

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATIONS OF THE AMOUNT, DURATION, AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

CITATION Medical and Remedial Care and Services
1915(g) of Item 19
the Social
Security Act

I. Definition

Case management is defined as services provided to individuals to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services. The Department utilizes a broker model of case management in which recipients are referred to other agencies for specific services they need. These services are determined by individualized planning with the recipient and/or the recipient's family, and other persons/professionals deemed appropriate and provided according to a written comprehensive plan of care which includes measurable person centered outcomes. All case management services must be provided by qualified staff. The provider must ensure that there is no duplication of payment, that there is only one primary case manager for each eligible recipient and that the recipient is not receiving other case management services from any other provider. Procedures are detailed in the Case Management Provider Manual.

II. Services To Be Provided

All Medicaid enrolled case management agencies are required to perform the core elements of intake, assessment, service planning, linkage, follow-up/monitoring, reassessment, transition/closure, and maintenance of records.

NOW Waiver Recipients

A minimum of one home visit per quarter to each recipient is required. More frequent home visits shall be required to be performed if indicated in the recipient's Comprehensive Plan of Care.

Infants and Toddlers with Special Needs

A minimum of one face-to-face meeting per quarter with each recipient's family is required. More frequent face-to-face meetings shall be required to be performed if indicated in the recipient's Individualized Family Service Plan (IFSP).

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EPSDT Recipients on the DD Request for Services Registry

A minimum of one face-to-face visit per quarter with each recipient (and their guardian) is required. More frequent face-to-face visits shall be required to be performed if indicated in the recipient's Comprehensive Plan of Care. Additional face-to-face visits may be performed if needed to obtain services.

THIS SECTION RESERVED

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III. Selection of Case Management Agency

Recipients have the right to select the provider of their case management services from among those available agencies enrolled for participation.

IV. Standards For Participation

- A. In order to participate as a case management services provider in the Medicaid Program, an agency must comply with licensure and certification requirements, provider enrollment requirements, case management manual, and when applicable, the specific terms of individual contractual agreements.
- B. Separate enrollment is required for each population and DHH designated region that the agency plans to serve, as well as for each office site it plans to operate. The agency may provide services only in the parishes of the DHH region for which approval has been granted.

V. Discharge

Discharge from a case management agency must occur when the recipient no longer requires services, desires to terminate services, becomes ineligible for services, or chooses to transfer to another case management agency.

SUPERSEDES: TN# 99-17

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