NEW MEXICO DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
MEDICALLY FRAGILE WAIVER (MFW)

CASE MANAGEMENT

Effective January 1, 2011

MFW case management is a collaborative process of assessment, planning, facilitation, care coordination, advocacy for choice, and arrangement of supports and services to meet the participant's health and community needs through available resources to promote quality cost-effective outcomes (see Case Management Society of America [CMSA] definition of case management, revised 2010).

MFW funded services are not replacements for the family system, informal caregiver support or other community services, but are supplements to the participant's natural supports. The participant's family and/or caregiver must continue all efforts in the care and support of the participant.

I. SCOPE OF SERVICES:

A. Case Management Services Include:

1. The CM will identify and facilitate community resources for the participant/participant representative and family, such as Family Infant Toddler (FIT) program, schools for the Individualized Educational Plan (IEP), Medicaid State plans (Salud), faith-based organizations and support organizations.
2. The CM will review and facilitate eligibility, Level of Care (LOC), Individual Service Plan (ISP) and MAD 046 form at least annually and more often as needed.
    a. Initial ISP and MAD 046 form will be reviewed at six (6) months.
    b. All participants enrolled in the FIT Program will be reviewed every 6 months.
    c. Any member of the Interdisciplinary Team (IDT) may call a meeting to consider changes to the LOC, ISP and/or MAD 046 form at any time.
3. The case manager (CM) shall not be an authorized (designated) participant representative.

B. Case Management Role in Pre-Assessments:

1. The date the applicant is logged into the MFW Central Registry is recognized as the date of registration.
2. The contracted Case Management Agency will complete a telephonic pre-assessment for all applicants 30 years and younger, and others as requested by the MFW Program Manager.
3. Other documents will be utilized in the pre-assessment as needed.

4. The CM will utilize the MFW Eligibility Training Manual to complete the pre-assessment tool.
5. The pre-assessment packet is forwarded to the MFW Program Manager for final determination.

C. Eligibility Determination and LOC/Funding:
1. After allocation, the Case Management Agency will complete the initial eligibility determination and approved ISP/MAD 046 form budget within 90 days from the date the Department of Health (DOH) receives the primary freedom of choice (PFOC). If unable to complete this process, the Case Management Agency will submit a Client Information Update (CIU) with the reason why the process cannot be completed.
2. The CM will meet with participant/participant representative to review and explain the MFW services, State Medicaid services and identify community resources. The family will be given a Medically Fragile Family Handbook to assist in reinforcing this information.
3. The CM will assist the participant/participant representative to set up the required appointment with the primary care provider (PCP) for a history and physical (H&P) that will be submitted as part of the LOC packet for prior authorization. The initial H&P must have been completed within 90 days of submission and must have been completed within 12 months of the annual LOC process.
4. Eligibility and LOC is determined by the CM and PCP. (The MFW parameters are used to make this determination.) Refer to the MFW Eligibility Training Manual for details. The LOC determines the funding resources available to the participant based on needs identified in the ISP during the LOC/ISP cycle.
5. The CM completes an assessment utilizing the MFW parameters and other appropriate resources and writes the Comprehensive Individualized Assessment-Family Centered Review (CIA/FCR).
6. The CM completes the DOH 378 form, the Long Term Care Assessment Abstract (LTCAA) form, applying the MFW parameters, the MFW Eligibility Training Manual, the CIA/FCR and the H&P.
7. The LOC packets consist of the following:
    a. CIA/ FCR
    b. LTCAA form
    c. PCP's H&P
    d. CIU for extensions
    e. Other supporting medical documents as needed
8. The PCP is sent the LOC packet to review. The PCP must sign and date the LTCAA form, stating that the PCP has seen and evaluated the participant and recommends the LOC.
9. Financial eligibility determination is the responsibility of the Income Support Division (ISD) specialist at the local ISD field office. The CM will help

arrange the participant's eligibility appointment with ISD and establish communication with the relevant ISD specialist to assist as needed.

10. After the PCP has reviewed, signed and dated the LTCAA form, the complete LOC packet is sent to the Medicaid Third Party Assessor (TPA) for prior authorization.
11. When the Medicaid TPA approves the LTCAA form, the participant is then deemed to meet the eligibility criteria for MFW and the LOC funding. The ISD specialist then needs to deem the participant financially eligible.
12. The approved LTCAA form is forwarded to the ISD office to be included in financial eligibility determination.
13. The participant is funded for services based on LOC and age:
    For those participants less than 21 years of age:
    a. $25, 000/year (regardless of assessed LOC)
    For those participants age 21 years and older:
    b. Adult Level I -- $70,000
    c. Adult Level II -- $60,000
    d. Adult Level III -- $48,000

D. IDT Meeting and ISP Development and Budget Development (MAD 046 form):

1. The participant/participant representative will have the opportunity to be involved in all aspects of the ISP.
2. The purpose of IDT meetings is to develop the ISP, review effectiveness of the ISP and revise the ISP.
3. In preparation for an IDT meeting, the CM will offer the participant/participant representative a menu of waiver services as appropriate and will document selected services.
4. The IDT will be comprised of the participant/participant representative, the PCP and all MFW providers and external providers. The MFW providers are expected to attend ISP meetings and all others are encouraged to attend.
5. The participant/participant representative will choose a provider from the MFW secondary freedom of choice (SFOC) list. Each service listed on the MAD 046 form has a separate SFOC.
6. The participant/participant representative is encouraged to contact provider agencies and interview the agency and potential providers. For private duty nursing (PDN) services, the participant/participant representative will meet with the potential Home Health Agency representative to discuss specific needs and skills that will be expected from the nurse and/or home health aide in an effort to match nurse and/or home health aide with the participant and family. The participant/participant representative has the final say in who provides services based on available choice. The participant/participant representative's signature on the SFOC indicates their choice of provider agency for a specific service.
7. When the participant is under the age of 21 years, Early Periodic Screening, Diagnostic & Treatment (EPSDT) services will be provided by the State Medicaid Plan. The CM will facilitate the choice of provider agency based on

the network. The participant/participant representative has the final say on who provides services based on available choices.

8. The following chart lists services for individuals 21 years and over, and services for those under 21 years on the MFW:

SERVICE CHOICES ON THE MAD 046 FORM

MFW Participant Less Than 21 Years of Age	MFW Participant More Than 21 Years of Age
Ongoing RN/Case Management (OCM)	Ongoing RN/Case Management (OCM)
Nutritional Counseling	Registered Nurse (RN), Licensed Practical Nurse (LPN), Home Health Aide (HHA)
Behavior Support Consultation	Therapy Services (Physical Therapy [PT], Occupational Therapy [OT], Speech Language Therapy)
PDN In-Home Respite	Nutritional Counseling
Institutional Respite	Behavior Support Consultation
Specialized Medical Equipment	PDN In-Home Respite
	Institutional Respite
	Specialized Medical Equipment
	RN 2 hrs/ISP cycle to attend IDT

9. The CM will facilitate the IDT meeting. The CM will contact team members at least two (2) weeks prior to the scheduled IDT meeting with date, time, location and purpose of the IDT meeting. This notification may be by phone, written or electronic communication. Documentation of phone, written or electronic notification will be maintained in the participant's CM file. The CM will also notify IDT members of cancellations and changes of IDT meeting.
10. The CM is responsible for the ISP signature sheet at the IDT meeting. The date, begin and end time of the IDT meeting will be written on the signature sheet by the CM.
11. The ISP signature sheet will be attached to the participant's ISP and distributed to the IDT with the ISP package. Team members who participate in the IDT by phone will be so indicated on the signature sheet in lieu of an actual signature.
12. The original copy of the ISP will be maintained at the participant's CM agency file.
13. It is the responsibility of each IDT member to request additional documents from the CM.
14. The ISP will include the following:
    a. Basic information includes at a minimum: the participant's name, address, phone number, date of birth, original identification number,

parent/guardian information, insurance information, race/ethnicity, primary language, primary diagnosis, ISP cycle and date of the IDT/ISP meeting to develop the plan.

b. A list of IDT members that includes both waiver and non-waiver providers with the following information:
    i. Name of team member, including the CM name
    ii. Title
    iii. Business location
    iv. Frequency of visits
    v. Phone number
    vi. Email address, if possible
    vii. Funding source
c. Present levels of functioning to include diagnosis, strengths and needs.
d. IDT members will discuss and enumerate issues, strengths and needs for the participant and family, and strategies that will be used to address them.
e. The ISP outcome is a statement of change that the participant/participant representative wants to achieve. These include individualized goals and objectives and care activities/strategies for each service delivered. These are based on reasonable and measurable outcomes for the participant.
f. The participant/participant representative shall have the opportunity to generate outcomes. Team members may assist the participant/participant representative to identify goals/outcomes and support their choices.
g. Each ISP outcome statement shall be accompanied by a description of the methods, strategies and activities used to work towards the outcome, timelines, criteria for measuring progress and person(s) responsible. The participant/participant representative and other medical team members (i.e., PCP and medical specialists) will prioritize the concerns involved in providing services.
h. An ISP statement for services and supports necessary to achieve the outcomes. The listing of services and supports shall include the frequency, duration, location, intensity (group or individual), method of delivery, and applicable payment information. Services and supports not funded by the MFW shall also be included.

15. The provider agencies will submit to the CM all service plan(s) within 10 working days following the initial IDT meeting and when revised.
16. The CM will complete the ISP within 15 working days following the IDT meeting.
17. The CM will submit the completed Waiver Review Form (MAD 046 form), commonly known as the budget, based on the decisions of the IDT meeting.
18. Each service requested on the MAD 046 form must have a corresponding care activity/strategy in the ISP.
19. Provider agencies must be present at the IDT meeting or provide their input to the CM or designee before the IDT meeting. The CM or designee will contact the provider following the meeting to update on changes.

20. The signed SFOC form for each service provider must be maintained in the participant's CM file.
21. It is the joint responsibility of the CM, provider agency, and participant/participant representative to monitor the MAD 046 form's maximum dollar amount allocated per LOC and ISP cycle to assure the budget does not exceed approved LOC.
22. The ISP packet is submitted to the Medicaid TPA for prior authorization. The ISP packet is comprised of the following:
    a. ISP with all corresponding care activity/strategy.
    b. MAD 046 form.
    c. Signature sheet of IDT meeting.
    d. CIU, if necessary.
23. The applicant for the MFW will be able to begin receiving services only after the Medically Fragile eligibility, funding LOC and financial eligibility have been approved, and the applicant is eligible to receive Medicaid services.
24. The LOC and ISP cycle dates do not change for the participant. If for any reason the LOC, ISP or MAD 046 form are unable to be completed prior to the end of the cycle, the MFW Program Manager or designee must approve the extension of services. The Case Management Agency will submit a CIU form requesting specific dates to be extended for LOC, ISP or MAD 046 form with rationale.

E. Re-Admits
1. When the participant has been hospitalized for more than 3 overnights, a "Readmit" LTCAA form must be submitted.
2. The CM will be notified in multiple ways when a participant has been hospitalized, e.g. by family, Home Health Agency, and hospital notifications.
3. The CM will contact the hospital to obtain necessary information to complete a readmit LTCAA form.
4. The CM and hospital CM and/or Discharge Planner and the hospital physician will communicate via phone or electronically about the LTCAA form to be submitted to Medicaid TPA.
5. The CM will prepare the fax transmittal sheet that includes:
    a. Readmit LTCAA form (to include the doctor's electronic signature).
    b. Hospital name.
    c. Admission date.
    d. Discharge date.
    e. Reason for admission.
6. The packet of information will be submitted to the Medicaid TPA for approval of readmit to the MFW within 10 calendar days of notification of discharge.
7. If the readmit process does not occur within the designated timeframe, the MFW eligibility and LOC/budget process must be initiated again.

II. CASE MANAGEMENT MONITORING

A. The CM will monitor the effectiveness of services provided to the participant as identified through the ISP, written reports, contacts and coordination of services.
B. The CM will have monthly contact with the participant/participant family.
    1. Face-to-face visits with the participant must occur at least every other month or more often.
    2. The CM will have a telephone conference with participant and/or family on the months that a face-to-face visit is not done.
    3. Monthly contacts must have supporting documentation by the CM that reflects active implementation of the ISP.
    4. At the face-to-face visits with the participant, health, safety and welfare are monitored. Face-to-face visits and phone contacts must have supporting documentation by the CM indicating the participant or family were actively involved in the input of strategies and decisions involving the coordination of participant services.
    5. When the participant is not able to participate and provide input regarding needs, effectiveness of ISP, or health and safety needs, the CM will clearly and concisely document in the monthly CM's contact notes that the participant was unable to directly convey his/her needs and the reasons why. The participant representative will provide information regarding the effectiveness of the ISP, health and safety measures implemented, and additional needs of the participant.
    6. The CM and the Home Health Agency are required monthly to discuss nursing and home health aide services. This will be documented in CM contact notes. The discussion and notes will reflect the implementation of the nursing and home health aide plans, review budget utilization, and review of family needs for support by Home Health Agency personnel.
C. The CM will comply with all policies and procedures regarding utilization review, including professional documentation standards.
D. The CM will review with the participant/participant representative the services identified in the ISP and perceived effectiveness of each service.
E. The CM will have ongoing contacts with waiver providers to review quality, effectiveness of the services and progress towards the ISP goals.
F. The CM will identify and resolve known situations that may be harmful or deemed potentially dangerous to the participant and/or others.
G. The CM, in conjunction with participant/participant representative, will identify problems with providers. The specific problems will be reported to the provider agency for resolution. The CM may need to participate in the resolution of the problems.
H. The CM will monitor the timeliness of services delivered.
I. The CM will report child and adult abuse, neglect and exploitation to the designated State agencies as per State and Federal regulations.

III. CASE MANAGEMENT AGENCY REQUIRMENTS

A. Case Management Agency:
   1. A CM may not provide any other MFW services to individuals for whom the agency provides case management services.
   2. The Case Management Agency may not employ as a CM any immediate family member or guardian of an individual served by the agency.
   3. The MFW may consider other options for contracting case management services when there is a lack of qualified Case Management Agencies within any geographic area of the State. At its discretion, the DOH may waive this requirement when there is a lack of qualified case management agencies within a specific geographic area of the state. This may include, for example, contracting with licensed Medicaid Home Health Agencies that have qualified licensed RNs for case management coordination of services.
   4. The Case Management Agency must maintain a current MFW provider status per DOH Provider Enrollment Unit policies, including compliance with the DDSD Accreditation Policy.
   5. The Case Management Agency must provide readily accessible case management services to participants on a statewide basis or by DDSD Region (preferred). At its discretion, the DOH may contract for case management services for one or more counties within a region.

B. Case Manager Requirements:
   1. A MFW CM must be a licensed RN in the State of New Mexico with current licensure as defined by the New Mexico Board of Nursing.
   2. A MFW CM must have at least two (2) years experience with the target population in pediatrics, critical care or public health fields. Specifically, one (1) year should have been in a home health program, community health program, hospital, publicly funded institution, long term care program, or any other program addressing the needs of special populations.
   3. The MFW CM will have knowledge and experience in:
      a. Human growth and social development.
      b. Various disease processes and assessment of the need for skilled intervention.
      c. Accessing existing community resources as well as development of resources and programs.
      d. Resources for support to individuals, families, and groups.
      e. Planning and management of services for individuals with medical fragility and developmental disabilities.
      f. Interpersonal communication skills.
      g. Interventions to act appropriately and quickly in a crisis.
      h. Working with the health, welfare, mental health, and judicial system affecting the MFW population.
   4. The MFW CM will be culturally sensitive to the needs and preferences of participants and households. Arrangement of written or spoken communication in another language may need to be considered.

C. Administrative Requirements:
   1. The Case Management Agency must comply with all applicable Federal, State, and waiver regulations, policies and procedures regarding case management code of ethics.
   2. The Case Management Agency will have an established method of information and data collection.
   3. The Case Management Agency will comply with all Federal, State, DOH and Human Services Department (HSD) regulations, policies and procedures, including but not limited to:
      a. Policies and procedures related to timely submission of medical eligibility determination.
      b. Policies and procedures related to service provision and appropriate supervision.
      c. Policies and procedures related to case management training.
      d. Policies and procedures related to reimbursement of case management services.
      e. Establish and maintain written grievance procedures.
   4. The Case Management Agency must purchase and maintain full professional liability insurance coverage.
   5. The Case Management Agency is responsible for assuring that all CMs have current New Mexico RN licensure.
   6. The Case Management Agency is responsible for providing ongoing and appropriate training to CMs.
   7. The Case Management Agency shall notify the DOH in writing of any changes in the mailing address of the Case Management Agency or any change in executive director, administrator or geographic location of services provided.

D. Documentation:
   1. Documentation must be completed in accordance with applicable Medically Fragile standards.
   2. All documentation forms will contain at least: participant name, date of birth, date of report, provider agency name, and CM's name and credentials.
   3. All report pages and notes will include at least the participant name, date and document title.
   4. All documentation will be signed and dated by the CM. Verified electronic signatures may be used. CM name and credential typed on a document is not sufficient.
   5. Each participant will have an individual clinical file (see general provider requirements).

IV. REIMBURSEMENT

Each Case Management Agency is responsible for providing clinical documentation that identifies case management components of the provision of ISP services, including assessment information, care planning, intervention,

communications care coordination, and evaluation. There must be justification in each participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of contacts. All services must be reflected in the ISP that is coordinated with the participant/participant representative and other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget.

A. Payment for case management services through this Medicaid Waiver is considered payment in full.
B. The case management services must abide by all Federal, State, HSD, and DOH policies and procedures regarding billable and non-billable items.
C. All billed services must not exceed the capped dollar amount for LOC.
D. Reimbursement for case management services will be based on the current rate allowed for the services.
E. The Case Management Agency must follow all current billing requirements by the HSD and DOH for CM services.
F. The Case Management Agency has the responsibility to review and assure that the information on the MAD 046 form for their services is current. If an error is identified, the Case Management Agency will work with the Medicaid TPA to correct the MAD 046 form.
G. The MFW Program does not consider the following to be case management duties and will not authorize payment for:
    1. Performing specific errands for the participant/participant representative or family that is not program specific.
    2. "Friendly visiting," meaning visits with participant outside of work scheduled.
    3. Financial brokerage services, handling of participant finances or preparation of legal documents.
    4. Time spent on paperwork or travel that is administrative for the provider.
    5. Transportation of participants.
    6. Pick up and/or delivery of commodities.
    7. Other non-Medicaid reimbursable activities.