CCQC

Train the Trainer: Case Management

Other Documents

COLORADO CASE MANAGEMENT SERVICES

				Case Management Activities	Comments
Type	**F2F**	**PH**	**C**		
ASSESSMENT ACTIVITIES					
A	x	x	x	Meeting with client/family members to discuss case management services, orientation, engagement, education.	
A	x	x	x	Completing case management assessment tool with consumer or family	Should be face to face if possible.
A	x	x	x	Updating case management assessment tool with consumer or family	Updating can occur at any time and information included in a progress note. Each meeting or call with the Individual may provide useful assessment information.
A	x		x	Gathering authorizations to get information from other providers.	Would be a collateral contact if guardian signature needed. NOTE: we are <u>required</u> to contact and coordinate with the client's primary care physician.
A	x	x	x	Reviewing bio-psychosocial with client and family to familiarize yourself and to ask questions.	CMs should read the most current bio-psychosocial and psychiatric assessment.
A	x	x	x	Review treatment priorities of client; where past treatment; what worked and what didn't	
A	x		x	Determine commitment to development and implementation of plan	This would be a discussion to determine the Individual's Stage of Change with regards to their willingness to get linked to necessary resources.
A	x	x	x	Determine how much support they are likely to need or currently have to implement plan.	
A	x		x	Client and family education about role of case manager	This should be face to face.
A	x		x	Team meetings or client staffings.	Consider inviting the Individual to staffing.
CASE MANAGEMENT CARE PLANNING					
Type	**F2F**	**PH**	**C**		
CP	x	x	x	Developing initial plan: coordinating treatment planning meetings	Usually multiple meetings are required. Individual should understand what case management is, how to use CM. CM should have time to assess strengths, needs, how the Individual engages, etc. See below.
CP	x	x	x	Developing the initial plan: making sure the individual understands the treatment planning process and how they will be included in planning.	Best practice is face to face
CP	x	x		Developing the initial plan: helping the individual prioritize their needs and identify strengths and the skills and supports they need as a result,	
CP	x	x		Developing the initial plan: on-going evaluation with the individual and your supervisor together of the strategy outlined in the plan, the effectiveness of the plan, etc.	Consultation with your licensed supervisor is not billable if it is for clinical supervision, but it is billable for a consultation on the case. When possible have these kinds of consultations with the Individual as well. BE CAREFUL: if the note looks like supervision it will be denied.
CP		x	x	Developing the initial plan: discussions with other members of the treatment team about their roles in the plan, their	Consultation with outside providers/social services/schools is billable. Planning and advocating with the treatment team members

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COLORADO CASE MANAGEMENT SERVICES

				perceptions about what would be most effective, and the level of participation they think will be required of the individual,	at Madison Center is billable ,
CP	x	x		Developing the initial plan: writing the treatment plan.	Best practice is to do this with the Individual. If not possible then always make sure you review completed document with them – never get a signed blank form or signature page. If the Individual refuses to sign then document in progress note why refused and continue to follow up to try to get signature.
CP	x	x	x	180 day review of care plan: meeting or series of meetings with Individual and family to review progress and appropriateness of plan.	Document your review of progress to date, change in status or Stage of Change, any changes in strategy or outcomes expected based on work in last 180 days. Remember you can do this at more frequent intervals if it is necessary
CP	x	x	x	Subsequent care plans: see above activities under Developing Initial Plan.	This should take place at least annually on a formal basis, however, updates to the current plan should take place as new needs for CM services are identified.
REFERRAL RELATED ACTIVITIES: Planning for Implementation of the Care Plan					
Type	**F2F**	**PH**	**C**		
RR	x	x	x	Meetings with the individual to map out a schedule and determine transportation needs for all appointments	Because of the limitations on transporting by CM, they should carefully review each appointment to make sure the Individual has a plan for getting there on the right day at the right time. This may also involve others who will be supports at the meetings. Having daily calendars is important. The CM can help fill them out with the level of detail needed by the Individual to support them getting to appointments on time.
RR	x	x	x	Discussions with the individual and their family about the reasons for various appointments and hoped for outcomes.	The Individual should be an informed and voluntary consumer of each service or support they are linked to. This can involve teaching about choices or assisting the individual to make choices.
RR	x		x	Gathering necessary data, filling out required forms with Individual, and developing lists of questions to ensure the individual gets the best results from the plan and the services and supports they are being linked to.	The regulations allow CMs to not just refer but to link Individuals to services. The CM role is to make sure that the Individual can maximize the outcomes for each appointment. This will be individualized based on the person's ability to manage the appointment on their own without supports. The CM should carefully plan for what supports they need to provide or ensure are available.
RR		x	x	Locating and obtaining commitments for services that are necessary and are needed by the individual where they are unable to locate these services on their own.	The CM may want to *"pre" review* the Individual's needs prior to adding a particular service to the care plan. E.g. find out about long wait times, financial issues, locations or times for services that are difficult, etc.
RR	x	x	x	Developing a timeline or strategy for when and how soon the different services listed on the care plan will need to be implemented.	Most Individuals will want basic needs met first. However, you need to meet the Individual where they are at and always respect their priorities for linkages to services. This includes mental health services as well. Individuals in care do not always agree that these are important or even necessary services.
REFERRAL RELATED ACTIVITIES: IMPLEMENTATION OF THE PLAN					
Type	**F2F**	**PH**	**C**		
RR		x		Calling and setting up appointments.	This is OK even if it is with your agency.
RR	x	x	x	Assisting the individual to get to the appointment (remember transporting a individual is not a	This can involve calls to Medicaid transportation, calls to family or other supports, referrals for travel training, or reviewing bus schedule and when they should plan on catching bus to be there

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				billable activity).	on time.
RR		x	x	Talking with services and supports to describe what the individual needs.	This is a form of advocacy that is allowable. It can be done face to face in a meeting with the Individual and provider if necessary to ensure appropriate services. See discussion on billing below if the meeting is with a Medicaid provider.
RR	x	x		Helping the individual to develop a list of the right questions to get the information and services they need.	This may also involve listing side effects or remaining/ problem symptoms. The CM may also want to make sure the Individual informs the provider about other pertinent appointments, changes in medications, etc. These should be done in writing so that they can be faxed to appointment and/or Individual can carry them to the appointment.
RR	x	x		Discussing with the individual how they will be expected to participate.	Some limited role play may be necessary to ensure that the Individual understands the structure of the meeting and the kinds and types of questions that will be asked. If the appointments are recurring, the CM may want to inform the Rehab Specialist to dicuss adding this to skills being taught. Can we say clinician as I don't think many of us have staff that we refer to as Rehab Specialists
RR	x	x		Discussing the rules they will be expected to follow.	Understanding how to approach reception, how to behave in waiting room, how to deal with wait times, how to request assistance, etc. If the appointments are recurring, the CM may want to inform the Rehab Specialist to dicuss adding this to skills being taught.
RR	x	x		Reminding individuals about appointments.	These calls can also include reviewing above information about the appointment with the Individual as well.
RR	x			Accompanying the individual to some appointments to ensure proper and effective linkage and services.	This is not billable if the provider of the service will be billing Medicaid for their work. It is billable if the appointment is with a non-Medicaid provider or support.
EVALUATION AND MONITORING: MONITORING IMPLEMENTATION AND COORDINATING CARE					
Note: you are not monitoring the client, you are monitoring the implementation of the care plan and its effectiveness					
Type	**F2F**	**PH**	**C**		
EM		x	x	Getting commitments from multiple providers to not just provide needed services but to coordinate their efforts with each other.	Discussion with each provider as to how you intend to coordinate the care of the Individual and how you will keep in touch with each of them and keep them informed of the work of the team. This can be done with the Individual in a joint meeting (billable only if provider is not billing Medicaid) where the Individual or you explain the process and why.
EM	x	x	x	Making sure that services are being provided according to the treatment plan;	Follow-up discussions with Individual, family or other supports, or providers of services. Get copies of notes from meeting and review with Individual. Were all questions answered and concerns addressed?
EM	x	x	x	Making sure that necessary communication between providers and the individual is happening.	Talk to both provider and the Individual or their supports. Discuss with Individual their evaluation of the effectiveness of the services being provided.
EM		x	x	Meeting or speaking over the phone with collateral contacts to see if the individual is participating in treatment, to evaluate the effectiveness of the interventions, to get status reports, and to map out	Confirming active participation, progress, to discuss alternatives if no progress or if progress is rapid and strategy and expectations need to change.

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				strategy.	
EM		x	x	Implement a communication strategy between members of treatment team and others involved in the Individual's care.	Phone calls, emails (not billable unless constructed with Individual's or family's input), written communication (same as emails for billing purposes), meetings with some or all members of treatment team to discuss strategy, implementation, progress, etc. Setting up phone call times – e.g. get a ½ hr commitment from a therapist and go over 3 cases at same time.
EM			x	Consultation with the licensed clinical coordinator on the case.	These are not clinical supervision meetings but consultations about cases that have not progressed, where engagement is difficult, where the Individual is decompensating, etc.
EM	x	x	x	Meetings with the client and their families to determine if they are getting all of the services on the plan as ordered; if not, why not?	Is the plan being appropriately implemented? If not, why not and how does strategy need to change?

F2F: Service can or should be provided face to face with Individual or Individual and their Family
PH: Service can be provided on the phone
C: Service can be a collateral contact that is either by phone or face to face

COLORADO 2009 UNIFORM STANDARDS CODING MANUAL

CASE MANAGEMENT SERVICES	
CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
T1016	Case management, each 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Services designed to assist and support a consumer to gain access to needed medical, social, educational, and other services. Case management includes: • **Assessing service needs** – consumer history, identifying consumer needs, completing related documents, gathering information from other sources; • **Service plan development** – specifying goals and actions to address consumer needs, ensuring consumer participation, identifying a course of action; • **Referral** and related activities to obtain needed services – arranging initial appointments for consumer with service providers/informing consumer of services available, addresses and telephone numbers of agencies providing services; working with consumer/service providers to secure access to services, including contacting agencies for appointments/services after initial referral process; and • **Monitoring and follow-up –** contacting consumer/others to ensure consumer is following the agreed upon service plan and monitoring progress and impact of plan.	• Consumer demographic information • Start and end time/duration • Each contact with and on behalf of consumer • Nature and extent of service • Date and place of service delivery • Mode of contact (telephone/face-to-face) • Issues addressed (adult living skills, family, income/ support, legal, medication, educational, housing, interpersonal, medical/dental, vocational, other basic resources) • Consumer's response • Progress toward service plan goals and objectives • Case Manager's dated signature, degree, title/position • Type of activity and specific functions o **Assessment** (consumer history, identifying consumer needs, completing related documents, gathering information from other sources) o **Service plan development** (specify goals and actions to address consumer needs, ensure participation of consumer, identify course of action) o **Referral** (arranging initial appointments for consumer with service providers/informing consumer of services available, addresses and telephone numbers of agencies providing services; working with consumer/service providers to secure access to services, including contacting agencies for appointments/services after initial referral process) o **Monitoring and follow-up** (contacting consumer/others to ensure consumer is following agreed upon service plan and monitoring progress and impact of plan)
NOTES	**EXAMPLE ACTIVITIES**
Case management involves linking the consumer to the direct delivery of needed services, but is not itself the direct delivery of a service to which the consumer has been referred. Case management does not include time spent transporting the consumer to required services/time spent waiting while the consumer attends a scheduled appointment. However, it does include time spent participating in an appointment with the consumer for purposes of referral and/or monitoring and follow-up.	• Assessing the need for service, identifying and investigating available resources, explaining options to consumer and assisting in application process • Contact with consumer's family members for assistance helping consumer access services

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Exercises:

5 most effective ways of coordinating medical care with remainder of treatment team?

Script to describe CM services : what do clients/ families need to hear?

5 most important activities to successfully transition a child from residential back to their community?

Breaking the cycle of inpatient, crisis, detox –what does CM do to help this?

5 ways a client becomes more independent –how do you measure this?

Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria

In addition to national and local coverage determinations (NCDs and LCDs), there are certain principles that apply to all Medicare claims. These are rooted in the Medicare laws and regulations. By drawing the attention of our provider community to these topics, we anticipate reducing the claim payment error rate and reimbursing for medically necessary services correctly and expeditiously. This is not an all-inclusive list, but it does represent frequent observations from our Medical Review and Medical Policy departments. The focus of this article is on professional services that are usually but not always billed to the carrier (Part B funds) as opposed to the fiscal intermediary (FI – Part A and B funds). However, the principles apply to FI services unless specific differences are noted in the Medicare manuals. We hope that this publication will be useful to our providers and their teams by facilitating the correct filing of claims and the submission of supportive information.

Documentation

General Information

Below are some key points:

• Medicare expects the documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24-48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.

• The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed.

• Every note must stand alone, i.e., the performed services must be documented at the outset. Delayed written explanations will be considered. They serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary.

• If the provider elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter must be documented in the medical record. Generally, the time must be documented when billing for all time-based codes, such as critical care, prolonged services, hospital discharge services, and others.

• All entries must be legible to another reader to a degree that a meaningful review may be conducted. All notes should be dated, preferably timed, and signed by the author. In the office setting, initials are acceptable as long as they clearly identify the author. If the signature is not legible and does not identify the author, a printed version should be also recorded.

Responding to Additional Documentation Request Letters and Requests from the Comprehensive Error Rate Testing Contractor

Although the terminology of these letters may vary, it is important to send all information that will support the claim. For non-laboratory services, this is the billing provider's responsibility, regardless if she or he has created it. For example, when seeking reimbursement for a diagnostic

test, the performing (billing) provider should not only submit the report but also the order and the referring provider's office notes that document the medical necessity for the study. If the information received fails to support the coverage or coding of the claim, in full or in part, the contractor must deny the claim, in full or in part (CMS Online Manual System, Pub. 100-8, Program Integrity Manual, Chapter 3, Section 3.4.1.2A).

There are situations where test reports or other elements of the documentation are housed at a different location from the performing provider's office, for instance an EKG or X-ray read in the hospital. Because it is the performing provider who is required to submit this documentation upon request, it would be best practice if providers kept a copy of this information in their records so that it is readily available. This is a very important issue, as it continues to generate a high error rate in CMS' CERT (comprehensive error rate testing) program and results in numerous recoupments of payments already made.

Cloning of Medical Notes

Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Evaluation and Management Coding

Procedure Code/Diagnosis Code Linking

It is not enough to link the procedure code to a correct, payable ICD-9-CM code. The diagnosis or clinical signs/symptoms must be present for the procedure to be paid.

Volume of Documentation vs. Medical Necessity

The Social Security Act, Section 1862 (a)(1)(A) states: "No payment will be made … for items or services …not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member." This medical reasonableness and necessity standard is the overarching criterion for the payment for all services billed to Medicare. Providers frequently "over document" and consequently select and bill for a higher-level E/M code than medically reasonable and necessary. Word processing software, the electronic medical record, and formatted note systems facilitate the "carry over" and repetitive "fill in" of stored information. Even if a "complete" note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service. Information that has no pertinence to the patient's situation at that specific time cannot be counted.

Shared Visits

Shared visits with non-physician providers (NPPs) may be reported as one visit, if each provider sees the patient separately and each documents separately. Each component of the visit must be medically necessary.

In the office/clinic setting:

• Providers may bill under the physician's provider identification number (PIN), if all "incident to" requirements are met (follow-up visit, direct supervision, etc.).

• The service must be billed under the non-physician provider's PIN if any of the "incident to" requirements are not met (example: new patient and/or physician not in the office suite).

In the hospital inpatient/outpatient/ER setting:

• Providers may bill under the physician's or NPP's PIN if the physician provides any face-to-face portion of the E/M encounter with the patient.

• The services must be billed under the NPP's PIN if there is no face-to-face encounter by the physician.

The medical necessity of a service is the overarching criterion of payment. All interventions must be aimed at benefiting the patient and not only satisfying a billing requirement. It must be apparent that the face-to-face encounter with the physician is medically necessary and benefits the patient (impacts evaluation, treatment, and outcome). Shared visits cannot be reported in the skilled nursing facility (SNF) or nursing facility (NF) settings.

Scribing

If a nurse or non-physician practitioner (PA, NP) acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note "written by xxxx, acting as scribe for Dr. yyyy." Then, Dr. yyyy should co-sign, indicating that the note accurately reflects work and decisions made by him/her.

It is inappropriate for an employee of the physician to make rounds at one time and make entries in the record, and then for the physician to make rounds several hours later and note "agree with above," unless the employee is a licensed, certified provider (PA, NP) billing Medicare for services under his/her own name and number.

Record entries made by a "scribe" should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter documentation requirement. Medicare pays for medically necessary and reasonable services, and expects the person receiving payment to be the one delivering the services and creating the record. There is no carrier Part B "incident to" billing in the hospital setting (inpatient or outpatient). Thus, the scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently, and there is no payment for this activity.

It is acceptable for a physician to use a scribe, but current documentation guidelines must be followed. The physician is ultimately accountable for the documentation, and should sign and note after the scribe's entry the affirmation above that the note accurately reflects work done by the physician.

Provider Qualification

Training and Expertise

CMS Online Manual System, Pub. 100-8, Program Integrity Manual, Chapter 13, Section 5.1 (*http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf*) outlines that "reasonable and necessary" services are "ordered and/or furnished by qualified personnel." Services will be considered medically reasonable and necessary only if performed by appropriately trained providers.

This training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty or must reflect extensive continued medical education activities. If these skills have been acquired by way of continued medical education, the courses must be comprehensive, offered or sponsored or endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States, and designated by the American Medical Association (AMA) as category I credit.

Drugs and Biological Products

General

In order to be covered under Medicare, use of a drug or biological must be safe and effective and otherwise reasonable and medically necessary. The medical reasonableness and necessity of drugs and biologicals are extensively discussed in the Medicare manuals.

First Coast Service Options, Inc. (FCSO) has published numerous local coverage determinations (LCDs) and educational articles about drugs and biologicals, specifically anti-cancer agents. Please refer to these publications for more detailed information. The training requirements listed under "Provider Qualification" apply.

Dosage and Frequency

Drugs or biologicals approved for marketing by the FDA are considered safe and effective when used for indications specified on the labeling. The labeling lists the safe and effective, i.e. medically reasonable and necessary dosage and frequency. Therefore, doses and frequencies that exceed the accepted standard of recommended dosage and/or frequency, as described in the package insert, are considered not medically reasonable and necessary and, therefore, not reimbursable.

Route of Administration

CMS Online Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.1 addresses medical reasonableness and necessity based on the FDA approval and labeling: "Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling." This statement extends to the mode of administration that is considered safe and effective, i.e., medically reasonable and necessary by Medicare's criteria. Furthermore, the CMS Online Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.2 K – Reasonable and Necessary, stipulates that "carriers and fiscal intermediaries will make the determination of reasonable and necessary with respect to the medical appropriateness of a drug to treat the patient's condition. Contractors will continue to make the determination of whether the intravenous or injection form of a drug is appropriate as opposed to the oral form."

Based on the above, for agents administered parenterally, the mode of administration (IV, IM, SQ) must be in keeping with the instructions in the package insert, as approved by the FDA. If a drug is available in both oral and injectable forms and both forms are equally effective, the oral preparation shall be used, unless there is a medical reason not to do so.

Wastage

CMS Online Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 17, Section 40, Discarded Drugs and Biologicals addresses wastage as: "CMS encourages physicians to schedule patients in such a way that they can use drugs most efficiently. However, if a physician must discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug discarded along with the amount administered.

Note: The coverage of discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of drug."

Payment for wastage will only be made when single-use vials have to be utilized. No reimbursement will be made for wastage in the case of multi-use vials.

Place of Service and Patient Safety

In situations when life threatening and other severe adverse reactions could be expected as a result of the administration of certain drugs or the performance of other services, the administration/performance of these services must take place in a facility equipped and staffed for cardiopulmonary resuscitation and where the patient can be closely monitored by qualified personnel for an appropriate period of time based on his or her health status. For specific services, FCSO may proscribe a place of service (POS) by way of an LCD or other publication.

Unit Dose and Decimal Point Errors

The number of billable units may not be equal to the dose administered. For example, if a HCPCS code descriptor calls for 100 mg of a given agent, the number of units for 1000 mg administered would be 10 and not 1000. Similarly, if the descriptor reads 50 mg and 100 mg are administered, the correct number of units to bill is 2.

Diagnostic Tests

Medical Necessity and Documentation

Code of Federal Regulations (CFR), Title 42, part 410.32, specifies that all diagnostic tests must be ordered by a provider who is the treating provider for the patient and who will use the test results in the patient's care (in regards to the treating provider, there may be exceptions for the diagnostic radiologist in certain institutional inpatient or outpatient patient settings). For laboratory tests, additional documentation of medical necessity may be requested of the referring (treating) provider (CMS Online Manual System, Pub. 100-08, Chapter 3, Section 3.4.1.2).

Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary. Like with any service reimbursed by Medicare, to support medical necessity there must be documentation in the medical record as to why a certain modality was chosen/performed. This entire documentation - not just the test report or the finding/diagnosis on the order – must be available to Medicare upon request (please see also under "Responding to

Additional Documentation Request (ADR) Letters and Requests from the Comprehensive Error Rate Testing (CERT) Contractor" in this article).

Portable Diagnostic Equipment

Medicare recognizes that the miniaturization of electronic devices is an on-going trend that may be associated with either improved or diminished test performance. Hand-carried diagnostic equipment ranges in complexity and capability from lightweight pocket-sized units completely contained within the examiner's hand, to complex equipment systems where only a part, such as the ultrasonic probe itself, is hand-held. The appropriate assignment of a specific ultrasound CPT code is not solely determined by the weight, size, or portability of the equipment, but rather by the extent, quality, and documentation of the procedure. To be reimbursable by Medicare, a diagnostic ultrasound test must meet at least these minimum criteria (this is not an all inclusive list):

• It must be medically reasonable and necessary for the diagnosis or treatment of illness or injury.

• It should be done for the same purpose as a reasonable physician would order a standard ultrasound examination.

• It must be billed using the CPT code that accurately describes the service performed.

• The technical quality of the exam must be in keeping with accepted national standards and not require a follow-up ultrasound examination to confirm the results.

• The study must be performed and interpreted by qualified individuals.

• The medical necessity, images, findings, interpretation and report must be documented in the medical record.

Purchased Interpretations

According to the CMS Online Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 1, Section 30.2.9.1 "A person or entity that provides diagnostic tests may submit the claim, and (if assignment is accepted) receive the Part B payment, for diagnostic test interpretations which that person or entity purchases from an independent physician or medical group if:

• The tests are initiated by a physician or medical group, which is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations;

• The physician or medical group providing the interpretations does not see the patient; and

• The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. No formal reassignment is necessary."

Furthermore, it is noted in the Final Rule of 2005 that "Arrangements involving reassignment must not violate any other applicable Medicare laws or regulations governing billing or claims submission, including, but not limited to, those regarding "incident to" services, payment for purchased diagnostic tests, and payment for purchased test interpretations."

Consequently, a provider who initiates (orders) a test cannot purchase the interpretation and bill it to Medicare as professional component. For example, if a physician or a group perform testing on their patients with their own ultrasound equipment, and a radiologist, who is not a member of the practice, reads the tests, the group can bill only for the technical component (modifier TC). The radiologist must bill Medicare separately for the interpretation (professional component, modifier 26).

Source: Eugene J. Winter, M.D., Medical Director for First Coast Service Options, Inc.

Competency and Skills Determination Form for Case Managers in North Carolina

The State of North Carolina requires that all persons providing Targeted Case Management Services to Individuals with serious mental illness, emotional disturbance, or substance abuse be competent in certain areas critical to their performance as a case manager for these populations.

Employee Name/number:

Directions for completing this form.

Employees:

1. The following chart lists each area of competency/ skill required. For each area the employee must have a supervisor sign-off that their competency in this area has been determined using one of the methods listed below.
2. Completion of the form is the responsibility of the individual employee. It is expected that the individual and their clinical supervisor will work together to determine how each area of competency will be determined and how opportunities for demonstrating competency will be provided.
3. All areas of competency should have been verified no later than _____ months/year from the first date of employment.
4. Once completed the chart should be turned into Human Resources who will file the form with other information in the employee's personnel file.
5. Employees who do not complete the form within the time period listed in #3 above will be subject to disciplinary actions.

Supervisors:

1. You are expected to meet with each individual case manager within the first 30 days of their employment to explain the "Competency and Skills" evaluation form and how you will work with them to help them complete the requirements.
2. Competency/skills can be determined by supervisors and managers other than the direct supervisor of the employee and opportunities should be made available for employees to be evaluated by other eligible managers and supervisors.
3. The following methods may be used by evaluators to verify the competency and skill of the case manager in each of the required areas:
    a. Direct observation
    b. Clinical supervision: discussion, role-play, etc.
    c. Chart review
    d. Peer review
    e. Discussion/Study Groups
    f. Case presentation
    g. Attendance at a training: note if post-test given on course content
    h. Other: please describe method

Competency and Skills Determination Form for Case Managers in North Carolina

Name of Employee: Employee #:

Credential/License:

Date of employment: Date form should be completed:

Populations the Case Manager will be working with: please check all that apply.

Individuals with:	Serious Mental Illness/Emotional Disturbance	Serious Substance Use Disorders	Co-occurring Substance Use and Mental Health Disorders	Women who are Pregnant
Adults				
Adolescents				
Children				
Families				

For each area assessed enter:

- **Case # if the competency skill assessed in relation to a specific Individual,**
- **List number of method used. If 8 or "Other" is entered, describe method in comments**
- **Enter signature and date**
- **In comments area enter any additional pertinent information, e.g. "really confident" , training post-test passed, excellent documentation, etc.**

Assessment Competencies and Skills

1. Competency: Knowledge of available formal and informal assessment resources in the state

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

2. Competency: Knowledge of the population/disability/culture of the recipients being served

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

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3. Skill: Apply interviewing skills such as active listening, supportive responses, open and Closed -ended questions, summarizing, and giving options

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

4. Skill: Collect all recent and relevant clinical and medical assessment and evaluation reports, integrating the findings, results and recommendations to form the basis of the recipient's individualized plan of care; engage recipients and families to elicit and gather, and integrate other pertinent information

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

5. Skill: Recognize indicators of risk (health, safety, mental health/substance abuse)

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

6. Skill: Gather and review information through a holistic approach, giving balanced attention to individual, family, community, educational, work, leisure, cultural, contextual factors, and recipient preferences

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

7. Skill: Consult other professionals and formal and natural supports in the assessment process

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

Competency and Skills Determination Form for Case Managers in North Carolina

8. Skill: Discuss findings and recommendations with the recipient in a clear and understandable manner

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

Person Centered PLANNING Competencies and Skills

1. Competency: Knowledge of The values that underlie a person-centered approach to providing service to improve recipient functioning within the context of the recipient's culture and community

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

2. Competency: Knowledge of models of wellness-management and recovery

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

3 .Competency: Knowledge of biopsychosocial approaches to serving and supports individuals, and evidenced based standards of care

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

4 .Competency: Knowledge of processes used in a variety of models for group meetings to promote recipient and family involvement in case planning and decision-making.

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

Competency and Skills Determination Form for Case Managers in North Carolina

5. Competency: Knowledge of Interventions appropriate for assessed needs

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

6.Skill: Identity and evaluate a recipient's existing and accessible resources and support systems

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

7.Skill: Develop an individualized care plan with a recipient and his or her supports based on assessment findings that includes measurable goals and outcomes

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

LINKING/REFFERING Competencies and Skills

1.Competency; Knowledge of community resources such as medical and behavioral health programs, formal and informal supports, and social service, educational, employment, and housing resources

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

2. Competency: Knowledge of current laws, regulations, policies surrounding medical and behavioral healthcare

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

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3...Skill: Research, develop, maintain, and share information on community and other resources relevant to the needs of recipients

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

4.Skill: Maintain consistent, collaborative contact with other health care providers and community resources

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

5.Skill: Facilitate the recipient's transition into services in the care plan in order to achieve the outcomes derived for the consumer's goals

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

6..Skill: Assist the recipient in accessing a variety of community resources

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

MONITORING/FOLLOW Competencies and Skills

1 .Competency: Knowledge of outcome monitoring and quality management

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

Competency and Skills Determination Form for Case Managers in North Carolina

2. Competency: Knowledge of wellness-management, recovery, and self-management

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

3. Competency: Knowledge of community consumer-advocacy and peer support groups

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

4.Skill: Collect, compile and evaluate data from multiple sources

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

5.Skill: Modify care plans as needed with the input of recipients, professionals, and natural supports

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

6.Skill: Monitor the motivation and engagement of the recipient and his or her supports

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

7.Skill: Encourage and assist a recipient to be a self-advocate for quality care

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

Competency and Skills Determination Form for Case Managers in North Carolina

Professional Responsibility

1.Competency: Knowledge of the importance of ethical behavior, the potential impact of unethical behavior on the recipient, and the potential consequences of violating ethical expectations

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

2.Competency: Knowledge of quality assurance practices and standards

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

3.Competency: Knowledge of confidentiality regulations

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

4. Compentency: Knowledge of required performance standards and case management best practices

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

5. Competency: Knowledge of definitions and fundamental concepts of culture and diversity

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

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6.Competency: Awareness of origins and tenets of one's personal value system, culture background, and beliefs; understands how this may influence actions and decisions in practice

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

7.Competency: Knowledge of differences in culture and ethnicity of recipients served

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

8.Skill: Use critical thinking skills and consultation with other professionals to make ethical decision and conduct ethical case management

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

9.Skill: Form constructive, collaborative relationships with recipients of various cultures and use effective strategies for conducting culturally-competent case management

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

10.Skill: Discern with whom protected health information can be shared

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

Competency and Skills Determination Form for Case Managers in North Carolina

11.Skill: Communicate clearly, both verbally and in writing

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

12.Skill: Discern when the severity of problems is beyond the case manager's skill or responsibility, and when referrals to other professionals are necessary

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

13.Skill: Identify areas for self improvement, pursue necessary education and training, and seek appropriate supervision

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

Targeted Case Managers specializing in working with pregnant women must have knowledge of the following:

1.Competency: Knowledge of pregnancy, delivery, and post-partum period

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

2. Compentencyl: Knowledge of medical conditions or histories that may complicate pregnancy

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

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3.Compentency: Knowledge of how substances including alcohol, prescription and nonprescription medications, and illicit drugs effect the fetus

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

4.Competency: Knowledge of signs and symptoms of pre-term labor

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		

5.Compentency: Knowledge of signs and symptoms of post-partum complications

Case #	Method:	Date and Signature:	Case #	Method	Date and Signature:
Comments:			Comments:		