# Care Management Guidelines

This document will provide guidance for the PCCM-e as to the Agency's expectations in the delivery of care management activities. This document is not to be used as an exclusive document, but as a supplement to existing policies and procedures to better assist the PCCM-e's care managing teams in their provision of service.

The PCCM-e staff member should introduce themselves, describe the purpose for contact, and explain to the recipient the PCCM-e's role and function in the management of their care. At a minimum, the PCCM-e must make three documented attempts to contact the recipient within 30 calendar days to conduct a health risk screening and assessment. One attempt must include outreach via postal service by mailing the recipient a letter of notification. The PCCM-e shall maintain documentation of proof that a letter was mailed to the EI.

The following components of care management visits/encounters maybe provided telephonically, face to face, or virtually according to the applicable Care Management Activity Schedule. Below is more information on these components.

**Telephonic Encounters**

The Agency's expectation for telephonic encounters requires a team approach to the delivery of thorough, conscientious, and person-centered care management that is consistent with that of face-to-face visits. Telephonic encounters may be provided as outlined in each population's Care Management Activity Schedule.

Telephonic Contact Encounter Requirements

- Confirm that you are speaking with the intended recipient or the designated representative for the recipient (e.g., friend, relative, co-worker). Care Managers can ask for confirmation of identifying information (e.g., last four digits of their social security number and/or date of birth). Do not disclose any personal health information if you have not confirmed who you are speaking to. Once you have received identification, confirm with the recipient whether it's an appropriate time to continue the appointment.

- After confirmation and prior to providing services a verbal consent to receive care management services shall be discussed and obtained from the recipient. Documentation of a verbal consent shall be maintained in the HIMS for each date of service for which payment is requested.

- Some case management tasks can be completed via text messages (e.g., texting a recipient to notify them of a scheduled call, or to advise them of your attempts to reach). However, no paid care management activity is allowed via text messaging. The PCCM-e must adhere to all HIPAA standards regarding texting recipients for the provision of health care services.

**Face- to Face Encounters (F2F)**

Face-to-face encounters are those with the recipient that are in-person at a location of the recipient's choosing. This encounter allows for a more personable approach that supports the gathering of objective and subjective data. Documentation must include the location of the encounter and a recipient signature for the date of service for which payment is requested in the HIMS.

**Virtual Encounters**

- Virtual encounters are an alternate method of providing care to recipients in lieu of face-to-face visits and should not be construed as a more convenient or simpler method of coordinating the care of recipients. Recipient signatures for virtual encounters must be attained within seven calendar days of the encounter. Visits without a valid recipient signature maybe subject to recoupment.

- Virtual encounters include audio and visual capabilities and must be HIPAA compliant. The Agency does not support the use of Facebook, including instant messaging for contacting the recipient or for conducting any ACHN care management related activities. Texting is not a paid care management activity.

- PCCM-e staff may opt for virtual encounters in the following instances:
    - To maintain contact with recipients when a previously scheduled in-person/face-to-face encounter cannot occur due to recipient's illness, illness in the recipient's home or other unforeseen circumstances.
    - Care plan reviews
    - Multidisciplinary Care Team (MCT) meetings
    - Maternity delivery encounters
    - To maintain contact with recipients when a previously scheduled in-person/face-to-face encounter cannot occur due to transportation related issues.

- Note the examples listed above are not intended as an all-inclusive list. Documentation explaining the choice of a virtual visit must be included in the HIMS.

- Encounters that require the recipient to attend F2F or virtually and the recipient is not in attendance are not eligible for payment. If paid in error, the payment will be recouped.

**Topics of Discussion**

The care management staff must cover the following topics during care management encounters:

- Purpose for the visit.
- Assessment of the recipient's physical, mental, and social condition, including how the recipient views their condition, and ways to improve the recipient's health outcomes. Assessment topics can include, but are not limited to:

- Diagnoses in the past 12 calendar months.
- Medical history and significant events.
- Prescribed medication and herbal supplements.
- Emergency Department history.
- Hospitalization history.
- DME filled in the past 12 calendar months.
- Past and present care management/coordination.
- Cost drivers.
- Employment history.
- Socioeconomic history.
- Barriers to care.

If the visit/encounter is face-to-face, the PCCM-e staff should leave written instructions, next steps, and contact information for questions and concerns. For a telephonic visit/encounter, the PCCM-e staff member must provide the recipient with a contact number and determine the need to follow-up with written documentation of the visit.

**Documentation**

Care management activities provided and not supported with documentation according to Agency guidelines are recoupable and will require completion of a Corrective Action Plan.

The PCCM-e must make available to Medicaid, at no charge, all information describing services provided to eligible recipients. The provider must also permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of Federal and State agencies.

Required HIMS Documentation includes but is not limited to:

- Progress notes for each care management encounter must be documented as outlined in with the Agency's policies and procedures.
- Documentation of each encounter must be complete, signed, and dated according to Agency guidelines before a request for payment is requested.
- Progress notes must not be prepopulated or pre/postdated.
- The progress note must summarize the care plan and the interaction with the recipient for the date of service for which payment is submitted.
- Progress Notes must provide enough detail and explanation to justify the request for payment. There must be clear continuity between the documentation.
- All documentation must be legible, signed and dated by the person (identified by name and discipline) who is responsible for providing or evaluating the service furnished. Additionally, the author of each entry must either, personally or electronically sign his or her entry. A stamped signature is not acceptable.

- Care Plans (as described in the Care Management Care Plan Requirements Policy).
- Consent for services
- Recipient signature
- Referrals
- Letters/notices

Mistaken Entry

A mistaken entry in the record shall be corrected by a method that does not obliterate, white-out, or destroy the entry. Corrections to a record shall have the name or initials of the individual making the correction and the date of the correction.

Amended Records

Documentation submitted for review may include amended records. Amended records are legitimate occurrences in the documentation of clinical services and include a late entry, an addendum and/or a correction to the medical record.

- Amended records must:
    - clearly and permanently identify any amendment, correction or delayed entry as such,
    - clearly indicate the date and author of any amendment, correction or delayed entry,
    - clearly identify all original content, without deletion, and
    - be amended prior to claims submission and/or medical record request.

Signatures

- The PCCM-e must obtain a signature to be kept on file, (such as release forms or sign-in sheets) as verification that the recipient was present on the date of service for which the provider seeks payment for face-to-face encounters.
- When payment has been made on claims for which a signature is not available and one of the Agency accepted exceptions is not applicable, the funds paid to the provider covering this claim will be recouped.

Electronic Records

- Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction. When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

- When a hard copy is generated from an electronic record the recipient's name and at a minimum date of birth or Medicaid Id number must be visible.