

Rule No. 560-X-40-.03 Description of Covered Services, Limitations, and Exclusions (General)

(1) Reimbursement is made only for services rendered pursuant to mentally ill adults, intellectually disabled adults, disabled children, foster children, pregnant women, AIDS/HIV-positive individuals, adult protective service individuals, ~~and~~ individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver (TAW) for Adults and individuals who meet the eligibility criteria for Substance Use Disorders as defined in Rule No. 560-X-40-.01. Case management services are those services which will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services. The case manager shall accomplish these services through telephone contact with clients, face-to-face contact with clients, telephone contact with collaterals, and/or face-to-face contact with collaterals. The core elements of the service shall include the following:

(a) Needs assessment - a written comprehensive assessment of the person's assets, deficits, and needs. The following areas must be addressed when relevant:

1. Identifying information.
2. Socialization/recreational needs,
3. Training needs for community living,
4. Vocational needs,
5. Physical needs,
6. Medical care concerns,
7. Social/emotional status,
8. Housing, physical environment, and
9. Resource analysis and planning.

(b) Case planning - the development of a systematic, client-coordinated plan of care which lists the actions required to meet the identified needs of the client. The plan is developed through a collaborative process involving the recipient, his family or other support system, and the case manager.

(c) Service arrangement - through linkage and advocacy, the case management provider will interface the client with the appropriate person and/or agency through calling and/or visiting these persons or agencies on the client's behalf.

(d) Social Support - the case management service provider will, through interviews with the client and significant others, determine that the client possesses an adequate personal support system. If this personal support system is inadequate or nonexistent, the case management service provider will assist the client in expanding or establishing such a network through advocacy and linking the client with appropriate persons, support groups and/or agencies.

(e) Reassessment/Follow-up - the case management service provider will evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

(f) Monitoring - the case management provider ascertains on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

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Statutory Authority: 42 C.F.R., §433; § 1915 (g), Social Security Act; State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193.

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