Providing a service that is an identified HCBS benefit, other funded service, or natural support (unfunded service).

- Preparation for an appeal or to provide testimony at an appeal before an Administrative Law Judge (ALJ).
- ICM billing related activities

Composition of a log note

A contact note must include:

- **Date / time** (as appropriate) and **signature**
- **Activity:** the icm activity that is being performed. This activity should relate to the service plan or a general icm activity including information on the type of activity (e.g., face-to-face monitoring, home visit, telephone call, etc.)
- **Finding:** the observations, assessments, or outcomes of the activity.
- **Follow-up action:** the actions to be taken with the information obtained from the activity, where needed.
- **Units / time billed:** total units and time billed for case management activity.