TARGETED CASE MANAGEMENT

Services
1. Ensure individuals receive timely access to psychiatric services and appropriate levels of psychiatric monitoring and participation in treatment planning based on individuals’ needs. Provide more frequent contacts during periods of instability.
2. Coordinate psychotropic medication for 30 days after discharge unless a subsequent service provider assumes this responsibility.
3. Provide psychotropic medications for individuals discharged from Psychiatric Inpatient or Crisis Residential services. Network180 provides payment for psychotropic medications for the first 30 days after discharge when inpatient services are authorized by Network180 for persons not on Medicaid who have not met the monthly Medicaid spend down amount, or are without other insurance coverage.
4. Case Managers will respond within 10 minutes to an Access Center request for a return phone call.
5. Case Managers are expected to provide clinical triage, crisis support, and face-to-face assessment during after-hours, weekends and holidays. When the Access Center determines that a face-to-face intervention is required, Case Managers will respond to the request in person within one hour. Case Managers will notify the Access Center of the resolution of the intervention.
6. The Case Manager may provide transportation if it is otherwise unavailable, or if it can be documented to be therapeutically beneficial. When the Case Manager is providing transportation to health-related services, and is providing a case management service linked to the individual’s individual plan of service (IPOS), only the time the allowable service is provided can be billed.
7. Provide discretionary funds necessary to meet the individual’s treatment specific needs, including but not limited to the cost of medications for individuals with no insurance. Network180 does not reimburse for the cost of medications for Medicaid-insured or commercially insured individuals with prescription coverage. Providers can utilize multiple strategies to ensure medication access for individuals including, but not limited to: development of a formulary or adherence to the Network180 formulary, accessing free or reduced medications through pharmaceutical company patient assistance programs and referrals to community resources.
8. Provide assistance with acquisition and retention of public benefits, including Medicaid and Medicare insurance, Social Security, DHHS Home Help Services, food assistance, etc. It is the responsibility of the Case Manager to understand the funding source of the individual being served as well as the benefit available for services in order to coordinate care and work within the specified benefit.
9. Transition or Transfer of Individuals.
   a. Transfer of individuals from one provider to another, or transitioning individuals from one service to another with the same provider must be initiated using the Targeted Case Management Interagency Transfer Request Form, or the Targeted Case Management Transitional Authorization Request Form, following the process identified in the Authorization section below.
b. Individuals shall not be transferred during periods of instability, such as hospitalization or housing crisis.

c. Provider may request higher intensity ACT services for an individual. Direct referral to the ACT Provider will be made for review of medical necessity.

10. Coordinate intensive services. Complete assessment and admission for Psychiatric Inpatient Hospitalization, Partial Hospitalization, and Crisis Residential admissions. Request authorization for these services through the Network180 Access Center, as determined by the individual’s benefit.

a. All step-down admissions from Inpatient to Crisis Residential or Partial Hospitalization must receive prior approval from the Network180 Utilization Management (UM) Department, as determined by the individual’s benefit.

11. Individuals must work with his/her benefit for acute psychiatric crisis services. This includes individuals with Medicare, Medicaid and other private insurance policies. Network180 will fund acute psychiatric crisis services for individuals with Medicaid and those without insurance. It is the responsibility of the case manager to understand the funding source of the individual being served as well as the benefit available for acute psychiatric crisis services in order to coordinate care and work within the specified benefit.

12. Participate in discharge planning for individuals during an Inpatient or Partial Hospitalization, SUD Intensive Stabilization or Crisis Residential admission.

13. Case Managers will make telephone contact with the program discharge planner within one business day following the date of admission for, or receipt of, a new authorization for Targeted Case Management services from the Network180 Access Center or UM Department.

14. Case Managers will make a minimum of one in-person visit to the program (programs in Kent County only) for the purpose of discharge planning with the individual and program staff within two business days following the date of admission for existing consumers, and within three business days for engagement and discharge planning with new referrals from the Access Center or UM Department.

15. Continue to make telephone contact with program discharge planners throughout the individual’s admission as appropriate to assist in discharge planning.

16. Participate in inpatient treatment team meetings in person, or by telephone if requested, and relay content of meetings to other care providers (e.g., agency psychiatrist). For individuals who are hospitalized in a facility outside of the community for more than ten days, it is expected that Case Managers will participate in more frequent treatment team meetings each week.

17. Provide follow-up after discharge from Inpatient or Partial Hospitalization, Crisis Residential, SUD Intensive Stabilization or the Jail:

a. Conduct a face-to-face visit with the individual within seven business days of discharge. This follow-up visit can be conducted by the Case Manager, Therapist, Nurse, or Supports Coordinator. During this visit, the individual will be assisted in adhering to his or her discharge plan and receive supports to prevent readmission.

b. All individuals who discharge from a substance abuse detoxification unit must be seen for follow-up within seven days.

18. Provider is responsible for consistent collaboration with Professional Consulting Services (PCS) when the individual receiving services is associated with the Prisoner Reentry Mental Health Program.

   Professional Consulting Services
   Craig Judd
   Kathlene LaCour
   Phone: 269-929-1292
   Fax: 269-965-5267

19. Report location of service delivery in progress/case notes and ensure place of service code is accurately reflected on all claims submissions.
20. Claims for services provided in a correctional facility must be submitted using the QJ modifier and are billable for face-to-face services. The place of service code is “09.” Incarcerated individuals receiving Targeted Case Management Services who are sentenced to prison shall be terminated from services.

21. Provide Targeted Case Management services in a psychiatric or medical hospital, or in a temporary nursing home placement, if the Case Manager is working on planning for mental health needs at discharge with the individual. Face-to-face contacts meeting the “for discharge planning” criteria may be reported to Network180 for payment/encounter reporting. Discharge planning activity must be clearly documented in the individual’s record. Use place of service codes “21” for a medical hospital, “51” for a psychiatric inpatient hospital, and “31” or “32” for skilled or nursing facility.

22. Provider may request higher intensity ACT services for an individual. Direct referral to the ACT Provider will be made for review of medical necessity.

**Behavioral Health Home Model**

The Behavioral Health Home model will be utilized to provide Targeted Case Management services in the Network180 provider system. Targeted Case Management delivered in the Behavioral Health Home model is a medically necessary service designed to assist individuals who have a serious mental illness or co-occurring behavioral disorder (mental health or substance use) to develop and implement strategies for obtaining strengths-based and individualized services and supports identified through a person-centered planning process. Behavioral Health Home services are designed to increase access, care coordination, and continuity of care. Behavioral Health Home programs must be accredited or in the process of obtaining accreditation as a Behavioral Health Home through CARF or an alternative organization that offers a Health Home accreditation.

Behavioral Health Home providers must provide individual and group psychotherapy, as clinically necessary, and as specified in the individual plan of service (IPOS). Provider must refer out for these services to another provider in the Network180 system of care if needed. Therapy services may not be provided by an individual’s Case Manager.

**Supplemental Behavioral Health Home Services**

Behavioral Health Homes must:

1. Provide same-day appointments.
2. Conduct a weekly, at minimum, interdisciplinary huddle to review complex individuals and those who are scheduled for new or routine medication management services.
3. Provide timely clinical advice by telephone during and outside of regular office hours, and must document telephonic advice in the electronic health record.
4. Provide access to routine and urgent-care appointments outside regular business hours, including providing continuity of health record information for care and advice when the office is not open and documenting after hours care in the electronic health record.
5. Have a process and materials that are provided to individuals/families on the role of the Behavioral Health Home, including the following:
   a. The Behavioral Health Home is responsible for coordinating care across multiple settings.
   b. Instructions on obtaining care and clinical advice during office hours and when the office is closed.
   c. The Behavioral Health Home functions most effectively as a Health Home if individuals/families can provide a complete health history and information about care obtained outside the Behavioral Health Home.
   d. The care team gives the individual/family access to evidence-based care and self-management support.
6. Behavioral Health Homes must provide a range of care services for individuals by:
a. Defining roles for clinical and nonclinical team members.
b. Having regular team meetings and communication processes.
c. Training and assigning care teams to coordinate care for individuals.
d. Training and assigning care teams to support individuals/families in self-management, self-efficacy, and behavior change.
e. Training and assigning care teams for individual population management.
f. Training and designating care team members in communication skills.


8. Behavioral Health Home must use electronic information to generate lists of individuals served and take action to proactively remind individuals or clinicians of services needed, including but not limited to:
   a. Individuals needing pre-visit planning.
   b. Individuals needing clinician review or action.
   c. Individuals taking a particular medication.
   d. Individuals needing reminders for preventative care.
   e. Individuals needing reminders for specific tests.
   f. Individuals needing reminders for follow-up visits such as for a chronic condition.
   g. Individuals who might benefit from a care management support.

9. Behavioral Health Homes must use electronic information to manage the population health of their program, including but not limited to:
   a. Using criteria and a systematic process to identify high-risk or complex individuals.
   b. Determining the percentage of high-risk or complex individuals in its population.
   c. Developing or implementing targeted interventions for high-risk or complex individuals.
   d. The care team performs the following for individuals served:
      i. Conducts pre-visit preparations.
      ii. Collaborates with the individual/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit.
      iii. Gives the individual/family a written plan of care.
      iv. Assesses and addresses barriers when the individual has not met treatment goals.
      v. Gives the individual/family a clinical summary at each relevant visit.
      vi. Identifies individuals/families who may benefit from additional care management support.
      vii. Follows up with individuals/families who have not kept important appointments.

10. The practice conducts the following activities to support individual self-management:
    a. Assesses individual preferences, readiness to change, and self-management abilities using PAM-13 and E-coaching tools.
    b. Provides educational resources in the language or medium the individual understands.

11. The Behavioral Health Home coordinates referral among health care providers by:
    a. Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information.
    b. Providing and tracking referrals provided to individuals/families for health care services and other community resources.
    c. Following up to obtain a specialist’s report or communication.
    d. Establishing and documenting agreements with specialists in the electronic health record if co-management is needed.
    e. Asking individuals/families about self-referrals and requesting reports from clinicians.

12. The Behavioral Health Home, on its own, or in conjunction with an external organization, engages in the following activities for individuals who receive care in inpatient or outpatient facilities, or individuals who are transitioning to other care:
    a. Identifies individuals who receive care in facilities (hospitals or crisis residential).
    b. Systematically sends clinical info to facilities as soon as possible.
c. Reviews information from facilities to identify individuals who require proactive contact outside of individual initiated visits or who are at risk for adverse outcomes.

d. Contacts individuals after discharge from facilities within 24 business hours.

e. Provides or coordinates follow up care to individuals who have been discharged from facilities within 24 business hours.

f. Coordinates care with individuals/families receiving ongoing disease management.

g. Communicates with individuals receiving ongoing disease management.

h. For individuals transitioning to other care, develops a written transition plan in collaboration with the individual.

i. Aids in identifying a new primary care physician or specialists and offers ongoing consultation.

13. Behavioral Health Homes will gather and share data related to development and evaluation of the Behavioral Health Home Model, as well as development of data-driven models of care, including but not limited to:

a. Behavioral Health Homes will administer the VR-12 survey every six months or as indicated by the evaluator. The first survey will serve as a baseline measurement and must be administered for all individuals in the health home during the first quarter of the fiscal year.

b. Behavioral Health Homes will administer the PAM-13 survey tool every six months, or as indicated by the evaluator, to measure individuals’ capacity to self-manage care. The first survey will serve as a baseline measurement and must be administered for all individuals in the health home during the first quarter of the fiscal year.

c. Behavioral Health Homes will submit data from their electronic health records as requested to be merged with Network180 data for the development of data dashboards to support population and disease management.

Utilization of Peers

1. Provision of peer supports is highly encouraged as part of the Targeted Case Management team.

2. Services must follow all applicable regulations and requirements set forth in the Additional Mental Health Services (B3s): Peer Specialist Services section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the Medicaid Provider Manual.

3. The intent of peer support services is for individuals employed in this capacity to function as an equal on the team, and from the unique perspective of having lived experience, in order to directly contribute to meeting the needs of individuals receiving Targeted Case Management services through Network180’s system of care. Underlying all peer support activities is the intent to promote positive outcomes in independence, community inclusion, and productivity for the individual served, and ongoing recovery for the individual providing peer supports.

4. Provider shall ensure team members are educated regarding the value and potential contribution to the team and well-being of the individual served that can be provided by individuals with lived experience. Team members shall be encouraged to utilize the services of peers as appropriate.

5. Provider shall encourage individuals providing peer supports to obtain certified peer support specialist certification within the first two years of employment. Provider is encouraged to allow ongoing training and education for individuals providing peer supports.

6. Provider shall ensure supervisors have received education on supervision of individuals providing peer supports. Regular support and/or education may be beneficial in order to provide effective supervision and support of individuals with lived experience.

7. Provider shall provide regular 1:1 supervision of individuals providing peer supports.

8. Provider shall allow individuals providing peer supports, as part of their paid work day, to attend internal and/or external groups whose purpose is to provide support and a sense of community for individuals providing peer-delivered services.
9. Provider shall ensure guidelines are in place to effectively support individuals providing peer supports who are experiencing, or are at risk of experiencing, mental health crisis.

**Access and Authorization**

1. The Network180 Access Center or Utilization Management (UM) Department will determine eligibility for Targeted Case Management services according to the Medical Necessity Criteria section of the Medicaid Provider Manual.

2. Following Network180 eligibility determination, Network180 staff will complete the referral process to Provider. In most cases the initial authorization will be performed through an in-person contact. An in-person contact may not be required in certain circumstances, including but not limited to the following:
   a. State Psychiatric Facility discharges
   b. Transfer between Network180 provider agencies
      i. In the event of a transfer between Targeted Case Management providers, the current provider will fax a Targeted Case Management Interagency Transfer Request form to the Access Center. A discharge date will be entered in the Network180 system for the existing program and a new authorization will be created and faxed to the new provider. Services will not be transferred without mutual clinical agreement on the timing of the transfer and the clinical circumstances involved with the case.

3. Individuals must receive a face-to-face meeting with a professional within 14 calendar days of non-emergent request for services. In the time period between an initial referral from the Access Center or UM Department and the intake appointment with Provider, the Access Center is responsible for service. Provider assumes responsibility after the individual signs the agency’s consent for treatment.

4. If Provider does not open the case, Provider must send discharge information to the Access Center.

5. Provider will send all discharge summaries to the Access Center. The Access Center will enter discharge dates based on the date the summaries are received by the Access Center to maintain an accurate authorization database for the Network180 system.

**Referral Process**

1. Provider will supply a standard schedule for Targeted Case Management intakes to the Network180 Access Center via the SharePoint scheduling site.

2. The Access Center or UM Department will schedule the intake appointment based on the intake schedule provided.

3. Access Center clinicians or Utilization Review (UR) Specialists will provide the individual’s name, Network180 case number, and any comments associated with the referral on the schedule.

4. Intake appointments will be scheduled at least 48 hours after the individual has been authorized for services, unless otherwise specified by Provider.

5. Individuals referred will be given Provider’s contact information and the individual’s scheduled intake appointment time.

6. Provider will access all the referred individual’s clinical records via the Network180 EHR.

**Reauthorization**

1. The Network180 UM Department will determine reauthorization for Targeted Case Management services. The reauthorization determination will be based on whether the individual continues to meet medical necessity for services. Reauthorization episodes will not exceed 12 months, and will be supported by the current IPOS, which documents medical necessity for continuation of scope, duration, and intensity of services.

2. The request for reauthorization must be submitted 14-30 days prior to the expiration of the current authorization.
3. A reauthorization request shall be submitted on the Targeted Case Management Reauthorization Request Form. Additionally, Provider will verify and document the individual’s eligibility for Network180 services by providing updated demographic and financial status (including Ability to Pay) information to the Network180 Reimbursement Unit.

Utilization Management Review Process
1. Network180 will notify Provider of reauthorization requests to be reviewed by the Network180 UM Department.
2. The request will be reviewed by a Utilization Review (UR) Specialist. All relevant documentation supporting medical necessity for the service must be included in the request. If medical necessity for the service is supported by the documentation submitted, the UR Specialist will enter the authorization as requested.
3. If the documentation provided does not support medical necessity for the service being requested, or if documentation does not support the amount, scope or duration of the request, the UR Specialist will notify Provider of the decision on the Service Authorization Review Form and, if applicable, authorize the service based on the amount, scope or duration determined by the reviewer.
4. Network180 will send Notice of Action and appeal information to the individual or guardian as appropriate. Provider shall be available to the individual or guardian to discuss the rationale for the authorization decision, assist with other options as suggested, and, if requested, provide assistance with filing a local appeal and/or requesting a Medicaid Fair Hearing.

Rapid Readmission
1. The rapid readmission procedure will be effective for any eligible individual up to 90 days after discharge from Provider. Provider will develop utilization procedures to ensure individuals who are in need of service and eligible for care are not prematurely discharged.
2. Provider discharge summary will indicate whether individuals are “eligible” for readmission to the agency. The discharge summary will be forwarded to the Access Center and included in the individual’s case record.
3. If an individual presents at the Access Center within 90 days after discharge, and meets medical necessity for Targeted Case Management services, a new authorization for Targeted Case Management services will be created. The individual will be given an appointment per the Referral Process section. No other documentation is required.
4. If an individual contacts Provider within 90 days after discharge requesting readmission to Targeted Case Management services, Provider will complete an in-person assessment to determine if the individual continues to be eligible. If Provider believes the individual meets medical necessity for Targeted Case Management services, the individual will be readmitted immediately. Provider will inform the Access Center and a new authorization will be created. If Provider believes the individual is no longer eligible, the individual must be screened at the Access Center to determine the appropriate level of care.
5. If the individual contacts or presents to Provider after 90 days of discharge, the individual will be directed to the Access Center for screening and determination of eligibility.

Acute Readmission
1. For individuals who meet rapid readmission parameters and are in need of intensive services weekdays between 8:00 a.m. through 5:00 p.m., Provider will admit the individual and re-open the case immediately to provide discharge planning.
2. For individuals who meet the rapid readmission parameters and are in need of intensive services after 5:00 p.m. or on weekends, the Access Center will admit the individual. It is expected that Provider will assume the treatment, and discharge planning the next business day in the hospital.
StreetReach

The purpose of the StreetReach program is to promote recovery among individuals who meet the federal definition of chronic or episodic homelessness, and who have a serious mental illness or co-occurring serious mental illness and substance use disorder. The program will provide outreach, engagement, and treatment to individuals who are not otherwise being served by the public mental health system. Services are intended to help link individuals to mental illness and substance use disorder treatment within the Network180 system of care, provide assistance with public benefits acquisition, and provide housing supports to help individuals sustain housing. Contingent on MDHHS funding from the PATH grant, Provider must integrate contractual PATH activities into the StreetReach program. Providers of this service must comply with all Targeted Case Management for Adults with Mental Illness requirements, except as noted below.

Access and Authorization

1. StreetReach is an “open access program. Provider must complete the Demographic Intake Form and Financial Status Report and fax the forms to the Network180 Reimbursement Unit, along with a copy of the signed Network180 System Wide Release of Information.
2. Initial authorizations for StreetReach services will be for 12 months.

Reauthorization

1. Network180 will enter the reauthorization for StreetReach services. Reauthorization episodes will not exceed 12 months and will be supported by the current IPOS, which documents medical necessity for continuation of scope, duration, and intensity of services.
2. Reauthorization requests must be submitted 30 days prior to the expiration of the current authorization.
3. A reauthorization request shall be submitted on the StreetReach Reauthorization Request Form. Additionally, Provider will verify and document the individual’s eligibility for Network180 services by providing updated demographic and financial status (including Ability to Pay) information to the Network180 Reimbursement Unit.

TARGETED CASE MANAGEMENT FOR CHILDREN AND FAMILIES

In addition to the requirements specified in the Lakeshore Regional Entity Attachment A: Service Description for Targeted Case Management, Providers of this service must adhere to the following requirements.

Services

1. Targeted Case Management Provider must also provide Home-Based Services. This is necessary to allow for a smooth transition of care between Home-Based Services and Targeted Case Management, minimizing the impact of change experienced by families.
2. Providers of Targeted Case Management services can directly provide Respite, Community Living Supports, Parent Management Training-Oregon Model (PMTO), Trauma Focused CBT, and Prevention Groups upon Network180 approval. Being an approved Targeted Case Management Provider allows the delivery of these services referenced above if staff are appropriately credentialed and trained to provide the services.
3. Provider is expected to maintain a 1:8 ratio of supervision.
4. It is the expectation that face-to-face contact is based on the needs of the family. Families must have a minimum of quarterly face-to-face contact with required monthly phone calls.
5. Provider must have the ability to submit CAFAS/PECFAS electronically at admission, every three months, and at discharge.
6. Provider will be expected to use a CQI process between supervisors and staff completing the CAFAS/PECFAS to ensure consistency and accuracy.

7. Integrate Community Living Supports (CLS) services into treatment. This must be clearly documented in the IPOS. CLS Services must be provided in accordance to the Lakeshore Regional Entity Attachment A: Service Description for Community Living Supports Services.

8. Coordinate Respite Services and successfully manage allotted budget amounts. Respite Services must be provided in accordance to the Lakeshore Regional Entity Attachment A: Service Description for Respite Services.

9. Provider must have crisis intervention availability 24 hours a day, 7 days a week.

10. Provider will help coordinate access to psychiatric services within 30 days of identified need. This includes access through the qualified health plan, primary care physician or through the agency psychiatrist.
   a. Psychiatric coverage will remain the responsibility of the referring provider for up to 30 days post discharge.

11. Coordinate services with the primary health care provider using the Notification/Coordination with Primary Care Physician form. Coordination with the primary health care provider will include documentation of diagnosis and medications if applicable, and will occur ongoing as needed.

12. Complete the Child Health and Developmental Screening form.

13. Provider must coordinate other medically necessary services they are not currently contracted to provide.

14. If the child is in foster care, Provider must coordinate with foster care agency a minimum of once monthly, document this contact using the Foster Care-Therapist Coordination Form, and keep a copy of it in the child’s file.

   a. Provider must have face-to-face contact with the child if receiving any of the above mentioned services when the length of stay is greater than or equal to three days.
   b. Provider must have face-to-face contact with the child within seven days following discharge from the above mentioned services.

16. Update demographics, financials, and health measures when a significant change occurs, or minimally annually.

17. Family Skills Training:
   a. A Family Skills training encounter is expected to be a minimum of 45 minutes.
   b. If meeting monthly with the family, no more than one Family Skills training encounter can be utilized per month.
   c. The expectation is that when a Family Skills encounter is delivered in a month, there may not be more than four units of Targeted Case Management delivered.
   d. If meeting quarterly with the family, no more than one Family Skills Training encounter can be utilized per quarter. A Family Skills encounter cannot be used in place of meeting with the family quarterly.

18. Billable Activity:
   a. Provider cannot bill during a monthly probation meeting.
   b. Provider cannot bill during a court hearing. Services provided to the child/family before/after the court hearing are billable.
   c. Provider cannot bill for attendance at an IEP meeting. Provider may bill during a school meeting if the school meeting is used for behavior planning, clinical support, and sharing information to better serve the child. Provider will need to ensure the school is not billing Medicaid for that time as well.
   d. Provider cannot bill for attending a psychiatric assessment, medication review or medical appointments.
   e. Provider cannot bill time in the detention facility.
f. Provider can bill when visiting a child who is receiving Psychiatric Inpatient services. The notes must reflect discharge planning and returning to the community.
g. Provider may bill during crisis assessments. Provider can bill for the time they are actively providing clinical service such as stabilizing and assessing. Time spent coordinating with the hospital, coordinating transportation, and other coordinating functions is considered indirect non-billable time.

19. If the child/family is seeking placement in a residential setting, or the child is placed in a residential setting, Provider is responsible for following the guidelines set forth in the Out of Home Placement referral and requirement documents.

20. If a child is placed in Hawthorn, Provider must:
   a. Orchestrate the admission with the family.
   b. Maintain weekly contact with the Hawthorn therapist.
   c. Provide a weekly email update to the Child and Family Ombudsperson referencing psychiatric stabilization and discharge planning.
   d. Maintain contact with the family and plan for discharge to the family home.

Access and Authorization
1. Individuals seeking Targeted Case Management services through the public mental health system must access these services through the Network180 Access Center or Kent School Services Network (KSSN) screening site if a youth attends a KSSN school.
2. The Access Center or KSSN screening site will authorize an appropriate level of service based on:
   a. The results of an in-person clinical screening, and
   b. Collaboration with the child/family in accordance to person/family-centered planning principles.
3. A child/family requesting a screening for eligibility must be seen within 14 days from the request for service.
4. The child/family will be given the opportunity to choose from the available provider panel.
5. Initial authorization to Targeted Case Management will be for six months with 72 15-minute units.
6. KSSN screening sites will fax the KSSN Authorization Fax Cover Sheet, KSSN Behavioral Health Care Plan, and Demographic Intake and Financial Intake Forms to the Network180 Reimbursement Unit. An authorization will be faxed to Provider.
7. If requesting services for a sibling of an authorized child, the Sibling Services Brief Screening Form and Demographic Intake and Financial Intake Forms must be included with the request for services. The Network180 Utilization Management (UM) Department will review the authorization request and authorize as appropriate.

Reauthorization
1. Network180 will determine reauthorization for Targeted Case Management services. The reauthorization determination will be based on the following criteria:
   a. Child/family has consistently utilized Targeted Case Management services face-to-face at least monthly through the authorization period.
   b. There is a clear and defined need for Targeted Case Management services with identified goals and plan for the use of Targeted Case Management in supporting and/or stabilizing the family.
   c. A recent significant Targeted Case Management related event has occurred that requires short term support to stabilize the child/family (e.g., lost housing, recent expulsion, mental health crisis).
2. The request for reauthorization must be submitted 14 to 30 days prior to the expiration date of the current authorization. Supervisors are required to sign off on this request.
3. The reauthorization request must be submitted on the In-Home Services Reauthorization Request Form and accompanied by the most recent quarterly report.
4. At the time of the reauthorization request, Provider will verify and document the individual's eligibility for Network180 services by providing updated Demographic Intake and Financial Intake Forms (including Ability to Pay) to the Reimbursement Unit, and documenting medical necessity to the UM Department. All relevant documentation supporting medical necessity for the service must be included in the request.

5. Reauthorization will be given for at least one month with eight 15-minute units but not more than three months with 24 15-minute units.

**Utilization Management Review Process**

1. The request for reauthorization will be reviewed by a Utilization Review (UR) Specialist. If medical necessity for the service is supported by the documentation submitted, the UR Specialist will enter the authorization as requested and fax the authorization to Provider using the electronic health record electronic faxing system.

2. If the documentation provided does not support medical necessity for the service being requested, or if documentation does not support the amount, scope or duration of the request, the UR Specialist will notify Provider of the decision on the Service Authorization Review Form, and, if applicable, authorizes the service based on the amount, scope or duration determined by the reviewer.

3. Network180 will send Notice of Action and appeal information to the individual or guardian as appropriate. Provider shall be available to the individual or guardian to discuss the rationale for the utilization decision, assist with other options as suggested, and, if requested, provide assistance with filing a local appeal and/or requesting a Medicaid Fair Hearing.

**Discharge**

1. The discharge date must be submitted to the Network180 Access Center within seven calendar days of discharge from service.

2. The Network180 Access Center will enter the discharge date based on the information given by Provider.

3. Provider will submit discharge CAFAS data electronically.

4. Upon discharge, Provider will give the family the Parent Guide to Re-accessing Network180 Services.

5. Provider will send all discharge summaries to the Access Center within 30 calendar days of discharge from Targeted Case Management.

6. The discharge summary shall provide discharge recommendations. If Provider is recommending less intensive services or other community service, discharge recommendations shall include the service, the service provider, and the appointment date/time.

7. These services are expected to be moderate in duration to stabilize the family situation and set up services as necessary.
   a. It is anticipated that cases will be discharged when clinically appropriate, including prior to the expiration of the initial authorization.
   b. It is anticipated 85% of cases authorized will be successfully discharged from services by the expiration of the initial authorization.

**Specialized Family Case Management**

The purpose of this program is to provide Targeted Case Management services to children under the age of 18 who have both an intellectual/developmental disability and a serious emotional disturbance. The primary goals of the program are to (1) provide comprehensive service addressing mental health and intellectual/developmental disability issues that will promote normal development and healthy family functioning; (2) support and preserve families; (3) reunite families who have been separated; and (4) reduce the usage of, or shorten the length of stay in psychiatric hospitals and other substitute settings. Treatment is based on the child’s needs with a focus on the family unit. The service style must support a strengths-
based approach, emphasizing assertive intervention, parent and professional teamwork, and community involvement with service providers.

Providers of this service must comply with all Targeted Case Management for Children and Families requirements, except as noted below.

**Services**
1. The focus of treatment must be reflective of the child or adolescent’s DSM/ICD diagnosis and functional impairment as identified in the CAFAS tool.
2. The expected caseload is 18-20 families per FTE (caseload cannot exceed 20).
3. There must be a minimum of three one-hour contacts of in-person service activity with the child and/or family per month, excluding group services.
4. A minimum of 50% billable units monthly will be delivered with the family in the family home.
5. Provider must offer support/educational groups for parents/caregivers and siblings specific to this population.
   a. It is expected that this will run six to eight weeks.
   b. Groups will be offered a minimum of four times per year and will be offered no more than six times per year.
   c. Expected minimum attendance for parents is four; expected attendance for children is six.

**Access and Authorization**
1. Individuals seeking Specialized Family Case Management through the public mental health system must access these services through the Network180 Access Center.
2. The Access Center will authorize an appropriate level of service based on:
   a. The results of an in-person clinical screening, and
   b. Collaboration with the child/family in accordance to person/family-centered planning principles.
3. Initial authorization for Specialized Family Case Management will be for seven months.
4. If requesting services for a sibling of an authorized child, the Sibling Services Brief Screening Form and Demographic Intake and Financial Intake Forms must be included with the request for services. The Network180 Utilization Management (UM) Department will review the authorization request and authorize as appropriate.

**Reauthorization**
1. Network180 will determine reauthorization for Specialized Family Case Management services. The reauthorization determination will be based on the following criteria:
   a. High probability of decompensation without continued service.
   b. Treatment goals have not been completed but progress is anticipated.
   c. Child/family are consistently engaged in treatment.
   d. Transitioning children that potentially meet Adult Targeted Case Management criteria into the adult system.
   e. Multiple system involvement with potential improvement with Network180 services.
   f. Provider has identified ineffective interventions and has identified alternative interventions to facilitate successful termination of services.
2. If eligible for reauthorization, the service will be reauthorized for at least one month but not more than three months.

**Discharge**
1. The discharge date must be submitted to the Network180 Access Center within seven calendar days of discharge from service.
2. The Network180 Access Center will enter the discharge date based on the information given by Provider.
3. Provider will submit discharge CAFAS data electronically.
4. Upon discharge, Provider will give the family the Parent Guide to Re-accessing Network180 Services.
5. Provider will send all discharge summaries to the Access Center within 30 calendar days of discharge from Specialized Family Case Management.
6. The discharge summary shall provide discharge recommendations. If Provider is recommending less intensive services or other community service, discharge recommendations shall include the service, the service provider, and the appointment date/time.
7. These services are expected to be moderate in duration to stabilize the family situation and set up services as necessary.
   c. It is anticipated that cases will be discharged when clinically appropriate, including prior to the expiration of the initial authorization.
   d. It is anticipated 85% of cases authorized will be successfully discharged from services by the expiration of the initial authorization.