CHAPTER 90
CASE MANAGEMENT FOR PEOPLE WITH MENTAL RETARDATION, CHRONIC MENTAL ILLNESS, OR DEVELOPMENTAL DISABILITIES

PREAMBLE

These rules define and structure medical assistance case management services provided in accordance with Iowa Code section 225C.20 for consumers with mental retardation (MR), chronic mental illness (CMI), or a developmental disability (DD) and consumers eligible for the HCBS children's mental health waiver. Provider accreditation standards are set forth in 441—Chapter 24.

Case management is a method to manage multiple resources effectively for the benefit of Medicaid consumers. The service is designed to help consumers gain access to appropriate and necessary medical services and interrelated social and educational services. Case management ensures that necessary evaluations are conducted; individual service and treatment plans are developed, implemented, and monitored; and reassessment of consumer needs and services occurs on an ongoing and regular basis.

441—90.1(249A) Definitions.

"Adult" means a person 18 years of age or older.

"Child" means a person under 18 years of age.

"Chronic mental illness" means the condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment.

People with chronic mental illness typically meet at least one of the following criteria:

1. They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).
2. They have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

1. They are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
2. They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
3. They show severe inability to establish or maintain a personal social support system.
4. They require help in basic living skills.
5. They exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness.

For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

"Department" means the department of human services.

"Developmental disability" means a severe, chronic disability that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the age of 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

"Medical institution" means an institution that is organized, staffed, and authorized to provide medical care as set forth in 42 Code of Federal Regulations 435.1009, as amended to October 1, 2001. A residential care facility is not a medical institution.

"Mental retardation" means a diagnosis of mental retardation which:

1. Is made only when the onset of the person's condition was before the age of 18 years;
2. Is based on an assessment of the person's intellectual functioning and level of adaptive skills;
3. Is made by a psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills; and
4. Is made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

"MR/CMI/DD case management" means a service provided under the medical assistance program designed to assist eligible individuals with mental retardation, chronic mental illness or developmental disabilities and children eligible for the HCBS children's mental health waiver in gaining access to appropriate and necessary medical services and interrelated social and educational services. MR/CMI/DD case management is intended to manage multiple resources and to ensure that necessary evaluations are conducted; that individual service and treatment plans are developed, implemented, and monitored; and that reassessment of consumer needs and services occurs on an ongoing and regularly scheduled basis. MR/CMI/DD case management does not include direct services.

"Targeted population" means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of mental retardation, chronic mental illness or developmental disability; or
2. A child who is eligible to receive HCBS mental retardation waiver or HCBS children's mental health waiver services according to 441—Chapter 83; or
3. A child who has a primary diagnosis of mental retardation or developmental disability, resides in a child welfare decategorization county, and is likely to become eligible to receive HCBS mental retardation waiver services.

441—90.2(249A) Eligibility. A person who meets all of the following criteria shall be eligible for MR/CMI/DD case management:

90.2(1) The person is eligible for Medicaid or is conditionally eligible under 441—subrule 75.1(35).

90.2(2) The person is a member of the targeted population.

90.2(3) The person does not reside in a medical institution or is within 30 days of discharge from a medical institution.

90.2(4) The person has applied for MR/CMI/DD case management in accordance with the policies of the provider.

[1] **90.2(5)** The person has been authorized for MR/CMI/DD case management in accordance with rule 441—90.3(249A).

[1] Effective date of January 1, 2003, delayed 70 days by the Administrative Rules Review Committee at a special meeting held December 19, 2002.

***441—90.3(249A) Authorization and need for service.**

90.3(1) *Authorization required.* Assessment of the need for MR/CMI/DD case management is required at least annually as a condition of payment under the medical assistance program. The department will authorize up to 12 months of service when it has determined that the consumer has a need for service.

a. For applicants who have not received MR/CMI/DD case management within the 12 months before application, the department may include up to 4 prior months in the authorized period for the provider to complete the assessment, intake, and enrollment of the consumer.

b. For applicants who have received MR/CMI/DD case management within the previous 12 months, the provider shall obtain authorization before providing services.

c. For ongoing services, the provider shall obtain authorization before the previous authorization expires.

d. A service authorization may be suspended when a consumer loses eligibility for no more than two consecutive months but is expected to regain eligibility during the two-month period. A consumer who regains eligibility within those two months may resume services for the time remaining under the previous authorization. If the previous authorization expires during the two-month period, the provider shall obtain a new authorization before resuming services.

Payment will not be made for MR/CMI/DD case management provided when the authorization is suspended. MR/CMI/DD case management services will be canceled for consumers who do not regain eligibility by the end of the two-month period.

90.3(2) *Need for service.* The department shall determine the initial and ongoing need for service based on evidence presented by the MR/CMI/DD case management provider, including diagnostic reports, documentation of provision of services, and information supplied by the consumer and other appropriate sources. The evidence shall demonstrate that all of the following criteria are met:

a. The consumer has a need for MR/CMI/DD case management to manage multiple resources pertaining to medical and interrelated social and educational services for the benefit of the consumer.

b. The consumer has functional limitations and lacks the ability to independently access and sustain involvement in necessary services.

c. The consumer is not receiving other paid benefits under the medical assistance program or under a Medicaid managed health care plan that serve the same purpose as MR/CMI/DD case management.

90.3(3) *Managed health care.* For consumers receiving MR/CMI/DD case management under a Medicaid managed health care plan as described in 441—Chapter 88, Division IV, the department delegates authorization and determination of need for service to the managed health care contractor. The managed health care contractor shall authorize services according to the criteria and procedures set forth in this chapter.

90.3(4) *Transition authorization.* In order to ensure that consumers with a need for MR/CMI/DD case management continue to receive service, consumers receiving MR/CMI/DD case management on January 1, 2003, shall be considered authorized for MR/CMI/DD case management for up to 12 consecutive months, beginning with January 2003.

a. During the period of time covered by the transition authorization, the department or, for services under a managed health care plan, the managed health care contractor may implement a determination of the need for service in accordance with subrule 90.3(2).

b. Based on the determination of need, the department or the managed health care contractor may authorize additional months of service or terminate payment.

c. If the outcome of the determination of need results in notice of termination of payment, and the consumer appeals that decision in accordance with rule 441—90.6(249A), then the consumer is entitled to continuation of services in accordance with rule 441—7.9(17A) for the duration of the transition authorization or until the appeal decision becomes final, whichever comes first.

441—90.4(249A) Application. The provider shall process an application for MR/CMI/DD case management no later than 30 days after receipt of the application. The provider shall refer the applicant to the department's service unit if other services are needed or requested.

90.4(1) *Application record.* The application shall include the consumer's name, the nature of the request for services, and a summary of any evaluation activities completed. The provider shall maintain this documentation for at least five years.

90.4(2) *Application decision.* The provider shall inform the applicant or the applicant's legally authorized representative of any decision to approve, deny, or delay the service in accordance with notification requirements at 441—subrule 7.7(1).

90.4(3) *Delayed services.* The application shall be approved and the consumer put on the referral list for assignment to a case manager when MR/CMI/DD case management cannot begin immediately because there is no opening on a caseload. The provider shall notify the applicant or the applicant's legally authorized representative in writing of approval and placement on the referral list. If an applicant is on a referral list for more than 90 days from the date of application, this shall be considered a denial of service.

90.4(4) *Denying applications.* The provider shall deny applications for service when:

a. The applicant is not currently eligible for Medicaid; or

b. The applicant does not meet the eligibility criteria in rule 441—90.2(249A); or

c. The applicant or the applicant's legally authorized representative withdraws the application; or

d. The applicant does not provide information required to process the application; or

e. The applicant is receiving MR/CMI/DD case management from another Medicaid provider; or

f. The applicant does not have a need for MR/CMI/DD case management.

441—90.5(249A) Services.

90.5(1) *Covered services.* MR/CMI/DD case management shall include the following:

a. Assessment of need for case management, intake, and enrollment into case management and coordination of needed interdisciplinary diagnostic and evaluation services.

b. Development, implementation, and maintenance of a current and appropriate treatment plan that directly involves those concerned with the consumer, including the consumer, the consumer's legal representative, and the consumer's family. Other participants may include the case manager, service providers, and others whose appropriateness is identified through the evaluation, diagnostic, or reevaluation process.

c. Linkage of the consumer's needs to required treatments and services without restricting the consumer's choice of service providers in violation of Section 1902(a)(23) of the Social Security Act.

d. Coordination and facilitation of decision making according to the consumer's needs and abilities.

e. Monitoring of overall service delivery.

f. Crisis assistance planning and intervention.

90.5(2) *Excluded services.*

a. MR/CMI/DD case management is not a direct service. No direct treatment services are covered.

b. Medicaid payment for services to consumers who are conditionally eligible under 441—subrule 75.1(35) shall be made only when the consumer has met the spenddown requirements for the certification period.

The consumer is responsible for paying for services used to meet spenddown. The consumer shall be notified of this responsibility and shall acknowledge that the provider must be paid within 30 days of the date on the second invoice or MR/CMI/DD case management will be terminated.

90.5(3) *Service contacts.* Providers of MR/CMI/DD case management shall:

a. Make at least one contact per month with the consumer, the consumer's legal representative, the consumer's family, service providers, or another person, as necessary to develop or monitor the treatment plan; and

b. Make a face-to-face contact with the consumer at least once every three months.

90.5(4) *Service requirements.* MR/CMI/DD case management shall be implemented and provided in consultation with the consumer, the parents (if the consumer is a child), the consumer's legal representative, the consumer's family members, and others requested by the consumer and shall include the following:

a. Report of diagnostic category and consumer's county of legal settlement using Form 471-2464, Report for Enhanced Services.

b. A social history which contains current and historical information and is updated annually, in accordance with 441—subrule 24.4(1).

c. Assessment, in accordance with 441—subrule 24.4(2).

d. Individual service plan, in accordance with 441—subrule 24.4(3). The plan shall be based on the consumer's assessed needs, abilities, situation and desires and shall include the following:

(1) Reference to all provided services, including identification of providers and time frames for services.

(2) Documentation of the need for MR/CMI/DD case management as it corresponds with the goals and objectives.

(3) Crisis plan for emergencies.

(4) Discharge plan.

(5) Documentation of the parties involved with the development of the plan.

(6) Schedules for case monitoring and client reassessment.

(7) Plan for communication by the case manager to all providers to ensure coordination and planning.

e. Documentation of service provision in accordance with 441—subrule 24.4(4), including documentation of service contacts as described in subrule 90.5(3).

f. Incident reports in accordance with 441—subrule 24.4(5).

g. An annual report documenting the need for MR/CMI/DD case management, the appropriateness of service interventions, the goals and objectives, and the consumer's progress.

h. Documentation that the case manager has developed and, no less than quarterly, has carried out a process for determining the client's progress toward achieving the goals and objectives identified in the individual service plan.

90.5(5) *Consumer rights.* Consumer rights may be limited or restricted only with the consent of the consumer or the consumer's legally authorized representative, and only if:

a. The limited right is explained; and

b. A service activity to address the limitation is developed and documented in the service plan with an explanation that describes how the consumer will work toward having the restriction removed; and

c. Periodic evaluations of the limit are conducted to determine continued need.

441—90.6(249A) Terminating services.

90.6(1) MR/CMI/DD case management shall be terminated when:

a. The consumer does not meet eligibility criteria under rule 441—90.2(249A); or

b. The consumer has achieved all goals and objectives of the service; or

c. The consumer has no current need for MR/CMI/DD case management; or

d. The consumer receiving MR/CMI/DD case management based on eligibility under an HCBS waiver is no longer eligible for the waiver; or

e. The consumer or the consumer's legally authorized representative requests termination; or

f. The consumer is unwilling or unable to accept further services; or

g. The consumer or the consumer's legally authorized representative fails to provide access to information necessary for the development of the service plan or implementation of MR/CMI/DD case management.

90.6(2) The provider shall notify the consumer or the consumer's legally authorized representative in writing of the termination of MR/CMI/DD case management, in accordance with 441—subrule 7.7(1).

441—90.7(249A) Appeal rights.

90.7(1) *Appeal to the provider.* After notice of an adverse decision by the provider of MR/CMI/DD case management, the consumer or the consumer's representative may request an appeal as provided in the appeal process established by the provider agency.

90.7(2) *Appeal to the department.* After notice of an adverse decision by the department pertaining to authorization and need for service, the consumer or the consumer's representative may request

reconsideration by the department by sending a letter to the department not more than 30 days after the date of the notice of adverse decision. The consumer or the consumer's representative may appeal an adverse reconsideration decision by the department as provided in 441—Chapter 7.

90.7(3) *Appeal to the managed health care contractor.* After notice of an adverse decision by a managed health care plan, the consumer or the consumer's representative may request a review as provided in rule 441—88.68(249A).

These rules are intended to implement Iowa Code sections 249A.4, 249A.26, and 249A.27.

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