DEPARTMENT:	Case Management
SUBJECT:	Complex Case Management Program
PRODUCT LINE:	Commercial, Medicaid
POLICY NUMBER:	HM74
ORIGINAL POLICY EFFECTIVE DATE:	03/19/2015
LAST REVISED DATE:	12/10/2025
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Policy: To ensure Group Health Cooperative of Eau Claire (GHC) consistently identifies and manages its highest risk members with complex conditions. All eligible members have the right to participate in complex case management or to decline to participate. Medicaid case management policy changes need to be approved by DHS before implementation.

Scope:

Case management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and ensuring access to available resources, services, and care to promote quality, cost-effective outcomes. Complex case management's goal is to help members regain health and improve functional capabilities.

Case Management Systems:

An electronic care management system is used to complete assessments and document care management processes including care plans with associated problems, interventions, goals, and barriers to meeting goals and complying with the care plan. The electronic care management system automatically documents member interactions for each entry in the electronic care management system such as staff name, the date and time of all actions on the case, and all member interactions. The electronic care management system includes automated prompts, reminders, and automated reminder tasks to ensure appropriate outreach/follow up and next steps in management to meet the member's needs.

Evidence-based clinical guidelines:

Case management processes and algorithms are built upon evidence-based clinical practice guidelines. All case management processes are based on the Case Management Society of America (CMSA) standards of practice. Management of chronic conditions and wellness are based on evidence-based clinical practice guidelines as outlined below:

1. Diabetes: American Diabetes Association
2. Hypertension: Joint National Committee 8
3. Asthma: NIH/National Heart, Lung, and Blood Institute, CDC
4. COPD: ACP clinical practice guideline on diagnosis and management of stable chronic obstructive pulmonary disease (COPD)
5. Heart failure: ACC/AHA Guideline for the Management of Heart Failure
6. Perinatal: American Academy of Pediatrics and American College of Obstetrics and Gynecology clinical practice guideline
7. Substance abuse: American Society of Addiction Medicine (ASAM), Substance Abuse and Mental Health Services Administration (SAMHSA)
8. Wellness: United States Department of Agriculture (USDA), US Department of Health and Human Services Office of Disease Prevention and Health Promotion

Case Management Staffing:

Our experienced case management staff has diversified backgrounds from the following fields of study: nursing, human services, psychology, and social work who are trained in case management, behavioral change, and motivational interviewing principles and work with members to accomplish the following:

1. Establishing with a PCP and other providers. All members are encouraged to choose a PCP to coordinate their care and to establish with a specialty provider when services are needed that fall outside the scope of the PCP. When a member is not established with a PCP or specialty provider when applicable, the case manager will help member find a provider. Members are encouraged to follow up with their providers on a regular basis to obtain preventive services but also for management of their chronic conditions. For new enrollees, GHC staff through welcome call assessments and case management assessments identifies members' providers and health care needs and helps members transition their care to in- network providers whenever possible.

   In difficult Medicaid case management situations, a member may be locked in to seeing one primary care provider to avoid duplication of services and fragmentation of care. The health plan must submit a written request to the managed care analyst, in advance of a lock-in request of a member to one primary provider.
2. Supporting the member through transitions of care
3. Educating on self-management of health conditions
4. Coordinating care with Community Based Organizations, network providers, and county services
5. Educating and getting members to schedule preventive health services
6. Procuring needed services and support systems
7. Meeting the members needs and goals
8. Addressing gaps in care
9. Improving well-being

Methods for Identifying Members Eligible for Complex Case Management:

There are a number of methods for identifying members who may be eligible for complex case management. The GHC website includes information on how providers can refer a member to our programs and how the member can enroll. The member's caregiver can also enroll the member. Referrals to the complex case management program come from multiple avenues which include but are not limited to the following:

1. UM program: utilization review process through the prior authorization of inpatient and outpatient services including hospital discharge planning and any transition of care
2. Discharge planner or other hospital staff
3. Member services department calls
4. Frequent or inappropriate ER utilization
5. Hospitalization within past 6 months for a medical condition
6. Member welcome calls
7. Member health assessments
8. QI telephonic outreach/programs
9. GHC disease management programs

10. Prospective risk scoring from our data analytics software
11. Claims
12. All newly enrolled SSI members are identified on the monthly enrollment file from DHS
13. WISHIN Daily Provider Activity Report
14. GHC Health Promotion program
15. ETF's Wellness Program Vendor Report
16. Member's provider
17. Community or county agencies
18. Member's caregivers or support person
19. Member self-referral

Members with Special Healthcare Needs

The above methods are used to identify members with special healthcare needs. During the welcome call assessment, members with special healthcare needs are assessed to identify any ongoing special conditions that are not being managed or require regular care monitoring and these members are offered and referred to case management. Members with special healthcare needs include all SSI members and members who fall into any of the following categories:

1. Children with serious emotional disturbance
2. Children who have multiple significant chronic health problems that affect multiple organ systems and result in functional limitations
3. Pregnant women and those who are 0-12 months postpartum
4. Members who have been incarcerated in the past 12 months
5. Members with a mental illness and another chronic condition
6. Members who are homeless

Case Management Determination of Needs and Risk Stratification:

Identification of the member's health needs and risk stratification is the first step toward planning, developing, and implementing a personalized and comprehensive care plan with the member/member's support system and the case management team. To improve health outcomes of members, GHC continuously monitors and enhances the risk stratification methods. Risk stratification methods are reviewed at least annually. Multiple sources are used in the needs determination and risk stratification process and include the health risk assessment, claims, medical and pharmacy utilization patterns, member input, ER utilization, and hospital admission within the past 6 months for a chronic medical condition, and the prospective risk score. The initial assessment of the member's health status is an important part in determining the member's unique needs, coordination of services, and preventing duplication of services. When duplication of services is identified, GHC will contact providers or DHS if applicable (the method of contact will be determined based on the clinical situation or through our contract analyst) to share results of our assessment of the members' needs to prevent duplication of services. All member's eligible for case management will have an initial assessment completed and the assessment evaluates the following items and includes a description of the case management processes and procedures for addressing each item.

1. Health Status:

a. Medical Conditions (including chronic and urgent conditions): Members are screened for medical conditions including presence or absence of comorbidities by using a health needs or health risk assessment which asks them questions regarding medical conditions they have or have had in the past or medical conditions they are at risk for. GHC staff also reviews claims data, medical records from providers, reports from outside vendors to identify medical conditions. Medical conditions that are unmanaged are identified as problems in the case management care plan in the electronic care management system. Assessment of weight and blood pressure occurs during the assessment.
b. Self-reported health status: The self-reported health question has been found to be a reliable measurement of general health and attempts to measure health in all its dimensions. Self-reported health status is evaluated during the initial health assessment and is used to get an understanding of how the member views their health to help predict overall health for our members. This item is documented in the electronic care management system in the Start of Care Assessment.
c. Event or diagnosis that led to the member's identification for complex case management: This is documented in the referral in the electronic care management system for all product lines except SSI. All SSI members are evaluated for case management enrollment based on their complex care needs. This process helps staff to understand the reasons for eligibility and is used to help better identify member's needs.
d. Current medications (dosage and frequency): This data is documented in the initial health assessment and is used to ensure that members are on appropriate medications for their condition. Case managers evaluate for medication side effects or interactions, medication compliance, and access to medication fills/pharmacies, and accomplish medication reconciliation upon discharge from hospital. Medications are documented in the electronic care management system.

2. Documentation of Clinical History: During the initial health assessment, members are asked about past medical conditions and treatments, hospitalization frequency, ER services frequency, and surgeries to get a complete picture of the member's needs. Claims are also reviewed to determine past clinical history. All pertinent past clinical history is documented in the electronic case management system in the assessment or the care plan.
3. Initial Assessment of ADLs: Assessment of ADLs including bathing, dressing, toileting, transferring, feeding and continence occurs during the initial assessment to identify needs of the member and to discuss resources including community resources or covered benefits/services that would be available to address ADL needs. ADL needs and interventions related to these needs are documented in the electronic care management system.
4. Initial Assessment of Behavioral Health Status: Members are asked about behavioral health status including learning disabilities, mental health conditions, and substance use disorders during the initial health assessment. Both urgent and chronic needs are assessed along with risk for behavioral health conditions. Claims are also reviewed to check for these conditions. All needs related to behavioral health status are documented in the electronic care management system.
5. Initial Assessment of Social Determinants of Health: Lack of access to social and economic opportunities can lead to poor health outcomes so it is important to address social determinants of health so these needs can be addressed to reduce barriers to accessing health care or improving

health. Social determinants of health are evaluated on the initial health assessment and resources to address these needs are discussed with the member during the assessment. A resource letter outlining the resources is also sent to the member when applicable. Issues related to social determinants of health, interventions, and goals to address these items are documented in the assessment and the care plan in the electronic care management system. Social determinants assessed on the initial health assessment include:

a. food insecurity
b. housing
c. transportation
d. financial
e. vocational
f. health literacy
g. safety
h. language barriers
i. violence
j. social supports

6. Initial Assessment of Life Planning Activities: During the initial health assessment, members are asked what life planning documents they have in place and this is documented in the electronic care management system in the assessment. All life planning activities and documents are discussed with the member during the assessment and members are encouraged to complete these. A resource letter is sent to members outlining advance directives with a link to documents. Needs related to life planning activities would be documented in the electronic care management system.
7. Evaluation of Cultural and Linguistic Needs: Members are asked questions regarding these needs on the initial assessment to identify any barriers to communication and to understand cultural beliefs. Resources are discussed with the member to meet these needs during the assessment. Need for interpreter services is documented in the electronic care management system and is used to outreach to these individuals. Education is sent in their native language when needed as well. Cultural beliefs are documented in the electronic care management system, so staff understand and work within their belief system to meet their needs.
8. Evaluation of Visual and Hearing Needs: These needs are evaluated and addressed during the initial assessment. When needs are identified, the case management staff discusses resources for their specific need and the need and interventions related to the respective need is documented in the electronic care management system.
9. Evaluation of Caregiver Resources: The member's formal and informal supports (whether paid or unpaid) including care giver are assessed during the initial health assessment as well as the need for any resources to support the treatment plan. These resources/services are discussed during the assessment and sent in a resource letter. With all telephonic outreach, the need for resources for members and caregivers is assessed and resources given if needed. Member's formal and informal supports are documented in the contact section of the electronic care management system. Needs and interventions related to caregiver resources or support are documented in the electronic care management system.

10. Evaluation of available benefits/resources: Benefits and resources to meet the member's needs (whether paid or unpaid) are discussed during the welcome call upon enrollment, during the initial health assessment as well as during follow up case management outreach. Benefits and resources are sent to the member in the resource letter and may also be sent via email, or video. Member's needs are continually evaluated in order to coordinate benefits and provide resources to meet their needs. Any needs identified are documented in the electronic care management system along with interventions related to addressing the need. Benefits that are covered by the health plan or carved out are clearly delineated with the member. Case management staff refers members to these carved out services and will coordinate these services for the member. Services that supplement those the health plan has been contracted to provide may include but are not limited to community health services, county health services, wellness programs, transportation services, and pharmacy benefit management services. Interventions related to benefits and resources for members are documented in the care plan and the assessment.
11. Coordination of Services: See Coordination of Member Services Policy.
12. Evaluation of Community Resources: During the initial assessment and follow up telephonic outreach, member's needs are assessed. Community and county resources and benefits to address the identified needs are discussed with the member. GHC maintains a list of resources and has partnerships with community-based organizations and local health departments in all counties that we serve and also has partnerships with WIC and PNCC organizations to provide services to our members to ensure continuity and culturally appropriate care and services. Case management staff routinely contact state, county, and community agencies to identify resources for members. The community resources evaluated include but are not limited to the following: community mental health, transportation, wellness programs, nutritional support, hospice, and palliative care programs. Community resource needs are documented in the electronic care management system when they are identified.
13. Referrals to available resources: The case management staff facilitate referrals and coordinate services to ensure members needs are met. As needs are identified during the assessment process or through the request of the member/caregiver, or through other means, appropriate resources are identified and discussed with the member. GHC maintains a directory of resources and uses county health department websites to identify resources for members. We also have relationships with many Community Based Organizations (CBOs) who provide resources. Referrals are coordinated by either having the member follow up, GHC staff may do a three-way call with the member, or GHC staff may follow up directly with the resource. Members are informed of resources either telephonically, letter, email, or video. Case management staff follow up with the member to ensure the effectiveness of the coordination. Resource referrals are tracked in the care plan, are problem based, and are entered as an intervention. Referral follow up is documented in the care plan and is entered as an intervention. Referrals are tracked in the electronic care management system and reviewed to identify areas of high need.
14. Identification of Barriers: Barriers to care can lead to unmet health needs and are important to identify to help members meet their health care goals. Barriers are assessed and identified during the initial health assessment and through all subsequent outreach to the members. Barriers that are assessed include but are not limited to language and literacy issues, cultural and spiritual beliefs, visual and hearing impairments, psychological impairment, financial and insurance issues,

motivation (readiness to change), lack of understanding of their condition, and transportation. Documentation of assessment of barriers and barriers identified occurs in the initial assessment, the care plan summary, and the care plan.

15. Member Strengths: During the assessment, the member's strengths are determined and entered into the "Strengths" section of the care plan.
16. Development and communication of self-management plans: Self-management resources and tools allow members to have a central role in managing their health care and foster a sense of self-responsibility and empowerment for one's health and well-being. By helping members self-manage, they have control over improving their health which leads to improved health outcomes. Case managers work with members to encourage members to use self-management tools based on their individual needs to accomplish their goals. Interventions related to self-management are documented in the electronic care management system. Self-management may include but is not limited to ensuring members can perform ADLs, iADLs, monitor items related to their chronic condition (weight, salt intake etc.), manage nutritional or physical activity recommendations, and strategies to improve compliance with appointments and inform their case manager if they need assistance with transportation. These self-management strategies are communicated to the member (or member's caregiver/supports) either verbally and/or written depending on the member's preference.

Risk Stratification Criteria

High risk:

1. Uncontrolled medical or behavioral health conditions with complications, high risk for complications, multiple comorbidities, highly complex treatments, or noncompliance with treatment
2. Frequent hospital admissions or recent hospital admission for a chronic medical/ behavioral health condition
3. Multiple ER visits or recent ER visit for a chronic medical/behavioral health condition
4. High risk score
5. Physical limitations such as severely limited functional status, cannot accomplish ADLs/iADLs, high risk for falls
6. High resource needs: homelessness, food insecurity, safety issues, lack of transportation

Moderate risk:

1. Chronic condition but is managing well
2. Moderate risk score
3. End of life care
4. Moderate resource needs

Low risk:

1. Healthy with no chronic diseases
2. Health condition with no needs identified
3. No ER visits or hospital admissions in the past year
4. Low or no resource needs
5. Low risk score

CM Process:

1. Member is eligible for case management as determined by the section entitled: Methods for Identifying Members Eligible for Case Management
2. Member outreach is attempted as follows:
    a. Non-SSI members:
        i. Three outbound calls are made and an unable to reach letter are sent within the first two weeks of identification of eligibility for case management
        ii. If no response, do not open a case.

    b. SSI members:
        i. Three outbound calls are made and an unable to reach letter are sent within the first two weeks of receiving the new enrollment file
        ii. After this 2-week timeframe,
            1. outbound calls are attempted- one call per week for the first 60 days of enrollment for SSI members or until reached
            2. Targeted letters (unable to reach letter) are mailed once per week for the first 60 days of enrollment or until reached
        iii. If still unable to contact, member will be designated as low risk and outreach will be based on the low-risk status.
3. Upon contacting the member, the initial health needs assessment (HRA) is completed either telephonically or face to face with either the member or their designee (legal guardian) if applicable. Goal for completing the initial assessment (HRA) is 100%. If we are unable to contact the member, an assessment is mailed to the member. Member responses are documented in the assessment in the electronic care management system. A task is entered into the electronic care management system for one year to ensure HRAs are completed at least annually (every 12 months). Members are not required to complete an HRA, and refusals are documented in the electronic care management system.
4. The initial health needs assessment and information gathering is accomplished from a review of claims, conversation with the member and member's support systems, and discussion with the member's providers and will identify specific needs of the member in the following areas noted above.
5. A case is opened, and the member is placed in the complex case management program in the electronic care management system.
6. Member's health needs and initial risk stratification are determined based on a review and analysis of the initial assessment as well as the items as described above and the risk level is assigned (low, moderate, or high) and documented in the electronic care management system.
7. Individual Care Management Plan Development: A member centric and evidence based comprehensive individualized care plan is generated from the health needs assessment and information gathering as described above. Care plans are developed in accordance with any applicable State quality assurance and utilization requirements and respective clinical practice guidelines to ensure they are evidence based. Care plans are developed by appropriately qualified

case management staff who use a person-centered process, and in consultation with any providers caring for the member. Case management staff undergo extensive training when onboarding and annually on case management processes. Goal for completing the care plan is 100%. The essential components of the care plan will consist of the member's problems or health needs, prioritized goals, specific barriers to meeting the goals, and interventions including self-management strategies. Collaborative approaches to be used including participation of caregivers and family members are documented in the care plan. Resources to be used and any continuity of care or transitions of care will be documented in the care plan. The member's personal healthcare preferences are considered and documented in the care plan. The member's caregivers and support people are listed in the contact section of the electronic care management system. The care plan is housed in the care plan section of the electronic care management system. Care plans are reviewed and updated by the GHC case management staff with each member interaction, each interdisciplinary care team review, every contact with the member's care team (provider, community or county agency resources), after every subsequent assessment, and when there is a change in status such as new medical condition, hospitalization, or ER visit. The care plan is discussed/reviewed with the member with each interaction and is revised when requested by the member. Member's agreement with the care plan is documented in the care plan in the electronic care management system. The care plan is sent to the member and the member's provider after completion of the initial assessment and the annual assessment. The care plan is also shared with the ICT by reviewing the electronic version during the meeting. Care plans are also shared with the member and with the member's providers upon request or when applicable. Care plans are also submitted to WISHIN (Wisconsin HIE) so that providers can access member's care plans. Documentation that care plan was shared with the member and provider is documented in the correspondence of the electronic care management system.

8. Care Plan Goals: Goals are measurable, timebound and prioritized. Goals must be specific to the member's situation and needs and are developed with the member or care giver's preferences and desired level of involvement. Goals are initially determined during the initial assessment but are reevaluated during every annual health risk assessment and with each member interaction. Progress toward overcoming barriers and meeting treatment goals is evaluated with each member interaction and is documented in the goal section of the care plan as a percent completion for each goal. If the member does not demonstrate progress over time, the case manager reassesses the applicability of the goals to the member's circumstances and modifies the goals as appropriate.
9. Member's Strengths: Strengths are documented in the care plan and member's overall perception of their health is documented in the Start of Care Assessment.
10. Complex Case Management Follow-Up Schedule: Case management member telephonic outreach frequency is determined based on the member's needs and the risk level. These frequencies are a guide and may be adjusted based on the needs or preferences of the member:
    a. High risk level– at least every 3 months
    b. Moderate risk level- at least every 6 months
    c. Low risk level– at least every 12 months
    d. Declines CM-
        i. SSI members: keep the case open. Set risk level to low and call at the low risk level frequency as above.

ii. Non-SSI members: close the case.

e. CM staff will follow up within 7-10 days after providing any of the following: self-management support, member education, counseling, and referral to disease management programs or a health resource. If more frequent follow up is not felt to be necessary, then the follow up would default to the outlined schedule above.

f. Members will be contacted telephonically within 5 days of inpatient hospital discharge to coordinate care and to address the following:
   i. Medication review and reconciliation, including a comparison of medications prescribed versus taken by the member and medication schedule
   ii. Members ability to set up, administer, and monitor their own medication
   iii. Review discharge instructions
   iv. Educate on treatment plans including managing chronic conditions
   v. Assist with follow-up appointments (within 5 days of D/C)
   vi. Arrange for transportation

11. Assessing progress. Assessing progress to overcoming barriers to care and for assessing and adjusting the care plan is documented in the electronic care management system. Progress to overcoming barriers is addressed with each intervention and progress toward overcoming barriers is addressed in the care plan note section. With each member interaction, the care plan is assessed and updated to show progress.
12. All high-risk SSI members will participate in the interdisciplinary care team (ICT) meeting every week. SSI members will have a face to face visit every month.
    a. The care plan is updated at each ICT meeting and face to face visit.
13. Risk level for each member will be reviewed and updated with every member contact and with every ER visit and hospitalization, upon claims review, and at the ICT meetings. Risk level will be documented in the electronic case management system.
14. Rescreening with a health needs assessment or health risk assessment occurs annually (12 months) for all members. Members may be reassessed before 12 months if there is a significant health status change such as inpatient admission, ER visit, change in functional status, or new chronic condition. All assessments are documented in the electronic care management system and care plans are updated after every assessment. A Discharge Assessment is completed within 5 days of hospital inpatient discharge. After every reassessment, the members risk level is reviewed, analyzed, and assigned based on criteria as above and is updated in the electronic care management system.
15. Care coordination billing (SSI members only) will be as follows:
    a. G9001 – Coordinated care fee; initial rate (Initial assessment and care plan)
       i. Reimbursed once per 365 calendar days
       ii. Modifier N/A
    b. G9002 – Care coordination fee; maintenance (subsequent telephonic intervention)
       i. Reimbursement for implementation and maintenance of the care plan
       ii. Reimbursed once per month
       iii. Add modifier for risk level
    c. G9006 – Coordinated care fee; home monitoring (home visit)
       i. Add modifier for risk level

ii. Reimburse one per DOS
iii. Designate POS as follows:
1. 04 – homeless shelter
2. 12 – home
3. 14 – group home
4. 16 – temporary lodging

d. G9007 – Coordinated care fee, team conference
i. Reimburse four per calendar month per member
ii. Add modifier for risk level
e. G9012 – Transitional care management (hospital follow up)
i. Add modifier for risk level

16. Case management satisfaction survey will be completed by the member after 9 months in the program or when the case closes, whichever is sooner.
17. A case may be closed in the following situations:
a. Member is no longer on plan
b. Non-SSI members who refuse case management
c. Non-SSI members whose goals are met and are managing well

Interdisciplinary Care Team (SSI Only)

The purpose of an interdisciplinary care team is to provide a comprehensive and multidisciplinary team that serves in a consultative role and resource that can rapidly implement intensive interventions to meet the member's needs. The ICT has expertise in medical, behavioral, and social determinants of health. The member's case manager conducts the ICT meeting unless otherwise documented in the electronic care management system. The ICT meetings are conducted telephonically unless otherwise documented in the electronic care management system.

The interdisciplinary care team may consist of but is not limited to the following:
a case manager, health management staff with expertise in behavioral health and substance abuse or social worker license, county or community case workers or social workers, member's providers, a pharmacist, and a behavioral health RN. The ICT core team consists of at least two licensed health care professionals.

Risk Level Monitoring

The percentage of members in each case management risk level is monitored monthly to help determine case load mix for case managers and to ensure that we are enrolling members with high intensity needs into the high-risk level. The risk levels for the SSI product line are monitored monthly. When the percentage of SSI members in the high-risk level exceeds 5% of the SSI enrollment, the Case Management Manager notifies the GHC Compliance and Government Programs Manager. The GHC Compliance and Government Programs Manager notifies our DHS contact, the Managed Care Analyst from the Bureau of Quality and Oversight, within 15 days of the next calendar month.

Home Visits/ Face to Face Visits (SSI Members Only)

For SSI members, a home visit (face to face) occurs every month for members participating in the ICT. This visit can be done by any member of the ICT and should be done at a convenient location for the member. Locations may include member's home, clinic, hospital, church etc. Member's participating in the ICT should be willing to participate in home visits.

Addressing identified health concerns in the face-to-face visit
As health concerns or opportunities to improve health are identified during the face-to-face visit, these concerns or needs are reviewed during the ICT meetings, and the care plan is updated with the identified health concern and interventions and goals related to addressing the concern. Education to the member or member's caregiver is documented in the care plan.

Care Coordination Activities
Any member of the ICT can coordinate care or services for the member including referrals or scheduling services. GHC case management staff will ensure that coordination of care is occurring and will work with ICT members to verify that services are scheduled and completed. All care coordination activities are documented in the care plan and shared during the ICT meetings.

The encounter and the staff that complete the face-to-face visit will be documented in the care plan.

SSI Case Management Activity and Billing Audit

The billing for SSI case management activities is audited to ensure that activities are being accurately billed according to the Medicaid SSI HMO Care Management Benefit Billing and Reimbursement Guide. Every quarter the Health Management Auditor audits five random cases of each case manager to verify that billing was completed and is accurate. Care coordination billing is audited as follows:

1. Care coordination activities are audited to ensure the appropriate level of activity (appropriate HCPCS code) is billed. The following codes are audited including:
    a. G9001: Coordinated care fee; initial rate
    b. G9002: Care coordination fee; maintenance
    c. G9006: Coordinated care fee; home monitoring (home visit)
    d. G9007: Coordinated care fee, team conference
    e. G9012: Transitional care management
2. The following risk level modifiers are audited to ensure they are accurate and appropriate for the activity and the level of activity billed:
    a. High
    b. Medium
    c. Low
3. The following place of service modifiers are audited to ensure they are accurate and appropriate for the activity and the level of activity billed:
    a. 04 – homeless shelter
    b. 12 – home
    c. 14 – group home

d. 16 – temporary lodging

Case Management Training:

The case management staff are encouraged to become certified in case management by CMSA (or an equivalent certification organization). Case management staff receive annual training on the following topics:

1. Motivational interviewing
2. Shared Decision Making
3. Stages of Change model
4. Effective member outreach
    a. Various topics presented and these are based on identified member needs
5. CLAS competency
6. Impact of social determinants on health
7. Trauma informed care

Case Load Standards:

To ensure case management staff and the ICT have manageable caseloads and have adequate time to effectively coordinate the delivery of integrated care, GHC monitors care management team workloads based on their roles and responsibilities within the team. GHC has caseload standards in place and these are developed based on the case complexity, the need for licensed healthcare professionals and other care management staff to coordinate with other providers/community resources, the need for in-person contacts, management duties, including providing direction to care management team members and ensuring adequate documentation of care management activities. Caseloads are reviewed monthly and the standards are adjusted accordingly.

1. Case Manager: 350-500 cases
2. Case Management Coordinator/Case Management Specialist: 250 cases
3. Behavioral Health Coordinator: 300 cases
4. Health Education Specialist: 300 cases
5. Patient Care Coordinators: 30-40 calls per day

Michelle Bauer MD.

APPROVED: _____ DATE: 12/10/2025

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REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision
01/08/2016	Betsy Kelly, RN	Changed care management to case management, added types of case management, case management process
07/29/2016	Lynne Komanec, RN	Additional language on special health care needs added to second paragraph and reassessment added to section D
10/01/2016	Michele Bauer, MD	Revised to meet SSI guidelines for 2017
02/14/2017	Michele Bauer, MD	Added low care level to CM status and adjusted frequency of telephonic interventions
03/01/2017	Michele Bauer, MD	Revised caseload standards
04/14/2017	Michele Bauer, MD	Updated members of the ICT
05/22/2017	Michele Bauer, MD	Clarified section on risk stratification and added criteria for moderate and low risk levels
8/29/2017	Michele Bauer, MD	Added clarifying language on member outreach for assessments and re-evaluating risk levels
11/2/2017	Michele Bauer, MD	Revised criteria for risk levels, added home visit requirement, added eligibility criteria based on the HNA
10/10/2018	Michele Bauer, MD	Revised case load standards and added language about criteria for closing a case.
10/8/2019	Michele Bauer, MD	Updated outreach attempts process
3/20/2020	Michele Bauer, MD	Added information about DHS Optional Health Survey Data
10/2/2020	Michele Bauer, MD	Updated methods for identification and caseloads
11/2/2020	Michele Bauer, MD	Changed contact frequency for SSI members who decline CM
3/1/2021	Michele Bauer, MD	Updated descriptions of programs under CP guidelines
10/7/2021	Michele Bauer, MD	Added rescreening and referral processes, updated caseloads, and CM staff
1/25/2022	Michele Bauer, MD, CMO	Added D-SNP processes
4/13/2022	Michele Bauer, MD, CMO	Added purpose of ICT
5/24/2022	Michele Bauer, MD, CMO	Clarified transitional care components and changed policy title from process to program. Clarified screening includes paid or unpaid services/supports. Clarified that chronic

		and urgent conditions are assessed in the initial screening.
6/13/2022	Michele Bauer, MD, CMO	Updated community resource section.
7/18/2022	Michele Bauer, MD, CMO	Added process for PCP lock in, process connecting members with providers, clarified ICTs-who conducts and where conducted, added goals for completing HRAT, care plans, and ICTs. Clarified how often HRAs are completed.
11/15/2022	Michele Bauer, MD, CMO	Removed reference to the chat app. Updated process for assessing progress with care plan.
11/15/2023	Michele Bauer, MD, CMO	Deleted DSNP processes and moved to its own policy. Updated caseloads and clinical practice guidelines.
8/25/2024	Michele Bauer, MD, CMO	Added information on caseload standards, SSI billing audit process, risk level monitoring, and members with special healthcare needs.
9/1/2024	Michele Bauer, MD, CMO	Updated call frequencies.
2/3/2025	Michele Bauer, MD, CMO	Updated process for determining member strengths. Updated methods for determining risk and methods for identifying members for case management. Updated self-management strategies to include that case managers help with appt compliance.
5/2/2025	Michele Bauer, MD, CMO	Updated care plan section
7/30/2025	Michele Bauer, MD, CMO	Clarified risk stratification method monitoring to meet DHS contract requirements.
12/10/2025	Michele Bauer, MD, CMO	Added details of the SSI care coordination activities billing audit.