**Case Manager Policies and Procedures Example**

*Disclaimer:  The Division of Healthcare Financing has provided the following document as an example.  Case managers may use this example as a starting point to develop policies and procedures that are specific to their circumstances.  Policies and procedures must meet the minimum standards established in Chapter 45 of the Department of Health’s Medicaid Rules. Case managers are encouraged to develop additional policies and procedures that address their specific needs, but are reminded that they must follow the policies and procedures that they adopt.*

Case Management Agency:

**Participants Served:** The case management agency will serve participants in \_\_\_\_\_\_\_\_\_\_\_\_\_ County or counties. The case management agency will accept participants who are eligible for the Comprehensive and Supports Medicaid waivers. The case management agency will also assist and provide targeted case management services to participants who are completing the eligibility process for the Supports and Comprehensive Waivers. The case management agency will only work with participants who qualify for these waivers once an eligibility determination has been made. The case management agency intends to provide services to both children and adults. If serving participants who live further than 50 miles from the case management agency, to ensure availability to complete all required on site activities such as home visits and service observations, the case management agency will plan to operate in the following manner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Criteria for Order of Acceptance:** The case management agency will accept participants on a first come first serve basis depending on if the case management agency has capacity on its caseload. If two participants apply for services at the same time, the case management agency will work with the participant that the case management agency feels it has the best ability to serve. Criteria used for this determination includes the location of the participant, potential conflicts, caseload capacity, the needs of the participant, and the intensity of support required.

**Initial Case Management Interview:**  Prior to accepting a participant for case management services, the case management agency will meet with the participant and his or her legally authorized representative (LAR) to discuss the agency and its services, answer questions, and learn more about the participant in order for all parties to have a clear understanding of agency and participant expectations. Meeting with the case manager does not obligate the participant to choose them as a case manager, but allows both parties to determine if they would like to work together. Additional ways the case management agency provides information on its services include: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible person to make decisions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is responsible for all decisions regarding acceptance of participants to whom case management services will be provided.

**Criteria for Acceptance Decisions:**  Acceptance decisions will be made on a case by case basis. All participants must meet the following criteria to receive case management services from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

1. Be eligible for the Medicaid Comprehensive or Supports Waivers or the ability to become waiver eligible
2. Commit to receiving monthly case management services in a manner that meets the current Division of Healthcare Financing service definition for case management, including allowing the participant's case manager to complete a home visit as required, develop the participant's Individualized Plan of Care (IPC), with the participant's input, and allow the participant's case manager to observe the participant and the participant's provider during waiver services.
3. Commit to being an active participant in planning services and developing the IPC.
4. Commit to choosing a case manager that is free of conflict and ensuring that any conflicts are disclosed upon acceptance by the case manager.

In addition to the participant and their legally authorized representative (LAR) agreeing to the above, an acceptance decision will also take into consideration the case manager’s current caseload size, education and knowledge of the participant and their needs. The participant will be notified in writing of the final acceptance decision, which is based on the case manager’s availability and ability to meet the participant needs and expectations, within \_\_\_\_\_\_\_\_\_\_\_ business days.

**Denial of Services Appeal process:**  Should the case manager deny case management services to the participant, the participant or his/her LAR can request, in writing, a reconsideration of this denial. If there are any additional facts that should be presented they should be included in the written request. The case manager will notify the participant by letter within \_\_\_\_\_ business days of the appeal decision, including a written explanation of the outcome of the appeal and the next steps that should be taken.

**Referrals to other services providers including other case managers:**  At least every six months or as other situations requiring referrals arise, the case management agency will supply a list of providers that provide service in the desired region to the participant served and the LAR. Should the participant and/or their LAR indicate they would like a new case manager, the case management agency will provide them with a provider list or directions on where to find the provider list on the Department of Health/Division of Healthcare Financing section of the website. The case management agency will assist as requested. Should the participant or his/her LAR decide they no longer require its services the case management agency will refer them to the local Benefits and Eligibility Specialist for the State of Wyoming to determine the next steps they should take.

**Written Notification of Denial of Services:**  As stated above, any denial of services to any participant will be communicated in writing within 14 days of the denial. The reason for the denial, and the process for requesting a reconsideration, will be included.

**Conflict Free Policy:** Per Wyoming Medicaid Rule, Chapter 45, Section 5, the case management agency cannot provide conflicted case management services. The case management agency will not be able to work with participants or providers that the case manager is related to in the third degree. The case management agency agrees to follow these guidelines in order to be in compliance with state and federal laws. Should the case management agency identify that there is a conflict between the case management agency and a chosen provider, the case management agency will immediately offer choice to the participant and allow him/her to determine if s/he would like to work with the case management agency or the provider. Should the participant choose to change case managers, the case management agency will utilize its back up case manager until a new case manager can be chosen. Should the participant decide to change providers, the case management agency will assist the participant in choosing a new provider and complete the transition no later than 30 days from the identification of the conflict. Should there be any other conflict of interest that is not identified in Chapter 45 rules, the case management agency will notify the participant and their LAR to discuss the conflict. The team will come up with a solution to resolve the conflict as quickly as possible. The solution could include a change in provider or case manager.

**Case Manager Availability:** The case management agency intends to be available \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (days) from the hours of \_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_. The case management agency may work outside of these established hours to complete home visits, service observations and other duties needed to fulfill its role as a case manager. The participant can reach the case manager at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for after-hours emergencies and important issues that cannot wait until scheduled office hours. Please note that case management is not a 24 hour service. The participant may need to leave a message, to which the case management agency will respond within \_\_\_\_\_\_\_ hours. Should the participant need immediate assistance, it is important that the participant contact the participant's established support team.

If the case manager goes on vacation or is unavailable for an extended period of time, the case management agency will inform the participant, if possible, at least \_\_\_\_\_\_ week(s) in advance. At the time the case management agency informs the participant that they will not be available, the case management agency will give the participant information regarding the expected length of absence.

**Back-up Case Manager:** The case management agency has a backup case manager for each participant served, as identified in the Electronic Medicaid Waiver System (EMWS), who will assume case management responsibilities in the event that the current case manager is unable to provide case management services. The case manager will meet with the backup case manager for each participant on his or her caseload in order to update the backup case manager on a quarterly basis to review each participant’s medical condition and overall status. The case management agency will notify participants of the need to transition to the backup case manager using the following method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The backup case manager will be utilized for the following reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medication Assistance Policy and Procedures:** The case management agency will act as the second line monitor for participants on the waiver who receive medications. The case management agency is responsible for ensuring that medical needs are addressed and medication regimens are delivered in a manner that promotes the health, safety and well-being of the participant. In order to do this, the case management agency must have access to the following information for all participants to whom the case management agency provides case management:

1. Current medications, including PRN medications, which are currently prescribed, as well as over the counter medications that are currently used by the participant.
2. Notification of a person’s medical appointments, including the outcome and follow up required.
3. Access to provider’s Medication Assistance Records (MARs) and PRN medication usage records on at least a monthly basis.

Through review of the above information, the case management agency will monitor and review trends regarding the usage of the participant's over the counter, PRN, and prescription medications. This information will be documented in the case manager’s monthly case review notes. Should there be anything from this review that needs further discussion, a team meeting will be scheduled to ensure that medical needs are met.