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1.0 Description of the Procedure, Product, or Service

HIV case management is a service that assists eligible recipients to gain access to needed medical assistance as described in the North Carolina State Medicaid Plan as well as to services not included in the State Plan. The goal of HIV case management services is to facilitate the recipient's medical, social, and educational needs.

HIV case management includes the following core service components: assessment, care planning, referral/linkage, and monitoring/follow-up. Refer to **Subsection 5.3** for definitions of the core service components. The provision of this service requires the recipient to establish and maintain a medical home with Community Care of North Carolina (CCNC) or a primary care physician. CCNC or the primary care physician shall be responsible for the coordination of the recipient's overall health care.

Note: References to the provider throughout this policy denote the HIV Case Management agency.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service. The case management agency providing services is required to verify the recipient's eligibility and Medicaid coverage category.

2.2 Eligible Categories

2.2.1 Medicaid Card

Recipients with regular Medicaid identification (MID) cards may be eligible for HIV case management services.

2.2.2 Recipients with Medicaid for Pregnant Women Coverage

Medicaid for Pregnant Women (MPW) is limited to medical conditions related to pregnancy or complications of pregnancy. Pregnant women who are covered by MPW may be eligible for HIV case management services due to the potentially adverse impact of HIV upon the pregnancy, the fetus, and/or the infant.

2.3 Ineligible Categories

2.3.1 Medicaid for Family Planning Waiver

Recipients who are covered by Medicaid for Family Planning Waiver benefits are not eligible for HIV case management services.

2.3.2 Medicare Qualified Beneficiaries

Medicaid recipients with Medicare Aid coverage are not eligible for HIV case management services.

Refer to Section 2 of the *Basic Medicaid Billing Guide* (on DMA's Web site at <http://www.ncdhhs.gov/dma/basicmed/>) for additional information on Medicaid eligibility.

2.4 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

3.0 When the Procedure, Product, or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.4** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary (refer to **Subsection 3.2** below) and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria: Medical Necessity

Recipients shall have a documented diagnosis of HIV disease or HIV seropositivity. Acceptable documentation includes at least one of the following:

- a. Confidential positive HIV test results using antibody (Ab) testing (2 or more repeated positive (Ab) tests by ELISA), or a positive ELISA/EIA confirmed by Western Blot, or a positive HIV RNA test
- a. Physician's statement
- b. Hospital discharge statement or other medical report that verifies diagnosis
- c. Copy of approval for participation in the North Carolina AIDS Drug Assistance Program (ADAP)

Infants (birth to 12 months) born to HIV-infected mothers can receive HIV case management services without regard to their HIV status.

4.0 When the Procedure, Product, or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health

in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.4** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates that of another provider; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Program Administration

4.2.1 Non-Covered Institutions

Medicaid does not cover HIV case management services while a recipient is institutionalized in one of the following facilities:

- a. A general hospital, psychiatric hospital, or nursing facility or inpatient detoxification
- b. An intermediate care facility for the mentally retarded (ICF-MR)
- c. Any form of incarceration
- d. A halfway house that provides case management

HIV case management services may be provided on the day of admission or the day of discharge from a facility. These services shall not duplicate the responsibilities of the discharge planner.

4.2.2 Non-Covered Activities

The activities listed below are not covered HIV case management services. This listing is not all inclusive.

- a. Institutional (hospital and nursing facility) discharge planning
- b. Recipient outreach activities, such as contacting potential recipients
- c. Direct services, such as transporting recipients or delivering food and medication
- d. Activities that are deemed administrative expense, such as time spent in billing, writing progress notes, or attending supervisory conferences
- e. Activities that are not specific to the recipient (that is, services directed to assist another family member)
- f. Counseling and therapy services, including treatment adherence, religious and pastoral care
- g. Case management activities that are an integral component of another covered Medicaid service.
- h. Activities integral to the administration of foster care programs

- i. Activities for which a recipient may be eligible that are integral to the administration of another non-medical program, except for case management that is included in an individualized education program (IEP) or individualized family service plan (IFSP) in accordance with Section 1903 (c) of the Social Security Act.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.4** of this policy.

5.1 Prior Approval

Prior approval is not required.

5.2 Medical Home and Written Physician Orders

When the recipient's aid category mandates enrollment in managed care the recipient must be enrolled or the HIV Case Management provider's chart must contain documentation from Department of Social Services (DSS)/ Community Care of North Carolina (CCNC) that a CCNC medical home is unavailable.

However, children with special health care needs currently would have the option of "opting out" of the managed care program." While this is an option, it should be noted, that it is not considered the best clinical course of action for the Medicaid recipient.

The requirement to enroll with a Primary Care Physician with CCNC/CA is not intended sever that individuals' relationship with their specialist, be it Pediatric HIV doctor or Infectious Disease doctor, rather it seeks to ensure that the patients receive evidence based preventive primary services and that services are coordinated with the medical home. For children this would include services such as well visits, immunizations, and developmental screenings that are not routinely offered by specialists.

Once the recipient enrolls with a CCNC/CA provider, it places an additional requirement for coordination of care on the primary care provider. As the gatekeeper the primary care physician provides authorization for pediatric or adult specialist services.

Individual's enrolled with a CCNC provider may qualify for additional services through the CCNC network if they meet certain high risk criteria. These services can include care management, disease management, transitional care and medication reconciliation.

The provider shall secure Carolina Access authorization for all recipients enrolled in managed care. This shall be updated at least annually with reassessment or at the discretion of the primary care provider. The primary care provider is responsible for documenting date, individual authorizing services and the duration of the Carolina Access (CA) authorization.

Regardless of enrollment the HIV Case Management provider remains responsible for promoting and coordinating the recipient's care with a primary care provider.

CCNC is charged with the coordination of the recipient's overall healthcare and can assist the providers in linking recipients to a primary care provider.

The provider shall obtain a physician's written order that details the need for the initiation of HIV CM services. An additional written physician's order shall also be obtained to attest to the medical necessity of ongoing case management services beyond two months (a maximum of 32 units). In order to ensure the continued appropriateness for HIV Case Management, if the recipient continues to have unmet needs, then the provider shall obtain a physician's written order annually.

5.3 Core Components

Each core service component shall be fully documented within the recipient record.

The provider shall adhere to strict confidentiality rules and obtain necessary release of information per agency policy and state and federal regulations. Ongoing communication with CCNC or the recipient's primary care physician is required to ensure appropriate coordination of care. The case manager shall engage in a mutual sharing of data that shall consist of the following criteria. Although the requirement is a monthly contact, it is DMA's expectation that the case manager shall obtain existing data versus requesting that new lab tests be conducted.

- a. Monthly contact with the primary care physician to include updates on:
 1. CD4 T-cell counts
 2. Viral load
 3. Changes in nutritional status based on self report or case manager observation.
 4. Number of hospitalizations during reporting period. Specify inpatient versus emergency room visits.
 5. Compliance with medication regimen
 6. Self report of new symptoms

- b. Women who qualify for HIV Case Management under MPW are considered to be in a high risk category. Therefore in addition to the criteria listed above in **Subsection 5.3.a**, the case manager should assure that the recipient is receiving her annual physical exam and that coordination of care occurs for the following risk factors:
 1. Tobacco use
 2. Homelessness
 3. Substance abuse

4. Intimate partner violence
5. Anemia
6. Hypertensive disorders
7. Other chronic diseases (SLE, sickle cell, asthma, seizure disorder)
8. Fetal complications (IUGR, anomaly, hydrops)
9. Hyperemesis
10. Mental illness

Note: Standards of care for HIV case management shall be followed.

5.3.1 Assessment

HIV case managers shall screen and evaluate the prospective recipient's status to determine the need for initial case management services. This is accomplished through an information gathering and decision making process which includes intake and assessment.

HIV case managers collect, analyze, synthesize, and prioritize information in order to identify needs, resources, and strengths. The case manager's signature is required on the assessment tool. The documentation in the assessment shall include observation of the recipient's physical appearance and behavior during the assessment interview. At a minimum, each area identified below shall be addressed.

- a. coordination and follow-up of medical treatments
- b. provision of treatment adherence education to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Treatment adherence education/counseling is a direct service and is not covered. The HIV case manager is responsible for "linking" the recipient to a provider of this service.
- c. Physical needs to include both activities of daily living and instrumental activities of daily living
- d. Mental health/substance abuse/developmental disabilities needs
- e. Social status
- f. Housing and physical environment status
- g. Financial needs
- h. Socialization and recreational needs

5.3.2 Care Planning

This component builds on the information collected through the assessment process and specifies goals and actions to address the medical, social, educational, and other services needed by the eligible recipient. Care planning includes activities to ensure the active participation of the recipient and others in an effort to develop goals and to identify a course of action to respond to the assessed needs.

The care plan may be completed with the initial assessment, at an annual reassessment, and as needed secondary to unanticipated events or changes in a recipient's status. The care plan shall be signed and dated by the case manager and recipient and the recipient's legally responsible representative. The case managers' signature shall constitute their legal signature, including first and last name with title or initials (if applicable) indicating licensure or certification.

For purposes of care planning for managed care recipients through CCNC, the case manager shall contact CCNC to obtain clinical information pertinent to establishing care plan goals.

5.3.3 Referral/Linkage and Resource Development

This component includes making referrals, scheduling appointments, and performing other activities that help link recipients to medical, social, and educational providers and to other programs and services identified in the care plan.

5.3.4 Monitoring and Follow-up Activities

This component includes activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the recipient. Monitoring and follow-up are conducted at least quarterly and as frequently as necessary to help determine whether:

- a. the recipient is receiving medical treatment;
- b. services are being furnished in accordance with the recipient's care plan;
- c. services in the care plan are needed;
- d. services in the care plan are adequate; and
- e. there are changes in the needs or status of the recipient, and if so, whether
 1. necessary adjustments have been made in the care plan and service arrangements with the providers or
 2. the recipient's goals have been met and the recipient has been discharged, if appropriate.

Examples of monitoring and follow-up activities include but are not limited to the following: reporting to the recipient's medical home regarding the recipients' status, reassessments and discharge/terminations.

5.3.5 Reassessments

The HIV case manager shall conduct a reassessment to determine the continued appropriateness of services and the continued need for services. The reassessment is conducted at least every 12 months and as needed secondary to unanticipated events or changes in the recipient's physical, mental or social status. The reassessment requirements are the same as those specified in **Subsections 5.3.1 and 5.3.2, Assessment and Care Planning**. Care plan progress, changes, and mutually agreed-upon goals shall also be addressed in the care plan completed at reassessment.

5.3.6 Discharge/Termination

- a. Reasons for termination include, but are not limited to, the following:

1. recipient desires services from another case management agency secondary to relocation or recipient choice;
 2. recipient's goals met per the plan of care;
 3. recipient's unwillingness or refusal to participate in agreed-upon care plan , and or refusal to establish or maintain a medical home with a primary care physician;
 4. recipient's decision to terminate services;
 5. lack of contact between recipient and case manager (case manager unable to contact recipient after repeated attempts over a three-month period);
 6. recipient's abuse of staff, property, or services;
 7. determination that recipient is HIV seronegative;
 8. recipient death.
- b. The HIV case manager shall discharge or terminate the recipient from services through a systematic process, which shall include the following:
1. written notification to the recipient of pending discharge at least seven business days in advance of discharge/termination.
Note: This requirement does not apply to the recipient's request for discharge which should be immediate in keeping with the request to discharge or transfer to another provider.
 2. clear delineation of the reason(s) for discharge; and
 3. preparation of a written discharge summary, which shall be prepared and placed in the recipient's HIV Case Management record within seven days of the final decision to terminate services. A copy of the summary shall be sent to the recipient's primary care physician.
- c. The discharge summary shall include, at a minimum, the following:
1. identifying information;
 2. referral and linkage to resources following discharge from HIV case management services;
 3. summary of services provided;
 4. reason and effective date of the discharge; and
 5. case manager's legal signature and credentials

5.4 Limitations

The number of billable units of HIV CM services provided to a recipient cannot exceed 16 units per calendar month.

Ongoing HIV CM services beyond two months or a maximum of 32 units requires a written physician order attesting to the medical necessity of the additional case management.

The recipient to staff ratio may not exceed thirty to one.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid's qualifications for participation as referenced in North Carolina Medicaid's Provider Administrative Participation Agreement ;
- b. be currently enrolled with N.C. Medicaid; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.
- d. attest by signature that services billed were medically necessary and were actually delivered to the recipient.

The following actions taken by DMA or its designee will render a provider ineligible for certification as a provider of HIV Case Management.

- a. previous actions taken to decertify agency as a provider of HIV Case Management
- b. provider number suspended as a result of sanctions imposed by Program Integrity
- c. failure to repay any monies owed to the North Carolina Medicaid program.

Provider agency types may include home health agencies, home care agencies, hospices, health departments, and hospitals, departments of social services, federally qualified health clinics, rural health clinics, community - based organizations (CBO), and local management entities.

Agencies shall obtain certification from DMA or its designee in order to be considered for enrollment with DMA as an HIV case management provider.

6.1 Certification Requirements

To qualify for reimbursement for HIV case management services, a provider shall meet all the criteria specified below.

- a. Have a documented successful record of three (3) years of providing or managing HIV case management programs. The provider certified prior to 10/01/2010 shall have two years to be in compliance.
- b. Ensure the provision of HIV case management services by qualified case managers as described in **Subsection 6.3.1** of this policy. The provider shall have six months from 10/01/2010 to come into compliance with this requirement.
- c. Ensure supervision of HIV case managers by qualified supervisors as described in **Subsection 6.3.2** of this policy. The provider shall have six months from 10/01/2010 to come into compliance with this requirement.
- d. Enroll each physical site with DMA as a provider of HIV case management services in accordance with §1902(a)(23) of the Social Security Act.
- e. Meet applicable state and federal laws governing the participation of providers in the Medicaid program.
- f. Maintain certification as a qualified provider of HIV case management services.
- g. Demonstrate compliance with initial and ongoing certification processes.
- h. Demonstrate compliance with the monitoring and evaluation of case management records through a quality improvement plan.
- i. Allow DMA or its designee, to review recipient records and inspect agency operation and financial records.

- j. Notify DMA or its designee of proposed changes such as business owner or name change, address or telephone number change, or plans for business dissolution within 30 calendar days of proposed change and no later than five business days of the actual change.
- k. Within one year of enrollment with Medicaid as a provider, the provider must have achieved national accreditation with at least one of the designated accrediting agencies. (Providers who were enrolled prior to 10/01/2010, shall achieve national accreditation within two years of this policy effective date). Designated accrediting agencies include the following: Utilization Review Accreditation Commission (URAC), Community Health Accreditation Program (CHAP) and Commission on Accreditation of Rehabilitation Facilities (CARF) and
- l. Secure a performance bond pursuant to S.L 2009-0451 Section 10.58(e)

6.2 Certification and Decertification Process

DMA or its designee is responsible for certifying qualified HIV case management provider to render services in accordance with professionally recognized standards and as specified by this policy, and also for decertifying those HIV case management agencies that fail to render services in accordance with professionally recognized standards and as specified by this policy.

6.2.1 Initial Certification

A provider shall comply with all the requirements specified below. The initial certification is valid for one year. Submit a complete and signed application to DMA or its designee that includes the following information as identified under Administrative, Case Management and Human Resource Requirements.

a. Administrative Requirements

1. A list of counties to be served;
2. Hours of operation, the agency shall maintain regularly scheduled hours of operation;
3. Emergency after hours response plan;
4. A list of potential community resources for the entire service area;
5. A copy of Articles of Incorporation, unless the agency is a local government unit;
6. The agency shall meet the following requirements
 - (a) have a physical business site at the time of application. The business site shall be verified by a site visit. This site cannot be in a private residence or vehicle.
 - (b) submit a copy of the agency's organizational chart
 - (c) submit a list of person who have five percent or more ownership in all or any one agency
 - (d) submit a business plan that provides specific information for development costs and projected monthly revenue and expense statement for the 12 months subsequent to the approval of the application and an actual revenue and expense statement for the 12 months preceding the application date. This plan

- (i.) includes assumed consumer base, services, revenues and expenses;
 - (ii.) outlines management of initial expenses;
 - (iii.) identifies the individuals responsible for the operation of the agency and shall include their respective resumes;
 - (iv.) shows a program development enhancement timetable; and
 - (v.) includes existing financial resources
- (e) have computer capability to meet the following criteria:
- (i.) Comply with Information Technology standards required by DMA, inclusive of maintenance of electronic records
 - (ii.) Meet HIPAA requirements for safety and security of all data
 - (iii.) Perform data analysis, inclusive of tracking and trending of outcome metrics
 - (iv.) Comply with electronic billing requirements
 - (v.) Comply with requirements for Electronic Funds Transfer (EFT)
 - (vi.) Communicate with Community Care of North Carolina (CCNC) or the primary care provider on a monthly basis as defined in **Subsection 5.3** of the HIV Case Management policy.
- (f) Comply with the completion of a precertification onsite visit .
- (g) meet all applicable state and federal licensure and certification requirements
7. The agency shall have the following written policies that are unique to the organization.
- (a) confidentiality policy, to include a copy of the informed consent form;
 - (b) recipient grievance policy;
 - (c) recipient rights policy;
 - (d) non-discrimination policy;
 - (e) code of ethics policy;
 - (f) conflict of interest policy;
 - (g) electronic records policy;
 - (h) medical records policy to include record retention, safeguard of records against loss, tampering, defacement or use of and secure transportation of records;
 - (i) policy to assure the recipient's freedom of choice among providers;
 - (j) transfer and discharge policy and ;
 - (k) identification of abuse, neglect, and exploitation policy;

b. Case Management Requirements

1. A description of the core components described in **Section 5.0** of the HIV Case Management policy, including the title and position of the individuals who will perform those functions. Applicable FTEs or functions must be documented to meet requirements;
2. A quality improvement plan , including **but not limited to plans for:**
 - (a) measuring recipient health outcomes;
 - (b) the monitoring and evaluation of case management records (refer to **Subsection 7.5** of this policy);
 - (c) tracking and reporting complaints and how they are resolved;
 - (d) conducting statistical studies including cost and utilization studies ;
 - (e) assuring accuracy with claims and service records; and
 - (f) assuring that the provider and staff meet the qualifications set forth in this policy;

c. Human Resource Requirements

1. human resource policies unique to the organization to include process for validation of credentials, continuing education requirements, and criminal background check on all employees;
2. plan for providing case management if the agency has insufficient case management staff to cover caseload.
3. plan for delegation of management authority for the operation of the agency and services
4. plan for utilizing the services of volunteers, including supervision requirements for maintaining recipient confidentiality
5. The agency shall submit the following
 - (a) a copy of the supervision and training plan;
 - (b) a copy of the case manager orientation plan and an annual in service education plan for the case managers;
 - (c) a copy of the agency's plan for networking with CCNC or the primary care provider;
 - (d) a copy of the agency's plan for tracking the case manager's demonstrated skill abilities, competencies and knowledge
6. The agency shall meet the following requirements
 - (a) Be owned and operated by individual(s) that have not been convicted of a felony charge related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct.
 - (b) Be owned and operated by individual(s) that have not been convicted of a felony charge related to the neglect or abuse of a recipient in connection with the delivery of health care services.

- (c) Employ qualified and trained case managers and supervisors, or contract with an agency or individual to provide case management or supervision who meets the qualifications as described in **Subsections 6.3** and **6.4**.

Applications that do not meet the above criteria after 90 days will be returned to the provider as incomplete and no further action shall be required by DMA or its designee.

6.2.2 Recertification

The recertification is valid for two years, unless otherwise specified. To be recertified, a provider shall:

- a. Submit a complete and signed renewal application to DMA or its designee within 60 calendar days of receipt.
- b. Submit copies of all items in **Subsection 6.2.1** that have changed since the initial certification.
- c. Submit copies of all HIV CM and supervisor credentials.
- d. Submit annual summary of quality improvement activities to include outcome metrics.
- e. Submit to a recertification on site visit including a review of recipient records or other clinical and business documentation as needed

Applications that do not meet the above criteria after 90 days will be returned to the agency as incomplete and no further action shall be required by DMA or its designee.

Note: DMA or its designee shall provide a provisional recertification for a period of six months if site visits show evidence of noncompliance with policy requirements. This will allow an opportunity for program monitoring as outlined in **Subsections 6.2.4, 7.5** and **7.6** to occur.

6.2.3 Quality Assurance Site Visits

A newly certified provider will be provided with four quality assurance (QA) site visits, to be completed within the first year following certification. The QA site visits are initiated by DMA's designee after the provider is certified. The purpose of the site visits includes the following:

- a. Technical assistance and consultation. The program consultant will conduct medical record reviews and compare NC Medicaid billing records with the provider's documentation. The consultant will provide guidance based on the review and the questions raised by the provider staff.
- b. Review of staff qualifications and documented training. Resumes of supervisors and case managers are reviewed for compliance with the criteria found in **Subsections 6.3.1** and **6.3.2**
- c. Review of case management services, adherence to core service components and related documentation. Program consultants from DMA or its designee conduct a chart review of 10% of the active caseload and closed caseload. Closed caseload is defined as those charts that were created since the last recertification or fourth QA visit.

- d. Investigate complaints. The program consultant shall investigate complaints from all referral sources including but not limited to: DMA's Program Integrity unit; the recipient; and other provider agencies.
- e. Ensure implementation of policy requirements which include quality improvement activities-The program consultant shall utilize the quality indicators found in Attachment B to this policy regarding policy requirements. Compliance with quality improvement activities shall be measured against the provider's unique policy. The provider shall be required to provide documentation to support their quality improvement activities.

Note: The responsibility for all recommended corrections, changes or improvements remains with the provider.

Failure to adhere to policy requirements will result in decertification or a provisional recertification or a referral to DMA Program Integrity Program.

If unmet program requirements are noted during any site visits, the provider shall submit a written plan of correction to DMA or its designee upon request within 30 calendar days. Upon review of the corrective plan of action, quality assurance visits will be scheduled as deemed necessary by DMA or its designee to determine if corrective action has taken place and the service is compliant with all of the program's requirements.

6.2.4 Decertification

If any one of the following conditions is substantiated, the provider may be decertified by DMA or its designee and disenrolled by DMA. This list is not all inclusive.

- a. Failure to provide core service components
- b. Fraudulent billing practices
- c. Owner(s) being convicted of a felony charge
- d. Failure to develop, submit, and implement a written plan of correction to resolve unmet program requirements cited by DMA or its designee; to make recommended corrections; or both within 30 calendar days
- e. Falsification of records
- f. Violation of a recipient's confidentiality
- g. Employment of staff who do not meet the criteria stated in **Subsection 6.3**
- h. Failure of staff to attend the DMA or its designee's mandatory basic training within 90 days of their employment date
- i. Failure of staff to obtain required continuing educational units (CEU), as specified in **Subsection 6.4**
- j. Failure to provide case management staff with supervision to meet the recipients' needs
- k. Failure to submit any required documentation within the time frame designated by this policy, DMA's designee, or both
- l. Failure to provide documentation as specified in **Subsection 7.5** that is sufficient to support the provider's billing
- m. Failure to implement and enforce a quality improvement program

- n. Failure to notify DMA or its designee, within 30 calendar days of proposed changes or five business days of actual changes, of any changes in agency name, director/ownership, mailing address, and telephone number(s), resulting in the designee's or DMA's inability to contact the provider
- o. Failure to comply with all applicable federal and state laws, regulations, state reimbursement plan, and policies governing the services authorized under the Medicaid program
- p. Failure of a provider to enroll any recipients within four months of certification
- q. Failure of a provider to achieve and or maintain the requirements for certification as defined in **Section 6.0** of this policy.

When a provider is decertified by DMA's designee, due process/appeal rights shall be issued to the provider in accordance with NCGS 150B-23(a) and 130A-24.

6.3 Staff Qualifications

It is the responsibility of the provider to verify staff qualifications and credentials prior to hiring and assure during the course of employment that the staff member continues to meet the requirements set in forth in this policy. Verification of staff credentials shall be maintained by the provider.

6.3.1 HIV Case Manager

An HIV case manager shall meet *one* of the following qualifications:

- a. Hold a master's degree from an accredited college or university in a human services field, including, but not limited to, social work, sociology, child development, maternal and child health, counseling, psychology, or nursing.
- b. Hold a bachelor's degree from an accredited school of social work.
- c. Hold a bachelor's degree from an accredited college or university in a human services field or related curriculum, including at least 15 semester hours in courses related to social work, counseling, or public health; and have six months of social work or counseling experience.
- d. Hold a bachelor's degree from an accredited college or university and have one year of experience in counseling or in a related human services field that provides experience in techniques of counseling, casework, group work, social work, public health, or human services.
- e. Be licensed, if applicable, by the appropriate licensure board in North Carolina as a registered nurse, nurse practitioner, physician, physician assistant, or certified substance abuse counselor and have two years of experience working in human services.

In addition, the case manager must possess two years case management experience. Twelve months of those two years must include experience with HIV+ persons. All case managers must possess or acquire through cross training a clinical understanding of HIV, as evidenced by documentation in their personnel file.

A standard year of work experience is calculated at 2080 hours per calendar year. An accredited educational institution is one that is nationally recognized. Refer to

a regional accreditation organization or the U.S. Department of Education Web site at <http://www.ed.gov>.

Case management experience should encompass the functions of intake, assessment, reassessment, service planning, case coordination, case conferencing, service plan implementation, crisis intervention, monitoring and follow-up of services provided, and case closure.

The case manager shall possess the following core competencies.

- a. Able to perform the assessment
- b. Able to provide client centered goals for meeting desired outcomes developed in the care plan
- c. Able to provide referral and linkage to clients serviced
- d. Able to provide effective and efficient monitoring of care and serviced rendered to clients
- e. Able to provide documentation and attestation as to accuracy of the entry by a personal signature

Knowledge, Skills and Abilities

The case manager must possess and demonstrate the following:

- a. Basic knowledge of HIV disease, prevention and treatment techniques. The knowledge should be based on current clinical practice, defined as standards of practice within one year from the date of hire. The basic knowledge shall include: methods of transmission and treatment, common definitions, general knowledge of medications used to treat HIV and barriers to medication and treatment compliance.
- b. Communication skills including listening, written, verbal and non-verbal skills
- c. Ability to gather information and data, and accurately synthesize into written form
- d. Ability to identify resources, both formal and informal
- e. Ability to initiate obtaining professional/clinical assessments
- f. Ability to evaluate environmental stressors
- g. Observation skills inclusive of human behavior, family dynamics, mood changes, etc
- h. Ability to assess the cultural environment and to interact in a culturally sensitive manner
- i. Ability to determine if identified services meet the intensity of needs of the recipient and are accomplishing the desired outcomes
- j. Prioritization skills including time management skills, planning and organizational skills and professional judgment skills

- k. Ability to review data and draw appropriate conclusions to address the needs of individuals served
- l. Ability to accurately document case management activities and attest to its accuracy by personal signature.

6.3.2 HIV Case Manager Supervisor

An HIV case management supervisor shall meet *one* of the following qualifications:

- a. Hold a master's degree from an accredited college or university in a human services field, including, but not limited to, social work, sociology, child development, maternal and child health, counseling, psychology, or nursing; and one year of human services experience.
- b. Hold a bachelor's degree from an accredited school of social work and have two years of human services experience.
- c. Hold a bachelor's degree from an accredited college or university in a human services field or related curriculum, including at least 15 semester hours in courses related to social work or counseling and have two years of experience in human services or public health.
- d. Hold a bachelor's degree from an accredited college or university and have either three years of human services experience or two years of human services experience plus one year of supervisory experience.
- e. Be licensed, if applicable, by the appropriate licensure board in North Carolina as a registered nurse, nurse practitioner, physician, physician assistant, or certified substance abuse counselor; and have either three years of human services experience or two years of human services experience plus one year of supervisory experience.

In addition, the case manager's supervisor must possess three years case management experience. Twelve months of those three years must include experience with HIV+ persons.

Case management experience must encompass the functions of intake, assessment, reassessment, service planning, case coordination, case conferencing, service plan implementation, crisis intervention, monitoring and follow-up of services provided, and case closure.

Knowledge, Skills and Abilities

In addition to those listed for the case manager, the case manager supervisor must possess and demonstrate the following knowledge, skills and abilities:

- a. Ability to direct and evaluate the scope and quality of case management services
- b. Knowledgeable in case management principals, procedures and practices
- c. Ability to conduct detailed analytical evaluations and studies and prepare related reports and recommendations
- d. Apply professional level of knowledge of federal and state assistance programs for HIV positive population

The provider shall identify the HIV case manager program supervisor within the organization. The supervisor is to provide “clinical/professional supervision”. This is defined as providing regularly scheduled assistance by a qualified professional to a staff member who is working directly with recipients. The purpose of clinical supervision is to ensure that each recipient receives case management services which are consistent with accepted standards of practice and the needs of the client and care plan.

Documentation of supervisory review of case manager’s caseload and proper utilization of case management services is required. The supervisor shall attest to the accuracy of the documentation by a personal signature to include credentials and title. Each recipient record should reflect supervisory review every 4 weeks at a minimum. The frequency of the reviews should be increased if the findings warrant such action. The review must include the following: The recipient record to assure that all required paperwork as defined by this policy is in the record. Progress notes should be reviewed for compliance with the requirements in **Subsections 7.5 and 7.6**. The billing should be checked for accuracy to assure it corresponds to the progress notes. This is not billable case management time.

6.3.3 Contract Staff

Providers as may elect to contract with qualified case managers and supervisors. The same qualifications and training requirements described in **Subsections 6.3.1 and 6.3.2** and training requirements described in **Subsection 6.4** are required of both employees and contractors.

6.4 Training Requirements

6.4.1 Training for Case Managers and Supervisors

All HIV case managers and case manager supervisors shall complete North Carolina state-sponsored, basic policy training within 90 days of their employment date and must be completed prior to any billed case management units. It is the responsibility of providers to retain copies of certificates of completion issued by DMA’s designee.

Upon successful completion of the basic training, the case manager or supervisor will be able to perform all of the following:

- a. describe basic HIV information and prevention techniques;
- b. describe the scope of work for case managers;
- c. identify and explain the core components of HIV case management;
- d. demonstrate an understanding of basic ethical issues relating to case management;
- e. demonstrate an understanding of the responsibilities and functions of the HIV case manager system of care and;
- f. demonstrate an understanding of the documentation requirements of this program as defined in **Subsections 7.5 and 7.6**.

6.4.2 Annual Training

All HIV case managers and supervisors are required to attend 20 hours annually of continuing education related to HIV case management. It is the responsibility of providers to retain copies of certificates of completion.

Annual training topics must include, but are not limited to the following:

- a. confidentiality;
- b. cultural competency;
- c. current trends in HIV disease management;
- d. ethics; and
- e. refresher core components of case management; and
- f. medical management/care of individuals who are HIV positive. Ten hours of the 20 hour annual requirement shall include clinically oriented training (clinical updates)
- g. Suggested resources include but are not limited to the following:
 1. Partners in Information Access for the Public Health Workforce
<http://phpartners.org/index.html>
 2. Regional HIV/AIDS Consortium
 3. North Carolina AIDS Education Training Center
 4. North Carolina Area Health Education Centers

6.5 Requests to Expand

Provider expansion requests shall meet each of the following criteria:

- a. Expansion requests for additional county coverage shall be submitted to DMA's designee.
- b. A new physical site shall be obtained if the area listed in the expansion request is more than 60 miles from the agency's existing office.
Note: The expansion site shall not be in a private residence or vehicle.
- c. If establishment of a new site is required, at least one case manager shall be designated for the new site. Case managers covering the expansion area shall meet the qualifications described in **Subsection 6.3**.
- d. The provider shall enroll with Medicaid for any new site. A separate provider number will be issued.
- e. The provider shall provide a resource list for the proposed area to be served.
- f. The provider is meeting recipients' needs as evidenced by having received no significant citations or corrective actions related to care delivery during the past 18 months.
- g. The provider is compliant with all applicable federal and state laws, regulations, state reimbursement plan, and policies governing the services authorized under the Medicaid program.

Expansion applications that do not meet the above criteria after 90 days will be returned to the agency as incomplete and no further action shall be required by DMA or its designee.

7.0 Additional Requirements

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.4** of this policy

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws; regulations; and agreements, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

7.2 Coordination of Care

The HIV case manager shall coordinate the recipients care by means of communication with CCNC or the recipient's primary care physician. Furthermore, the case manager shall facilitate coordination of service delivery when multiple providers or programs are involved in care provision in order to ensure the appropriate use of resources, recipients' freedom of choice, and the avoidance of duplication of efforts and services. HIV case management recipients may not receive other case management services that are Medicaid reimbursed, including but not limited to the following:

- a. Community Alternatives Programs (CAP), including CAP for disabled adults (CAP/DA), CAP for children (CAP/C), CAP for the mentally retarded/developmentally disabled (CAP/MR-DD), and CAP Choice
- b. At-risk case management for adults and children who are at risk of abuse, neglect, or exploitation
- c. Child service coordination, a case management program for children under age five
- d. Maternity care coordination, a case management program for pregnant women.
- e. Targeted case management and community supports for the mentally retarded or developmentally disabled (Enhanced Mental Health and Substance Abuse Services)

Medicaid payments for targeted case management shall not duplicate payments under other program authorities (such as child welfare and foster care services).

7.3 Transfer

HIV case management agencies shall have written policies governing transfers between case management providers. The receiving agency may elect to

- f. accept the recipient as an ongoing recipient and accept copies of all of the previous agency's forms (with the exception of the consent forms, which the receiving agency shall obtain upon transfer); or
- g. accept the recipient as a new recipient and complete all new forms.

Both providers shall

- a. plan a transition date in accordance with the recipient's wishes or as required by medical necessity;
- b. communicate with local department of social services Medicaid staff when transitioning between counties; and
- c. the discharging agency shall complete a discharge summary within seven business days of discharge.

7.4 Recipient Record Documentation Requirements

7.4.1 Record Retention

All providers shall keep and maintain all Medicaid financial, medical, and other records such as periodic records documented in progress note, policies and quality improvement activities, etc., necessary to fully disclose the nature and extent of services furnished to Medicaid recipients and claimed for reimbursement. This shall include the historical documentation of all corrections made to assessments and plans of care. These records shall be retained for a period of not less than five years from the last date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements as referenced in 10A NCAC 22F .017 and 10A NCAC 22F.0601.

The provider shall promptly retrieve the records and make them available for review by DMA or agents acting on behalf of DMA for claims review, audit, medical record review, or other examination during the retention period specified above. Should a case management provider close, the provider shall provide the following information in writing to DMA's designee within 30 calendar days of the closing date:

- a. physical location of the records (hard copy and electronic);
- b. name of contact person;
- c. contact person's telephone number.

7.5 Documentation Requirements

The recipient record identifies the name of the case management provider and recipient. At a minimum, the provider shall maintain the following documents within the recipient's record:

- a. intake forms (the provider shall incorporate proof of HIV status within the medical record within 15 calendar days);
- b. assessments;
- c. written attestation that all records are properly and safely stored and available as per **Subsection 7.4.1**.
- d. care plans with documented timelines for obtaining services;
- e. progress notes*;
- f. medication sheet (for those recipients enrolled with CCNC a copy of the medication sheet should be sent to CCNC's pharmacy home; coordinate any changes in medications with CCNC's pharmacy home.);
- g. contact sheets for resource development and coordination of service delivery;
- h. discharge notification and discharge summary, as applicable; and

- i. recipient consent form(s) that address release of information, consent for case management, and recipients' rights and responsibilities;
- j. physician's written order for HIV CM services obtained prior to implementation of case management services and also a physician's written order for HIV CM services to continue beyond 32 units (two calendar months). These orders shall attest to the medical necessity for HIV case management.

*Progress notes shall include the following, at a minimum:

1. documentation of case management activities that directly foster achievement of goals identified in the care plan;
2. the place of service delivery;
3. the date of service;
4. the nature, extent, and duration of time (duration of time is defined as one unit of service equals 15 minutes), to include the start and end time of the activity, in addition to the number of minutes and units
5. the case manager's legal signature, including first and last name with title or initials (if applicable) indicating licensure or certification;
6. statements that reflect individualized care;
7. quarterly updates in the care plan which include documentation of communication with the primary care physician;
8. documentation of all contacts, both direct and indirect, with the recipient;
9. documentation of all contacts with the recipient's support network, providers, and other participants in the plan of care;
10. documentation indicating if the recipient has declined services specified in the care plan.
11. documentation regarding achievement of care plan goals

7.6 Documentation Time Frame Requirements

- a. The initial assessment shall be completed within five business days of the referral date. Annual reassessments shall be conducted at least every 12 months and as needed secondary to unanticipated events or changes in the recipient's status.
- b. The care plan shall be completed within five business days of the assessment and reassessment completion date.
- c. Progress notes shall be documented and incorporated into the record **within 24 hours of contact**. The progress note must be timed and dated as to the time of the contact. The progress note shall be signed per **Subsection 7.5.e.5**.
- d. The contact sheet, which details a list of all service providers, family contacts, and other informal support persons, shall be completed with the care plan and reviewed and updated as needed, at least every three months.
- e. The recipient shall be contacted within 30 calendar days of the care plan completion date to monitor the recipient's progress. Thereafter, at least one contact with the recipient, recipient's support network, providers, and other participants, shall be made and documented at least every three months.
- f. The care plan shall be reviewed at least every three months. Changes shall be made as needed, and documented.

- g. Each recipient shall be surveyed annually to assess satisfaction with case management services and coordination.
- h. A written notice of termination or change in HIV case management services shall be forwarded to the recipient at a minimum of seven business days prior to termination or change.
- i. The provider shall document any deviations from the above (a through h) in the progress notes.

7.6.1 Electronic Records

An HIV case management provider may store clinical records, including those documents referenced in **Subsection 7.5**, electronically (i.e., on disk, microfilm, or optical imaging systems). Providers using electronic storage systems are subject to the following recordkeeping requirements.

- a. The provider shall keep electronic clinical records and electronic billing documentation for a minimum of five years.
- b. The provider shall promptly retrieve the records and make them available for review by DMA or agents acting on behalf of DMA for claims review, audit, medical record review, or other examination during the retention period specified above. Upon request, the provider shall supply electronic copies of all the signed documents referenced in **Subsection 7.5** to support services billed to the Medicaid program.
- c. With respect to claims review, audit, or other examination, the provider shall present clinical records along with the equipment necessary to read them.
- d. The provision for storing records electronically does not remove the requirement for retaining records for five years from the last date of service. Providers unable to maintain the historical documentation electronically shall maintain hard copies for the specified retention period.
- e. The provider shall ensure that all documentation with electronic signatures is consistent with state regulations (GS § 66-58.5) and the provider's policy.

7.7 Quality Improvement Plan

The provider shall develop and implement an internal quality improvement policy and program. The policy shall, include, but not be limited to the following:

- a. the person who is responsible for the quality improvement program;
- b. the process to measure quality of case management services and making improvements;
- c. method to review ten percent sampling of records at least every three months;
- d. method to review administrative review of the case management program;
- e. method to develop and measure key indicators, review of results;
See Attachment B for recommended key indicators.;
- f. method to survey recipient satisfaction at least annually.;
- g. the procedure to develop a corrective action plan for identified problems; and

- h. the procedure for follow-up to ensure that identified problems have been corrected.

Expected -outcomes of HIV case management for persons living with HIV include:

- a. early access to and maintenance of comprehensive health care and social services
- b. improved integration of services provided across a variety of settings
- c. enhanced continuity of care
- d. prevention of disease transmission and delay of HIV progression
- e. increased knowledge of HIV disease
- f. greater participation in and optimal use of the health and social service system
- g. reinforcement of positive health behaviors
- h. personal empowerment
- i. an improved quality of life.

8.0 Policy Implementation/Revision Information

Original Effective Date: May 1, 1994

Revision Information:

Date	Section Revised	Change
11/7/2006	Sections detailed below	Initial Promulgation of current coverage
11/7/2006	1.0	Description of the service made consistent with CMS definition. Deletes Intake as a “core service component.”
11/7/2010	3.2	Redefines specific documentation criteria for meeting medical necessity
11/7/2006	5.3.1	Defines areas to be assessed consistent with CMS definition.
11/7/2006	6.0	Establishes criteria for Certification, Recertification, Decertification , and Technical Assistance Site Visits.
11/7/2006	6.3.1	Establishes new qualifications for HIV Case Manager. It adds having a bachelor’s in any field with 1 year experience in counseling or in a related human services field. It eliminates the “high school prepared” category.
11/7/2006	6.3.2	Establishes new qualifications for HIV Case Manager Supervisor. It adds having a bachelor’s in any field with 1 year experience in counseling or in a related human services field.
11/7/2006	6.4.2	Increases the number of required CEUS to 20 hours annually.
11/7/2006	6.5	Establishes criteria for Expansion Requests
11/7/2006	7.3	Establishes criteria for Transfers
11/7/2006	7.5	Adds additional documentation requirements.
11/7/2006	7.6	Establishes stricter criteria for documentation time frame requirements
11/7/2006	7.6.1	Establishes criteria for Electronic Records
11/7/2006	7.7	Establishes criteria for provider to develop and implement an internal quality assurance program.
11/7/2006	Throughout the policy	Relevant application of EPSDT criteria is discussed
10/1/2009	5.4 and Attachment A, Section D	PAG notified of unit limitation. Provider may not bill in excess of 16 units per month per recipient.

Date	Section Revised	Change
2/23/2010		PAG notified of changes in policy since 11/7/2006. Based on proposed policy changes effective 10/1/2010
10/1/2010	Throughout	Wording change to reflect termination of MOA with DPH.
10/1/2010	1.0	Adds the requirement that recipients must establish and maintain a medical home with either CCNC or a primary care physician.
10/1/2010	4.2.2	Increases the number of “non-covered activities.”
10/1/2010	5.2	Defines role of CCNC as medical home.
10/1/2010	5.2	Establishes criteria for MD order for initiation of services, continuation beyond two months
10/1/2010	5.3	Adds monitoring criteria for monthly contact with primary care physician.
10/1/2010	5.3.2	Adds the role of CCNC in the process of Care Planning.
10/1/2010	5.3.4	Adds the role of CCNC in the process of monitoring.
10/1/2010	5.4	Establishes requirement for MD order for services beyond 2 months or maximum 32 units.
10/1/2010	6.1	Adds more requirements to become certified including ,provider must have 3 years of providing or managing HIV case management programs; must obtain national accreditation and must secure a performance bond.
10/1/2010	6.2	Increases the criteria required to become certified including the submission of a business plan, and the agency must possess certain computer capabilities and adds the number of policies they must submit.
10/1/2010	6.2.2	Changes the recertification cycle from 3 to 2 years and includes potential for a provisional recertification for a six month period.
10/1/2010	6.2.3	Renames and adds criteria for Quality Assurance Site Visits.
10/1/2010	6.2.4	Adds criteria for Decertification and changes time requirement for enrolling recipients.
10/1/2010	6.3	Adds additional requirements for case managers and supervisors regarding amount and type of experience and skills and knowledge they must possess.
10/1/2010	6.4.1	Adds requirement that case manager must attend basic training before the agency can bill for their work.
10/1/2010	6.4.2	Lists topics that must be included in annual training CEUs and lists possible training resources.

Date	Section Revised	Change
10/1/2010	7.6	Establishes requirement that Progress Notes shall be documented and incorporated into the record within 24 hours of contact.
10/1/2010	7.7	Changes name and adds additional requirements for Quality Improvement Plan
10/1/2010	Attachment B	Adds a table of Key Indicators for Quality Improvement.

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis codes to the highest level of specificity that supports medical necessity. Providers shall use valid ICD-9-CM diagnosis codes for recipient's diagnosis related to HIV disease, HIV seropositivity, or CDC-defined AIDS.

C. Procedure Codes

Only procedure code G9012, Targeted Case Management Services (HIV), is used for billing HIV case management.

CPT Code	Description
G9012	Targeted Case Management, each 15 minutes

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

1 unit = 15 minutes

F. Place of Service

Acceptable places of service include offices and the recipient's home. Recipients may also reside in adult care homes.

G. Co-Payments

Co-payments are not required for HIV case management.

H. Reimbursement

Providers shall bill their usual and customary charges.

There is a limit of 16 units per calendar month per recipient.

The provision of HIV Case Management is based on a one to one interaction between the case manager and the recipient. The provider shall not bill for units of service that represent billing for more than one recipient during any specified period of the day.

Providers shall accept Medicaid payments for HIV case management services as payment in full.

HIV case management cannot be billed on the same day as any Community Alternatives Program (CAP) service, including CAP/Choice. This also applies to behavioral health (mentally retarded and developmental delay) case management, child service coordination, maternity care coordination, and at-risk case management for adults or children.

HIV case management cannot be billed when a recipient is institutionalized, excluding the date of admission and the date of discharge. Refer to **Subsection 4.2.1**.

Attachment B: Key Indicators for Quality Improvement

Performance Measure:	Outcome Measure
Antiretroviral (AVR) Management	Percent of clients with CD 4 cell count below 200 cells/mm ³ receiving Pneumocystis Carinii Pneumonia (PCP) Prophylaxis
	Percent of clients with a CD4 count test in the past 4 months
	Percent of clients with a viral load test in past 4 months
	Percent of clients with an HIV primary care visit in the past 4 months
Adherence/Self Management	Percent of clients assessed for adherence to AVR Therapy in the past 4 months by an appropriate adherence counselor. Note: Adherence counseling is a direct service and is <u>not</u> covered under NC Medicaid's HIV Case Management policy.
Health Maintenance	Percent of clients who have died in the past 12 months due to an HIV/AIDS related illness
	Percent of clients with a mental health diagnosis who have kept their appointments with a mental health professional during the past quarter
	Percent of clients for whom a mental health assessment was performed during the past 12 months by a qualified behavioral health specialist
	Percent of clients receiving AVR for whom a lipid screening was performed during the past year.
	Percent of clients receiving an annual dental exam
	Percent of clients with hospitalizations in the past quarter that are related to their HIV diagnosis
	Percent of clients with hospitalizations in the past quarter that are related to their HIV diagnosis
Case Management	Percent of clients who have kept all of their appointments with their case manager during the past quarter
	Percent of clients who have dropped out of case management and the case manager has not been able to contact
	Percent of clients who have met their goals in the past quarter as defined by their individualized Plan of Care
	Percent of records with all of the required documents in the file.
	Percent of records where the billing matches the progress notes
	Percent of records with progress notes signed and dated by the case manager
	Percent of records meeting documentation time frame requirements as defined in Subsection 7.6 of this policy.