



# Case Management Model Act

## Supporting Case Management Programs



# **Case Management Model Act**

**Revised 2017<sup>i</sup>  
(CM Model Act)**

**The Case Management Model Act, revised version, was adopted by the Case Management Society of America (CMSA) Board of Directors in August 2017.**

## PREAMBLE

The Case Management (CM) Model Act establishes the key elements of a comprehensive Case Management Program that should be implemented at both the federal and state levels. The Case Management Society of America (CMSA) encourages public policymakers to review and use the provisions of this CM Model Act for legislative and regulatory initiatives geared to reducing health care costs, improving the coordination and transitions of care, enhancing quality, and promoting better clinical outcomes. This new version of the CM Model Act builds upon the initial CM Model Act of 2009, and has been updated to reflect the *Standards of Practice for Case Management, Revised 2016*.

Professional Case Managers are health care professionals and pioneers of health care change. They serve as health care team leaders that open new areas of thought, research and development. Professional Case Managers positively impact and improve Consumer well-being and health care outcomes.

Case Management is a person-centric, collaborative process of assessment, planning, facilitation, and advocacy to meet the individual's health needs and promote Population Health Management goals. In part, this is accomplished through enhanced communication links and the coordination of available resources to promote high quality, cost-effective outcomes. Case Management serves as a means for achieving Consumer wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation. Case Management supports the goals of value-based purchasing by promoting cost-effective strategies that support better quality, improved outcomes, and higher Consumer satisfaction.

Professional Case Managers help identify appropriate providers and facilities throughout the continuum of services. In addition, Professional Case Managers help ensure that available resources are being used in a timely and cost-effective manner to obtain optimum value for both the Consumer and the reimbursement source. As a general goal, Professional Case Managers often improve the Consumer's experience with care.

Case Management roles and functions lead to quality care and successful outcomes. Such outcomes cannot be achieved without the specialized skills, knowledge and competencies Professional Case Managers apply throughout the Case Management process. Professional Case Manager competencies include critical thinking and analysis, motivational interviewing, effective communication, positive relationship building, ability to plan and organize effectively, negotiation, cost-conscious allocation of resources, knowledge of health insurance and funding sources, client activation, empowerment and engagement, and the ability to effect change and perform ongoing evaluation.<sup>ii</sup>

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## SECTION I: SHORT TITLE

For purposes of the Case Management Model Act, the short title shall be “CM Model Act.”

## SECTION II: DEFINITIONS

- 2.1 Adverse Determination:** Any determination by a health plan or a Sponsor of health insurance coverage where the Consumer is not receiving the care requested by the Consumer or ordered by their attending provider. This includes not only a denial of care but any redirect or modification of a Consumer’s care which the Consumer or the attending provider deems to be a change in the recommended course of treatment.
- 2.2 Appeal.** Any request for a reconsideration of an Adverse Determination.
- 2.3 Care Coordination:** The deliberate organization of the Consumer’s care activities between two or more participants (including the Consumer) involved in a Consumer’s care to facilitate the appropriate delivery of health care services. Organizing care involves the arranging of personnel and other resources needed to carry out all required Consumer’s care activities, and is often managed by the exchange of information among participants responsible for different aspects of care. A primary goal is to ensure that the Consumer’s needs and preferences for health services and information sharing across people, functions, and sites are met over time. Care Coordination is often a key element of a Case Management Plan of Care.
- 2.4 Care Management:** Often refers to the management of long-term health care by professionals serving social welfare, aging and nonprofit care delivery systems, insurers, and health care providers. Care Management Programs typically include creating a healthcare delivery process that helps achieve better health outcomes by anticipating and linking Consumers with the services they need more quickly. It also helps avoid unnecessary services by preventing health problems from escalating. The term Care Management is often used interchangeable with Case Management.
- Editor’s Note:* The outsourcing of transitional Care Management (TCM), chronic Care Management (CCM) and/or complex Care Management services to companies who employ medical assistants, technologists, health assistants or other non-Licensed support Staff to provide monthly calls to patients with two or more chronic conditions under the general supervision of a Licensed RN does not constitute Care Management.
- 2.5 Case Management:** A collaborative process of assessment, planning, facilitation, Care Coordination, evaluation and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and

available resources to promote patient safety, quality of care, and cost effective outcomes. The term Case Management is often used interchangeably with Care Management.

- 2.6 Case Management Plan of Care:** A document or electronic record that represents the synthesis and reconciliation of the multiple plans of care produced by each provider to address a Consumer's specific health concerns. The Case Management Plan of Care serves as a blueprint shared by health care team participants to guide the Consumer's care. As such, it provides the structure required to coordinate care across multiple sites, providers and episodes of care.
- 2.7 Case Manager Extender:** Staff members who support the Case Management process and work under the supervision of a Professional Case Manager. The Case Manager Extender must meet the qualifications outlined in Section III of the CM Model Act.<sup>iii</sup>
- 2.8 Certification:** A professional credential, granted by a national organization, signifying that an individual has met the qualifications established by that organization. To qualify under these standards, the Certification program, including the exam, must:
- (a) Establish standards through a recognized, validated program;
  - (b) Include an evaluation process, examination, or practicum with an established baseline score; and
  - (c) Be research-based and validated.
- 2.9 Complaint:** A concern levied against an insurance company or an expression of dissatisfaction regarding the Program's products or services.
- 2.10 Consumer:** An individual who is the recipient of Case Management services. This individual can be, but is not limited to, a patient, beneficiary, injured worker, claimant, enrollee, member, college student, resident, or health care Consumer of any age group. The use of this term also infers the inclusion of the Consumers' Support Systems if applicable, which may include family, legal guardian(s), or significant others.
- 2.11 Contractor:** A business entity or individual that performs delegated functions on behalf of the Program.
- 2.12 Credentialing Verification.** A process of reviewing and verifying specific credentialing Criteria of a Professional Case Manager and other clinical Staff.
- 2.13 Criteria:** A broadly applicable set of standards, guidelines, or protocols used by the Program to guide the Case Management process. Criteria should be:
- (a) Written;
  - (b) Based on professional practice;
  - (c) Evidence/literature-based;

- (d) Applied consistently; and
- (e) Reviewed at least annually.

- 2.14 License or Licensure:** A legal credential, permit or equivalent to engage in a defined health care field that is:
- (a) Issued by any state or jurisdiction in the United States; and
  - (b) Required for the performance of job functions.
- 2.15 Sponsor:** The entity that pays for or otherwise supports Case Management services or Programs.
- 2.16 Population Health Management:** A process that strives to address health needs at all points along the continuum of health and well-being, through participation of, engagement with, and targeted interventions for the population. The goal of a Population Health Management Program is to maintain and/or improve the physical and psychosocial well-being of individuals through cost effective and tailored health solutions.
- 2.17 Professional Case Manager:** Professional Case Managers are Licensed and qualified healthcare professionals (e.g., Registered Nurses, Social Workers, and other interdisciplinary team members,) who help provide an array of services to assist Consumers and their families. Professional Case Managers help Consumers cope with complicated health or medical situations in the most effective way possible, thereby achieving a better quality of life. They help people identify their goals, needs, and resources. From that assessment, the Professional Case Manager and the Consumer — whether an individual or a family — together formulate a plan to meet those goals. The Professional Case Manager helps Consumers to find resources and facilitates connection with those services. The Professional Case Manager may advocate on behalf of a Consumer to obtain needed services. The Professional Case Manager also maintains communication with the Consumer to evaluate whether the plan is effective in meeting the Consumer's goals. Professional Case Managers must meet the qualifications outlined in Section III of the CM Model Act.
- 2.18 Program:** An organization that provides Case Management services pursuant to the CM Model Act.<sup>iv</sup>
- 2.19 Quality Management:** A systematic data-driven effort to measure and improve Case Management services.
- 2.20 Staff:** The Program's employees, including full-time employees, part-time employees, independent Contractors, and consultants.
- 2.21 Support System:** An individual or group of individuals, as indicated by the Consumer, that support the Consumer. This may include, but is not limited to, a

relative, spouse, partner, friend, neighbor, colleague, or health care proxy.

### **SECTION III: STAFF QUALIFICATIONS** <sup>v</sup>

**3.1 Professional Case Manager Qualifications:** Professional Case Managers shall maintain competence in their area(s) of practice by having one of the following:

- (a) Current, active, and unrestricted Licensure or Certification in a health or human services discipline that allows the professional to conduct an assessment independently as permitted within the scope of practice of the discipline; *and/or*
- (b) Baccalaureate or graduate degree in social work, nursing, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the persons being served. The degree must be from an institution that is fully accredited by a nationally recognized educational accreditation organization; and the individual must have completed a supervised field experience in Case Management, health, or behavioral health, as part of the degree requirements.

Editor's note: The Professional Case Manager is one who has the License/Certification to conduct an independent assessment, can use critical thinking skills, and knowledge to develop an individualized Plan of Care, and can see that it is successfully implemented, impacting quality and safety. Specific Professional Case Manager qualifications will be selected depending on the focus and scope of the Case Management services being established in the proposed legislation.

**3.2 Supervisor Qualifications:** Individuals who directly supervise Case Management practices shall have the following qualifications:

- (a) Bachelors (or higher) degree in a health-related field or human services profession; and
- (b) Licensure as a health professional; and
- (c) Certification as a Professional Case Manager.

**3.3 Case Management Extender Qualifications:** CM Extenders shall meet or exceed the following:

- (a) Have two years of related job experience;
- (b) Eight (8) hours of documented annual training; and
- (c) Work under the supervision of a Professional Case Manager.

### **SECTION IV: PROGRAM REQUIREMENTS**

**4.1 Supervision:** Pursuant to this CM Model Act, the senior clinical Staff person shall be responsible for clinical aspects of the Program, and should have periodic consultation with practitioners in the field.



- 4.2 Clinical Oversight:** The organization running the Program shall designate at least one senior clinical Staff person who has:
- (a) A current, unrestricted clinical License(s) (or if the License is restricted, the Program has a process to ensure job functions do not violate the restrictions imposed by the State Board); and
  - (b) Qualifications to perform clinical oversight for the services provided; and
  - (c) Post-graduate experience in direct patient care; and/or
  - (d) Board Certification (if the senior clinical Staff person is an allopathic or osteopathic physician).

*Editor's note:* The applicability and qualifications of the senior clinical Staff member can be further defined in the proposed legislation (or regulations) to include an advanced practitioner, PhD, and/or physician.

- 4.3 Interdisciplinary Collaboration:** The Program shall establish and implement mechanisms to promote collaboration, coordination, and communication across disciplines and departments within the Program, with emphasis on integrating administrative activities, quality improvement, and when applicable, clinical operations.

- 4.4 Case Management Extender:** A Case Manager Extender shall assist Professional Case Managers with those activities detailed in Section 5.2 but shall not provide direct medical, nursing or Case Management services without supervision. A Case Manager Extender can support administrative functions but cannot engage in the practice of Case Management, including completing risk assessments. Supportive role services can include scheduling provider appointments, handling correspondence, arranging for the delivery of DME supplies, onsite Consumer visits (e.g., to assess whether the Consumer has a wheelchair), gathering data, mailing educational materials, arranging transportation, among other activities.

*Editor's note:* The outsourcing of transitional Care Management (TCM) and chronic Care Management (CCM) services to companies who employ medical assistants, technologists, health assistants or other non-Licensed support Staff to provide monthly calls to patients with two (2) or more chronic conditions under the general supervision of a Licensed RN does not constitute Care Management. The Professional Case Manager is one who has the License/Certification to conduct an independent assessment, use critical thinking skills, and knowledge to develop an individualized Plan of Care, and see that it is successfully implemented, impacting quality and safety.

Defining the roles and functions of non-clinical support Staff as part of the care team under the supervision/delegation of a Professional Case Manager provides clarity for those who reference the Model Act for the purposes of legislation, coverage of quality Program services, or Program development, grant proposals,

etc.

**4.5 Written Job Descriptions:** The Program shall provide written job descriptions for Staff that address:

- (a) Required education, training, and/or professional experience;
- (b) Expected professional competencies;
- (c) Appropriate Licensure/Certification requirements; and
- (d) Scope of role and responsibilities.

**4.6 Credentialing Verification:** The Program shall verify the credentials of Professional Case Managers and other clinical Staff as follows:

- (a) Upon hire, verify the current Licensure, Certification, and academic degrees of Professional Case Managers and other clinical Staff;
- (b) At least yearly, verify that the individual does not appear on the List of Excluded Individuals and Entities maintained by the Office of the Inspector General of the U.S. Department of Health and Human Services;
- (c) At least every three years, re-verify the current Licensure, Certification, and degrees of Professional Case Managers and other clinical Staff;
- (d) At least every five years, document at least eighty (80) hours of continuing education (or the appropriate level of hours as required by a nationally recognized Certification body or a state licensing board) for each Professional Case Manager and other clinical Staff; and
- (f) At any time, implement corrective action in response to adverse changes in Licensure or Certification status.

*Editor's note:* The specific primary and secondary source verification requirements can be identified in the proposed legislation or accompanying regulations. The CM Model Act assumes that Professional Case Managers are qualified health care professionals who should be reimbursed for their services.

## **SECTION V: CASE MANAGEMENT PROGRAM GOALS**

**5.1 Case Management Goals:** The Professional Case Manager shall facilitate coordination, communication, and collaboration with Consumers, providers, ancillary services, interdisciplinary team, and others, to maximize positive Consumer outcomes based upon individual assessments of Consumers' needs and achieve Population Health Management goals. Professional Case Managers shall:

- (a) Use a Consumer-centric, collaborative partnership approach that is responsive to the individual Consumer's culture, preferences, needs, and values;
- (b) Facilitate Consumer's self-determination and self-management through the tenets of advocacy, shared and informed decision-making, counseling, and health education, whenever possible;

- (c) Use a comprehensive, holistic, and compassionate approach to care delivery which integrates a Consumer's medical, behavioral, social, psychological, functional, and other needs;
- (d) Practice cultural and linguistic sensitivity, and maintain current knowledge of diverse populations within their practice demographics;
- (e) Implement evidence-based care guidelines in the care of Consumers, as available and applicable to the practice setting and/or Consumer population served;
- (f) Promote optimal Consumer safety at the individual, organizational, and community level;
- (g) Promote the integration of behavioral change science and principles throughout the Case Management process;
- (h) Facilitate awareness of and connections with community supports and resources;
- (i) Foster safe and manageable navigation through the health care system to enhance the Consumer's timely access to services and the achievement of successful outcomes;
- (j) Pursue professional knowledge and practice excellence and maintain competence in Case Management and health and human service delivery;
- (k) Support systematic approaches to Quality Management and health outcomes improvement, implementation of practice innovations, and dissemination of knowledge and practice to the health care community;
- (l) Maintain compliance with federal, state, and local rules and regulations, and organizational, accreditation, and Certification standards;
- (m) Demonstrate knowledge, skills, and competency in the application of Case Management standards of practice and relevant codes of ethics and professional conduct; and
- (n) Define the roles and functions of non-clinical support Staff as part of the care team to provide clarity for those who reference the Model Act for the purposes of legislation, coverage of quality Program services, or Program development, grant proposals, etc.

## **SECTION VI: AUTHORIZED SCOPE OF SERVICES**

**6.1 Case Management Process:** Primary steps in the Case Management process shall include Interdisciplinary Collaboration covering:

- (a) Consumer identification, selection and engagement in Case Management:
  - i. Establish and implement Criteria for identifying individuals for Case Management services.
  - ii. Identify and select Consumers who can most benefit from Case Management services available in a particular practice setting.
  - iii. Focus on screening Consumers identified or referred by other professionals for Case Management to determine appropriateness for and benefits from services.

- iv. Engagement of the Consumer and family or family caregiver in the process.
  - v. Obtaining consent for Case Management services as part of the case initiation process.
- (b) Assessment and opportunity identification:
- i. Assessment begins after screening, identification and engagement in Case Management. It involves data gathering, analysis, and synthesis of information for the purpose of developing a Consumer-centric Case Management Plan of Care.
  - ii. Assessment helps establish the Consumer-Professional Case Manager's relationship and the Consumer's readiness to engage in their own health and well-being. It requires the use of effective communication skills such as active listening, meaningful conversation, motivational interviewing, and use of open-ended questions.
  - iii. Care needs and opportunities are identified through analysis of the assessment findings and determination of identified needs, barriers, and/or gaps in care.
  - iv. Assessment is an ongoing process occurring intermittently, as needed, to determine efficacy of the Case Management Plan of Care and Consumer's progress toward achieving target goals.
  - v. Assessment should cover medical, behavioral health, social determinants of health, and functional status.
  - vi. Assessment may include the use of laboratory data, molecular/genomic information and other types of clinical data.
  - vii. Assessment may include rating scales covering physical or behavioral health status.
  - viii. The Professional Case Manager shall complete a comprehensive, culturally and linguistically appropriate assessment of each Consumer.
- (c) Development of the Case Management Plan of Care:
- i. The Case Management Plan of Care is a structured, dynamic tool used to document the opportunities, interventions, and expected goals the Professional Case Manager applies during the Consumer's engagement in Case Management services. It includes: identified care needs, barriers and opportunities for collaboration with the Consumer, family and/or family caregiver, and members of the inter-professional care team to provide more effective integrated care, prioritized goals and/or outcomes to be achieved, and interventions or actions needed to reach the goals.
  - ii. Consumer and/or Consumer's family or family caregiver input and participation in the development of the Case Management Plan of Care is essential to promote Consumer-centered care and maximize potential for achieving the target goals.
  - iii. Maximize the Consumer's health, wellness, safety, adaptation, and self-care.

- iv. Implement policies to promote the autonomy of Consumer, and support Consumer and family decision-making.
- (d) Implementation and coordination of the Case Management Plan of Care:
  - i. The Case Management Plan of Care is put into action by facilitating the coordination of care, services, resources, and health education specified in the planned interventions.
  - ii. Effective Care Coordination requires ongoing communication and collaboration with the Consumer and/or Consumer's family or family caregiver, as well as the provider and the entire inter-professional health care team.
  - iii. Support of the physician or practitioner/Consumer relationship and Plan of Care.
  - iv. Emphasize prevention of exacerbations and complications utilizing evidence-based practice guidelines and Consumer empowerment strategies.
  - v. Promote smooth transitions of care whenever possible.
- (e) Establish proper caseloads:
  - i. Establish guidelines for reasonable Professional Case Manager caseloads with supporting rationale based on factors such as severity of cases, complexity of cases, role requirements of Professional Case Managers, and other relevant factors.
- (f) Monitoring and evaluation of the Case Management Plan of Care:
  - i. Ongoing follow-up with the Consumer, family and/or family caregiver and evaluation of the Consumer's status, goals, and outcomes.
  - ii. Monitor activities including assessing Consumer's progress with planned interventions.
  - iii. Evaluation if care goals and interventions remain appropriate, relevant, and realistic.
  - iv. Determination if any revisions or modifications are needed to the care needs, goals, or interventions specified in the Consumer's Case Management Plan of Care.
- (g) Closure of the Case Management services:
  - i. Establish and implement Criteria for discharge of Consumers or termination of Case Management services.
  - ii. Bring mutually-agreed upon closure to the Consumer-Professional Case Manager relationship and engagement in Case Management.
  - iii. Case closure focuses on discontinuing Case Management services when the Consumer has attained the highest level of functioning and recovery, the best possible outcomes, or when the needs and desires of the Consumer have changed.
  - iv. Appropriately terminate Case Management services.

Editor's note: The CM Model Act may be further revised to highlight specific issues and goals to be addressed by the Program.

## SECTION VII: PAYMENT OF SERVICES

- 7.1 Payment Methodologies:** Payment methodologies may include:
- (a) Fee-for-service;
  - (b) Bundled or unbundled rates;
  - (c) Episode of care rates;
  - (d) Case-based payments (e.g., prospective payment system for hospital reimbursement);
  - (e) Capitated payments (fixed payments per enrollee/covered beneficiary life for all covered medical services during a specified period of time); and/or
  - (f) Pay for Performance.

*Editor's Note:* See Appendix A: Supplemental Guidance on Coding. Appendix A describes the billing codes used for payment of Care Management Services in the Medicare Physician Fee Schedule (MPFS), where Professional Care Managers can be best utilized in team based models to ensure quality, efficient, and safe Care Management services to Program recipients.

- 7.2 Consumer Disclosure Requirements.** The Professional Case Manager shall provide the following notifications to Consumers regarding Case Management services:
- (a) Sponsored Model. The Sponsor of the Case Management Program shall provide advanced verbal and written notice to Consumers regarding any deductible, co-payment and co-insurance payment requirements before the Case Management services are rendered to the Consumer.
  - (b) Consumer-Direct Model. In cases where the Consumer is hiring the Case Management services directly, the Consumer shall be notified verbally and in writing in advance of any deductible, co-payment and co-insurance payment requirements before the Case Management services are rendered to the Consumer. Sufficient time must be provided for the Consumer to reconsider the Case Management engagement or to negotiate a reduce charge.

## SECTION VIII: TRAINING

- 8.1 Training Activities:** The Program shall offer a training program that includes:
- (a) Initial orientation and/or training for all Staff before assuming assigned roles and responsibilities;
  - (b) Ongoing training as needed to maintain professional competency and cultural competence;
  - (c) Training in state and regulatory requirements as related to job functions;
  - (d) Documentation of all training provided for Staff;
  - (e) Standards of practice governing the Professional Case Manager's profession and/or the practice of Case Management;
  - (f) Disclosure requirements;

- (g) Conflict of interest;
- (h) Confidentiality;
- (i) Organizational structure; and
- (j) Delegation oversight, if necessary.

## **SECTION IX: QUALITY MANAGEMENT**

- 9.1 Quality Management:** The Program shall maintain a Quality Management function that promotes objective and systematic monitoring and evaluation of the Case Management services rendered pursuant to the Program.
- 9.2 Quality Management Documentation:** The Program, as part of its Quality Management activities, shall provide:
- (a) Written documentation of the quality/performance improvement goals and activities utilized in the monitoring and evaluation of activities;
  - (b) Tracking and trending of data related to Case Management services and the quality performance goals; and
  - (c) The implementation of follow-up action plans to improve or correct identified opportunities for improvement.

## **SECTION X: ANTIFRAUD AND CONSUMER PROTECTIONS**

- 10.1 Antifraud Provision:** The Program shall establish and implement an antifraud program that educates Case Management Staff, no less than annually, on policies and procedures supporting the ethical framework for Case Management practice, including:
- (a) Advocacy for Consumer needs;
  - (b) Guidance for professional relationships with Consumers;
  - (c) Prohibition of relationships that could compromise professional objectivity;
  - (d) Resolution of conflicts of interest between the Professional Case Manager, Consumer, payer (or federal agency), providers, or other entities;
  - (e) Business, financial, and marketing practices;
  - (f) Resolution of perceived lapses in quality of care resulting from actions by Consumers, payers, Professional Case Managers, providers, organizations, or other entities affecting the Case Management process;
  - (g) Policies that address Professional Case Managers' handling of Consumer needs when such needs extend beyond the scope of the Program; and/or
  - (h) Prohibition of discrimination against a Consumer or group of Consumers by the Professional Case Manager or the Program.
- 10.2 Consumer Safety:** The Program shall implement a Consumer safety initiative to protect the welfare and safety of Consumers and Professional Case Managers. Such policies and procedures address:
- (a) For Consumer protection:
    - (i) The Americans with Disabilities Act, workers' compensation, and other laws protecting the rights of Consumers;

- (ii) Identification and reporting of suspected abuse, neglect, or other Consumer mistreatment;
  - (iii) Informed consent for services, advance medical directives, and power of attorney for health care;
  - (iv) Health benefits and benefits administration;
  - (v) Seeking resources for resolution of legal questions; and
  - (vi) Prevention of harmful acts.
- (b) For Consumer and Professional Case Manager protection:
- (i) Prevention of violence;
  - (ii) Prevention of infectious diseases; and
  - (iii) Reporting incidents of unusual occurrences.

## SECTION XI: COMPLAINTS

- 11.1 Grievance Procedures:** The Program shall maintain a system to receive and respond in a timely manner to Complaints and, when appropriate, inform Consumers of their rights to submit an Appeal. The Program shall:
- (a) Provide notice of the availability of a Complaint process and the method by which to access it;
  - (b) Establish and implement a policy for resolving disagreements regarding Consumer care options; and
  - (c) Provide administrative support to the Consumer when they are filing a Complaint.
- 11.2 Appeals Support.** Professional Case Managers shall support any Appeal of an Adverse Determination impacting a Consumer, where the Consumer or the Consumer's representative is filing the Appeal.

*Editor's Note:* The first step in appealing a denial of health care services, or an Adverse Determination, is to file an internal Appeal with the health plan. In many cases, the internal Appeals process must be exhausted before one is "eligible" to move to an external review. Typically, there are two entry points to initiate an Appeal.

- Medical Necessity or Clinical Appeal: The first entry point is to file a clinical or medical necessity Appeal. An insured individual, family member or attending provider will file this type of Appeal when the health plan has denied or reduced the level of care based on what the plan deems is "medically necessary." This decision is based upon evidence-based medical necessity Criteria or guidelines that must be fully accessible.
- Administrative Appeal: The second entry point is to file an administrative or grievance procedure Appeal. This type of Appeal typically addresses a non-clinical issue and is filed when there is a dispute about the level of benefits



covered by the specific insurance policy, such as a non-covered benefit or exclusion.

After the internal Appeal process has been exhausted, the insured individual, family member or attending provider may be able to file an external Appeal. This Appeal will typically be addressed by an IRO. In addition, the patient should also consider filing an external Appeal with the following entities:

- A state or federal government agency
- An accreditation agency
- An arbitration claim or a court hearing.

## **SECTION XII: REGULATORY OVERSIGHT & IMPLEMENTATION**

**12.1 Establishment of Regulations:** (Insert federal regulatory agency) shall have oversight of this Program and is authorized to develop regulations pursuant to the CM Model Act. Such regulations shall be promulgated within six months after the adoption of the CM Model Act, which shall include a public comment period.

**12.2 Deeming Authority:** The (insert federal agency) shall have authority to develop and implement a process to recognize and deem the quality standards from nationally recognized accreditation agencies that accredit Case Management Programs as meeting Section IX.

*Editor's note:* A regulatory agency may decide to recognize or deem other standards associated with a national accreditation organization related to other provisions of this Model Act.

## **SECTION XIII: OTHER PROGRAM REQUIREMENTS**

**13.1 Implementation Date:** This Program shall be implemented by (insert applicable date).

**13.2 Information Management:** The Program shall implement information system(s) (electronic or paper) to collect, maintain, and analyze information necessary for organizational management that:

- (a) Provides for data integrity;
- (b) Provides for data confidentiality and security;
- (c) Includes a disaster recovery plan; and
- (d) Includes a plan for storage, maintenance, and destruction.

**13.3 Confidentiality:** Pursuant to federal and applicable state law, the Program shall protect the confidentiality of individually identifiable health information (IIHI) and personal health information (PHI) that:

- (a) Identifies how IIHI/PHI will be used;
- (b) Specifies that IIHI/PHI is used only for purposes necessary for conducting Case Management, including evaluation activities;

- (c) Addresses who will have access to the IIHI/PHI collected by the Program;
- (d) Addresses communications and records transmitted or stored, including cellular phone, fax, or electronic systems; and
- (e) Requires employees of the Program to sign a statement that they understand their responsibility to preserve Consumer confidentiality.

**13.4 Regulatory Compliance:** The Program shall implement a regulatory compliance program that:

- (a) Tracks applicable laws and regulations in the jurisdictions where the Program conducts business; and
- (b) Ensures the Program's compliance with applicable laws and regulations.

## **APPENDIX A: SUPPLEMENTAL GUIDANCE -- CODING OVERVIEW**

The following billing codes are used for payment of Care Management Services in the Medicare Physician Fee Schedule (MPFS), where Professional Care Managers can be best utilized in team based models to ensure quality, efficient, and safe Care Management services to Program recipients:

### **Transitional Care Management Services<sup>vi</sup>** - effective 2013 under the MPFS

- CPT Code 99495 –Transitional Care Management Services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision making of at least moderate complexity during the service period, and face-to-face visit, within 14 calendar days of discharge
- CPT Code 99496 – Transitional Care Management Services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision making of high complexity during the service period, and face-to-face visit, within 7 calendar days of discharge

### **Chronic Care Management Services<sup>vii</sup>**– effective 2015 under the MPFS

- CPT Code 99490 - Chronic Care Management services, at least 20 minutes of clinical Staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.
- CPT Code 99487 - Complex chronic Care Management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or

functional decline; establishment or substantial revision of a comprehensive care plan; moderate or high complexity medical decision making; 60 minutes of clinical Staff time directed by a physician or other qualified health care professional, per calendar month.

- CPT code 99489 – Complex chronic Care Management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; establishment or substantial revision of a comprehensive care plan; moderate or high complexity medical decision making; 60 minutes of clinical Staff time directed by a physician or other qualified health care professional, per calendar month; each additional 30 minutes of clinical Staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)
- HCPCS code G0506 - Comprehensive assessment of and care planning for patients requiring chronic Care Management services (list separately in addition to primary monthly Care Management service)

#### **Advance Care Planning Services<sup>viii</sup>** -effective 2016 under the MPFS

- ACP Billing Codes (CPT 99497 and 99498) are ACP services provided by the physician or using a team based approach provided by physicians, non-physician practitioners (NPP), and other Staff under the order and medical management of the beneficiary's treating physician.

#### **Behavioral Health Integration Services<sup>ix</sup>**– effective 2017 under the MPFS

- Billing Codes G0502, G0503, and G0504 are used to bill monthly services furnished under the Psychiatric Collaborative Care Model (CoCM). G0507 is used to bill monthly services using Behavioral Health Integration (BHI) Models of care other than CoCM.

The following information and billing codes are used for annual wellness visits:

#### **Annual Wellness Visit<sup>x</sup>** – effective 2011 under the MPFS

Medicare covers an Annual Wellness Visit (AWV) (also referenced in some jurisdictions as an Annual Wellness Exam – AWE) for all beneficiaries who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not gotten either an Initial Preventive Physical Examination (IPPE) or an AWV within the past 12 months (that is, at least 11 months have passed following the month in which the IPPE or the last AWV was performed). Medicare pays for only one first AWV per beneficiary per lifetime and pays for one subsequent AWV per year thereafter. Medicare Part B covers AWV if performed by a: Physician (a doctor of medicine or osteopathy); Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist); or Medical professional (including a health educator, registered

dietitian, nutrition professional, or other Licensed practitioner), or a team of such medical professionals who are working under the direct supervision of a physician (doctor of medicine or osteopathy).

- G0438 - Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit
- G0439 - Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit.

## References

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<sup>i</sup> The CM Model Act can be used by third parties to develop or draft proposed legislative bills, regulations, white papers, and similar public policy projects with acknowledgement of CMSA as the source. For all other purposes, CMSA retains its copyright interests in the document. In such cases, please contact CMSA at (501) 225-2229 for additional information and/or permission to reproduce all or parts of this document.

<sup>ii</sup> CMSA Standards of Practice for Case Management, 2016

<sup>iii</sup> Under the CM Model Act (revised 2017), the Case Management Extender is a new term and a new professional position.

<sup>iv</sup> *Editor's note:* The focus of the CM Model Act is the Case Management Program itself. Depending on the legislative circumstances, the CM Model Act could be modified to address a legal entity or health care organization that provides the Case Management services.

<sup>v</sup> The term "Case Management" can mean many different things depending on the setting and circumstances. As applied to the management of health care conditions, both at the population and individual levels, it is important that Professional Case Managers meet baseline professional requirements. Since many Case Management Programs are funded in part by government agencies, these Programs should establish baseline requirements in the applicable legislation or regulations. Individuals who are not qualified Professional Case Managers could jeopardize the health and safety of Consumers, or otherwise not fully understand how to support the needs of those with complex medical conditions.

<sup>vi</sup> See <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf>

<sup>vii</sup> See <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf>. Also see <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Payment-Chronic-Care-Management-Services-FAQs.pdf>

<sup>viii</sup> See <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf>

<sup>ix</sup> See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-Fact-Sheet.pdf>

<sup>x</sup> See [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV\\_chart\\_ICN905706.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf)



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