

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

Table of Contents

1.0	Description of the Procedure, Product, or Service.....	1
1.1	Definitions	1
2.0	Eligibility Requirements	1
2.1	Provisions.....	1
2.1.1	General.....	1
2.1.2	Specific	2
2.2	Special Provisions.....	2
2.2.1	EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age	2
2.3	Eligible Categories.....	3
2.3.1	Medicaid Card.....	3
2.3.2	Beneficiaries with Medicaid for Pregnant Women Coverage	3
2.4	Ineligible Categories	3
2.4.1	Medicaid for Family Planning Waiver	3
2.4.2	Medicare Qualified Beneficiaries	3
3.0	When the Procedure, Product, or Service Is Covered.....	4
3.1	General Criteria Covered	4
3.2	Specific Criteria Covered.....	4
3.2.1	Specific criteria covered by both Medicaid and NCHC	4
3.2.2	Medicaid Additional Criteria Covered.....	4
3.2.3	NCHC Additional Criteria Covered	4
4.0	When the Procedure, Product, or Service Is Not Covered.....	5
4.1	General Criteria Not Covered	5
4.2	Specific Criteria Not Covered.....	5
4.2.1	Specific Criteria Not Covered by both Medicaid and NCHC.....	5
4.2.1.1	Non-Covered Institutions.....	5
4.2.1.2	Non-Covered Activities	5
4.2.2	Medicaid Additional Criteria Not Covered.....	6
4.2.3	NCHC Additional Criteria Not Covered.....	6
5.0	Requirements for and Limitations on Coverage	6
5.1	Prior Approval	6
5.2	Prior Approval Requirements	6
5.2.1	General.....	6
5.2.2	Specific	6
5.3	Limitations or Requirements.....	6
5.4	Medical Home and Written Physician Orders	7
5.4.1	Medicaid Opt-Out Option.....	7
5.5	Monitoring Criteria.....	7
5.5.1	Medicaid for Pregnant Women.....	8

5.6	Core Components	8
5.6.1	Assessment	9
5.6.2	Care Planning.....	9
5.6.3	Referral, Linkage and Resource Development	10
5.6.4	Monitoring and Follow-up Activities	10
5.6.5	Reassessments.....	10
5.6.6	Discharge or Termination	10
6.0	Providers Eligible to Bill for the Procedure, Product, or Service	11
6.1	Provider Qualifications and Occupational Licensing Entity Regulations.....	11
6.1.1	HIV Case Manager	12
6.1.2	Case Management Experience.....	12
6.1.3	Knowledge, Skills and Abilities	13
6.1.4	HIV Case Management Supervisor	13
6.1.5	Case Management Supervisor’s Experience.....	14
6.1.6	Contract Staff.....	15
6.1.7	Training Requirements	15
6.1.7.1	Training for Case Managers and Supervisors.....	15
6.1.7.2	Annual Training.....	15
6.2	Provider Certifications	16
6.2.1	Certification Requirements	16
6.2.2	Certification and Decertification Process	16
6.2.3	Initial Certification.....	17
6.2.4	Recertification.....	19
6.2.5	Decertification	20
7.0	Additional Requirements	21
7.1	Compliance	21
7.2	Coordination of Care	21
7.3	Transfer.....	21
7.4	Beneficiary Record Documentation Requirements.....	22
7.4.1	Record Retention	22
7.5	Documentation Requirements.....	22
7.6	Documentation Time Frame Requirements	23
7.6.1	Electronic Records.....	24
7.7	Quality Improvement Plan.....	24
7.8	Quality Assurance Site Visits	25
7.9	Requests to Expand.....	25
8.0	Policy Implementation/Revision Information.....	27
Attachment A:	Claims-Related Information	31
A.	Claim Type	31
B.	International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)	31
C.	Code(s).....	31
D.	Modifiers.....	32
E.	Billing Units.....	32

F.	Place of Service	32
G.	Co-payments	32
H.	Reimbursement	32

1.0 Description of the Procedure, Product, or Service

Human Immunodeficiency Virus Case Management (HIV CM) is a service that assists eligible beneficiaries to gain access to needed medical assistance. The goal of HIV Case Management services is to facilitate the beneficiary's medical, social, and educational needs.

HIV Case Management contains the following core service components: assessment, care planning, referral and linkage, monitoring and follow-up. Refer to **Subsection 5.6** for definitions of the core service components. The provision of this service requires those beneficiaries who are in eligible categories to establish and maintain a medical home with the Community Care of North Carolina (CCNC) Program and Network and North Carolina Community Care Networks, Inc (NCCCN) shall be responsible for the coordination of the beneficiary's overall health care. **Note:** References to the provider throughout this policy denote the HIV Case Management agency.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

a. Medicaid

None Apply.

b. NCHC

None Apply.

Note: Due to the age requirements for this program for NCHC beneficiaries, all references to actions required of the NCHC beneficiary denote the beneficiary’s legally responsible representative.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the

beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

i. EPSDT does not apply to NCHC beneficiaries

ii. Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

3. NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

2.3 Eligible Categories

2.3.1 Medicaid Card

Beneficiaries with regular Medicaid identification (MID) cards may be eligible for HIV Case Management services.

2.3.2 Beneficiaries with Medicaid for Pregnant Women Coverage

Medicaid for Pregnant Women (MPW) is limited to medical conditions related to pregnancy or complications of pregnancy. Pregnant women who are covered by MPW may be eligible for HIV Case Management services due to the potentially adverse impact of HIV upon the pregnancy, the fetus, or the infant.

NCHC beneficiaries are not eligible for MPW.

2.4 Ineligible Categories

2.4.1 Medicaid for Family Planning Waiver

Beneficiaries who are covered by Medicaid for Family Planning Waiver benefits are not eligible for HIV Case Management services.

2.4.2 Medicare Qualified Beneficiaries

Medicaid beneficiaries with Medicare ~~Aid~~ coverage are not eligible for HIV Case Management services.

Refer to *NCTracks Provider Claims and Billing Assistance Guide*:
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html> for
additional information on Medicaid eligibility.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid or NCHC shall cover procedures, products, and services related to this policy when they are medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover HIV CM for a beneficiary who has a documented diagnosis of HIV disease or HIV seropositivity. The documentation must contain at least ONE of the following:

- a. Confidential positive HIV test results using:
 1. antibody (Ab) testing (2 or more repeated positive (Ab) tests by Enzyme-linked immunosorbent assay ELISA),
 2. a positive ELISA or Enzyme immunoassay (EIA) confirmed by Western Blot; or
 3. a positive HIV Ribonucleic acid (RNA) test;
- b. Physician's statement, indicating diagnosis;
- c. Hospital discharge statement or other medical report that verifies diagnosis;
or
- d. Copy of approval for participation in the North Carolina AIDS Drug Assistance Program (ADAP).

3.2.2 Medicaid Additional Criteria Covered

In addition to the specific criteria covered in **Subsection 3.2.1** of this policy, Medicaid shall cover HIV CM services for Infants (birth to 12 months) born to HIV-infected mothers without regard to their HIV status.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid or NCHC shall not cover procedures, products, and services related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

4.2.1.1 Non-Covered Institutions

Medicaid and NCHC shall not cover HIV CM services while a beneficiary is institutionalized in ONE of the following facilities:

- a. A general hospital, psychiatric hospital, ~~or~~ nursing facility or inpatient detoxification;
- b. An intermediate care facility for the Intellectually and Developmentally Disabled (ICF-IDD);
- c. Any form of incarceration; or
- d. A halfway house that provides case management.

Note: HIV Case Management services may be provided on the day of a beneficiary's admission to a facility and on the day of discharge from a facility. These services must not duplicate the responsibilities of the discharge planner.

4.2.1.2 Non-Covered Activities

Medicaid and NCHC shall not cover any of the activities listed below as HIV CM services. The following list is not all inclusive:

- a. Institutional (hospital and nursing facility) discharge planning;
- b. Beneficiary outreach activities, such as contacting potential beneficiaries;
- c. Direct services, such as transporting beneficiaries or delivering food and medication;
- d. Activities that are deemed administrative expense, such as time spent in billing, writing progress notes, or attending supervisory conferences;
- e. Activities that are not specific to the beneficiary (that is, services directed to assist another family member);
- f. Counseling and therapy services, such as treatment adherence, religious and pastoral care;

- g. Case management activities that are an integral component of another covered Medicaid and NCHC service;
- h. Activities integral to the administration of foster care programs; or
- i. Activities that are integral to the administration of another non-medical program, except for case management that is documented in an individualized education program (IEP) or individualized family service plan (IFSP) according to Section 1903 (c) of the Social Security Act.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 - 1. No services for long-term care.
 - 2. No nonemergency medical transportation.
 - 3. No EPSDT.
 - 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid and NCHC shall not require prior approval for HIV CM.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Limitations or Requirements

The number of units of HIV CM services provided to a beneficiary cannot exceed 16 units per calendar month.

Ongoing HIV CM services beyond two (2) consecutive months requires a written physician order, by the beneficiary’s Primary Care Physician (PCP), attesting to the medical necessity of the additional case management.

The beneficiary to staff ratio may not exceed thirty to one.

5.4 Medical Home and Written Physician Orders

When the beneficiary's aid category mandates enrollment in managed care, the beneficiary shall be enrolled, or the HIV CM provider's chart must contain documentation from Department of Social Services (DSS) that a CCNC Program medical home is unavailable.

The requirement to enroll with a Primary Care Physician with CCNC Program Carolina Access (CA) is not intended to sever that individuals' relationship with their specialist, be it Pediatric HIV doctor or Infectious Disease doctor, rather it seeks to ensure that the patients receive evidence-based, preventive, primary services, and that services are coordinated with the medical home. For children, this would include services such as well visits, immunizations, and developmental screenings that are not routinely offered by specialists.

Once the beneficiary enrolls with a CCNC Program CA provider, it places an additional requirement for coordination of care on the PCP. As the gatekeeper, the primary care physician provides authorization for pediatric or adult specialist services.

Beneficiaries enrolled with a CCNC Program provider may qualify for additional services through the CCNC network if they meet certain high-risk criteria. These services can consist of care management, disease management, transitional care and medication reconciliation.

Regardless of enrollment, the HIV Case Management provider is responsible for promoting and coordinating the beneficiary's care with a PCP. NCCCN, Inc. and the CCNC Network are responsible for primary care case management.

The provider shall obtain a physician's or attending practitioner's written order that details the need for the initiation of HIV CM services. An additional written physician's order from the beneficiary's primary care physician must also be obtained to attest to the medical necessity of ongoing case management services beyond two consecutive months. In order to ensure the continued appropriateness for HIV Case Management, if the beneficiary continues to have unmet needs, then the provider shall obtain a physician's written order from the PCP annually.

5.4.1 Medicaid Opt-Out Option

Medicaid beneficiaries who are children with special health care needs currently have the option of "opting out" of the managed care program. While this is an option, it is not considered the best clinical course of action for the Medicaid beneficiary.

5.5 Monitoring Criteria

Ongoing communication with the CCNC Network or the beneficiary's primary care physician is required to ensure appropriate coordination of care. The CM shall engage in communication that shall consist of the criteria below. Agencies shall use DMA-3155, or similar tracker, to document communication with PCP or Medical Home.

The case manager shall have monthly contact with the CCNC Network or the beneficiary's primary care physician with updates on:

1. Changes in nutritional status based on self-report or CM observation.
2. Number of hospitalizations during reporting period. Specify inpatient versus emergency room visits.
3. Compliance with medication regimen.
4. Self-report of new symptoms and
5. Social determinants.

5.5.1 Medicaid for Pregnant Women

Female Medicaid beneficiaries who qualify for HIV Case Management under MPW are considered to be in a high-risk category. Therefore, in addition to the criteria listed above in **Subsection 5.5**, the CM shall assure that the beneficiary is receiving her annual physical exam and that coordination of care occurs for the following risk factors:

1. Tobacco use.
2. Homelessness.
3. Substance abuse.
4. Intimate partner violence.
5. Anemia.
6. Hypertensive disorders.
7. Other chronic diseases (SLE, sickle cell, asthma, seizure disorder).
8. Fetal complications (IUGR, anomaly, hydrops).
9. Hyperemesis.
10. Mental illness.

5.6 Core Components

Each core service component must be fully documented within the beneficiary record. The provider shall adhere to strict confidentiality rules and obtain necessary release of information according to the agency's policy and state and federal regulations.

Note: Standards of care for HIV Case Management, as described in the Core Components below, must be followed.

5.6.1 Assessment

HIV CM's shall screen and evaluate the prospective beneficiary's status to determine the need for initial case management services. This is accomplished through an information gathering and decision-making process, which consists of intake and assessment.

The HIV CM shall collect, analyze, synthesize, and prioritize information in order to identify needs, resources, and strengths. The CM's signature is required on the assessment tool. The documentation in the assessment must contain observation of the beneficiary's physical appearance and behavior during the assessment interview.

At a minimum, each area identified below must be addressed:

- a. Coordination and follow-up of medical treatments;
- b. Provision of treatment adherence education to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Treatment adherence education and counseling is a direct service and is not covered. The HIV CM is responsible for linking the beneficiary to a provider of this service;
- c. Physical needs, to include both activities of daily living and instrumental activities of daily living;
- d. Mental health, substance abuse, developmental disability needs;
- e. Housing and physical environment status;
- f. Financial needs; and
- g. Socialization and recreational needs.

5.6.2 Care Planning

This component builds on the information collected through the assessment process and specifies goals and actions to address the medical, social, educational, and other services needed by the eligible beneficiary. Care planning activities should ensure the active participation of the beneficiary and others, to develop goals and to identify a course of action to respond to the assessed needs.

The care plan must be completed with the initial assessment, at the annual reassessment, and as needed, secondary to unanticipated events or changes in a beneficiary's status. The care plan must be signed and dated by the CM, and beneficiary or the beneficiary's legally responsible representative. The CM's signature shall constitute their legal signature, consisting of first and last name with title or initials (if applicable), indicating licensure or certification.

For purposes of care planning for managed care beneficiaries through the CCNC Program, the CM shall use the NCCCN, Inc. web-based applications to obtain clinical information pertinent to establishing care plan goals. If the beneficiary is an open CM status with a CCNC Network, then they shall contact the CCNC Care Manager for coordination of care.

5.6.3 Referral, Linkage and Resource Development

This component consists of making referrals, scheduling appointments, and performing other activities that help link beneficiaries to medical, social, and educational providers and to other programs and services identified in the care plan.

5.6.4 Monitoring and Follow-up Activities

This component consists of activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the beneficiary. Monitoring and follow-up activities are to be conducted monthly, but at least quarterly, and as frequently as necessary to help determine whether:

- a. the beneficiary is receiving medical treatment;
- b. services are being furnished in accordance with the beneficiary's care plan;
- c. services in the care plan are needed;
- d. services in the care plan are adequate; and
- e. there are changes in the needs or status of the beneficiary, and if so, whether
 1. necessary adjustments have been made in the care plan and service arrangements with the providers, or
 2. the beneficiary's goals have been met and the beneficiary has been discharged, if appropriate.

5.6.5 Reassessments

The HIV CM shall conduct a reassessment to determine the continued appropriateness of services and the continued need for services. The reassessment is conducted at least every 12 months and as needed, secondary to unanticipated events or changes in the beneficiary's physical, mental or social status. The reassessment requirements are the same as those specified in **Subsections 5.6.1 and 5.6.2**, Assessment and Care Planning. Care plan progress, changes, and mutually agreed-upon goals, must also be addressed in the care plan completed at reassessment.

5.6.6 Discharge or Termination

- a. Reasons for termination include, but are not limited to, the following:
 1. beneficiary desires services from another case management agency secondary to relocation or beneficiary choice;
 2. beneficiary's goals met, per the plan of care;
 3. beneficiary's unwillingness or refusal to participate in agreed-upon care plan, or refusal to establish or maintain a medical home with a primary care physician;
 4. beneficiary's decision to terminate services;
 5. lack of contact between beneficiary and CM (CM unable to contact beneficiary after repeated attempts over a three-month period);
 6. beneficiary's abuse of staff, property or services;
 7. determination that beneficiary is HIV seronegative;
 8. beneficiary death.
- b. The HIV CM shall discharge or terminate the beneficiary from services through a systematic process, which must include the following:
 1. written notification to the beneficiary of pending discharge at least seven business days in advance of discharge or termination.

Note: This requirement does not apply to the beneficiary's request for discharge, which must be immediate in keeping with the request to discharge or transfer to another provider.

2. clear delineation of the reason(s) for discharge; and
3. preparation of a written discharge summary, which must be prepared and placed in the beneficiary's HIV Case Management record within seven days of the final decision to terminate services. A copy of the summary must be sent to the beneficiary's primary care physician.
- c. The discharge summary must include, at a minimum, the following:
 1. identifying information;
 2. referral and linkage to resources following discharge from HIV Case Management services;
 3. summary of services provided;
 4. reason and effective date of the discharge; and
 5. CM's legal signature and credentials.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, the provider(s) shall:

- b. meet Medicaid or NCHC qualifications for participation;
- c. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- d. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

The provider shall attest by signature that services billed were medically necessary and were actually delivered to the beneficiary.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

The following actions, taken by NC Medicaid, or DHHS designated contractor, shall render a provider ineligible for certification as a provider of HIV Case Management.

- a. previous actions taken to decertify agency as a provider of HIV Case Management.
- b. provider number suspended as a result of sanctions imposed by Program Integrity.
- c. failure to repay any monies owed to the North Carolina Medicaid program.

It is the responsibility of the provider to verify staff qualifications and credentials prior to hiring and assure, during their employment, that the staff member continues to meet the requirements set forth in this policy. Verification of staff credentials must be maintained by the provider.

6.1.1 HIV Case Manager

An HIV CM shall meet *one* of the following qualifications:

- a. Hold a master's degree from an accredited college or university in a human services field, including, but not limited to, social work, sociology, child development, maternal and child health, counseling, psychology, or nursing.
- b. Hold a bachelor's degree from an accredited school of social work.
- c. Hold a bachelor's degree from an accredited college or university in a human services field or related curriculum, including at least 15 semester hours in courses related to social work, counseling, or public health; and have six months of social work or counseling experience.
- d. Hold a bachelor's degree from an accredited college or university and have one year of experience in counseling or in a related human services field that provides experience in techniques of counseling, casework, group work, social work, public health, or human services.
- e. Be licensed, if applicable, by the appropriate licensure board in North Carolina as a registered nurse, nurse practitioner, physician, physician assistant, or certified substance abuse counselor and have two years of experience working in human services.

In addition, the CM shall possess two years' case management experience. All CM's shall possess, or acquire through cross training, a clinical understanding of HIV, as evidenced by documentation in their personnel file.

A standard year of work experience is calculated at 2080 hours per calendar year. An accredited educational institution is one that is nationally recognized. Refer to a regional accreditation organization or the U.S. Department of Education Web site at <http://www.ed.gov>.

6.1.2 Case Management Experience

Case management experience must encompass the functions of intake, assessment, reassessment, care planning, case coordination, case conferencing, care plan implementation, referral, linkage and resource development, crisis intervention, monitoring and follow-up of services provided and discharge or termination.

The CM shall possess the following core competencies:

- a. Able to perform the assessment;
- b. Able to provide beneficiary-centered goals for meeting desired outcomes developed in the care plan;
- c. Able to provide referral and linkage to beneficiaries serviced;
- d. Able to provide effective and efficient monitoring of care and service rendered to beneficiaries; and
- e. Able to provide documentation and attestation as to accuracy of the entry by personal signature.

6.1.3 Knowledge, Skills and Abilities

The CM shall possess and demonstrate the following:

- a. Basic knowledge of HIV disease, prevention and treatment techniques. The CM shall have documented proof within one year of their hire date that they possess this knowledge. The knowledge must be based on current clinical practice, defined as standards of practice prevalent from their date of hire through the date of verification. The basic knowledge must include: methods of transmission and treatment, common definitions, general knowledge of medications used to treat HIV and barriers to medication and treatment compliance;
- b. Communication skills, including listening, written, verbal and non-verbal skills;
- c. Ability to gather information and data, and accurately synthesize into written form;
- d. Ability to identify resources, both formal and informal;
- e. Ability to initiate obtaining professional or clinical assessments;
- f. Ability to evaluate environmental stressors;
- g. Observation skills inclusive of human behavior, family dynamics, mood changes, etc;
- h. Ability to assess the cultural environment and to interact in a culturally sensitive manner;
- i. Ability to determine if identified services meet the intensity of needs of the beneficiary, and are accomplishing the desired outcomes;
- j. Prioritization skills, including time management, planning and organization and professional judgment skills;
- k. Ability to review data and draw appropriate conclusions to address the needs of individuals served; and
- l. Ability to accurately document case management activities and attest to its accuracy by personal signature.

6.1.4 HIV Case Management Supervisor

An HIV Case Management supervisor shall meet *one* of the following qualifications:

- a. Hold a master's degree from an accredited college or university in a human services field, including, but not limited to, social work, sociology, child development, maternal and child health, counseling, psychology, or nursing; and one year of human services experience;
- b. Hold a bachelor's degree from an accredited school of social work and have two years of human services experience;
- c. Hold a bachelor's degree from an accredited college or university in a human services field or related curriculum, including at least 15 semester hours in courses related to social work or counseling and have two years of experience in human services or public health;
- d. Hold a bachelor's degree from an accredited college or university, and have either, three years of human services experience, or two years of human services experience plus one year of supervisory experience; or

- e. Be licensed, if applicable, by the appropriate licensure board in North Carolina as a registered nurse, nurse practitioner, physician, physician assistant, or certified substance abuse counselor; and have either, three years of human services experience, or two years of human services experience plus one year of supervisory experience.

In addition, the CM's supervisor must possess three years' case management experience.

6.1.5 Case Management Supervisor's Experience

Case management experience must encompass the functions of intake, assessment, reassessment, care planning, case coordination, case conferencing, care plan implementation, referral, linkage and resource development, crisis intervention, monitoring and follow-up of services provided and discharge or termination.

Knowledge, Skills and Abilities

In addition to those listed for the CM, the case management supervisor must possess and demonstrate the following knowledge, skills and abilities:

- a. Ability to direct and evaluate the scope and quality of case management services;
- b. Knowledgeable in case management principals, procedures and practices;
- c. Ability to conduct detailed analytical evaluations and studies, and prepare related reports and recommendations; and
- d. Apply professional level of knowledge of federal and state assistance programs for HIV positive population.

The provider shall identify the HIV CM program supervisor within the organization. The supervisor is to provide supervision that addresses both the clinical and professional aspects of the CM's job performance. This is defined as providing regularly scheduled assistance by a qualified professional to a staff member who is working directly with beneficiaries.

The purpose of clinical supervision is to ensure that each beneficiary receives case management services which are consistent with accepted standards of practice and the needs of the beneficiary and care plan.

Documentation of supervisory review of CM's caseload and proper utilization of case management services is required. The supervisor shall attest to the accuracy of the documentation by a personal signature to include credentials and title. Each beneficiary record must reflect supervisory review every 4 weeks at a minimum. The frequency of the reviews must be increased if the findings warrant such action. The review must include the following: the beneficiary record to assure that all required paperwork as defined by this policy is in the record and progress notes must be reviewed for compliance with the requirements in **Subsections 7.5 and 7.6**. The billing must be checked for accuracy to assure it corresponds to the progress notes. This is not billable case management time.

6.1.6 Contract Staff

Providers may elect to contract with qualified CMs and supervisors. The same qualifications and training requirements described in **Subsections 6.1.1, 6.1.2, 6.1.3 and 6.1.4 and 6.1.5** and training requirements described in **Subsection 6.1.7** are required of both employees and contractors.

6.1.7 Training Requirements

6.1.7.1 Training for Case Managers and Supervisors

All HIV case managers and case management supervisors shall complete North Carolina state-sponsored, basic training within 90 days of their employment date, and must be completed prior to any billed case management units. It is the responsibility of providers to retain copies of certificates of completion issued by NC Medicaid or DHHS designated contractor.

Upon successful completion of basic training, the CM or supervisor will be able to perform all the following:

- a. describe basic HIV information and prevention techniques;
- b. describe the scope of work for CMs;
- c. identify and explain the core components of HIV Case Management;
- d. demonstrate an understanding of basic ethical issues relating to case management;
- e. demonstrate an understanding of the responsibilities and functions of the HIV CM system of care; and
- f. demonstrate an understanding of the documentation requirements of this program as defined in **Subsections 7.5 and 7.6**.

6.1.7.2 Annual Training

All HIV CMs and supervisors shall complete twelve (12) hours of continuing education related to HIV Case Management annually. It is the responsibility of providers to retain copies of certificates of completion.

Annual training topics must include, but are not limited to the following:

- a. confidentiality;
- b. cultural competency;
- c. current trends in HIV disease management;
- d. ethics;
- e. refresher core components of case management; and
- f. treatment of individuals who are HIV positive. Six hours of the twelve hour annual requirement must include clinically oriented training (clinical updates).
- g. Suggested resources include, but are not limited to the following:
 1. Partners in Information Access for the Public Health Workforce
 2. Carolina Care Partnership
 3. North Carolina AIDS Education Training Center

4. North Carolina Area Health Education Centers

6.2 Provider Certifications

6.2.1 Certification Requirements

Provider agency types may include home health agencies, home care agencies, hospices, health departments, hospitals, departments of social services, federally qualified health clinics, rural health clinics, community-based organizations (CBO), and local management entities.

Agencies shall obtain certification from NC Medicaid, or DHHS designated contractor, to be considered for enrollment with NC Medicaid as an HIV Case Management provider.

To qualify for reimbursement for HIV Case Management services, a provider shall meet all the criteria below:

- a. Have a documented successful record of three (3) years of providing or managing HIV Case Management programs;
- b. Ensure the provision of HIV Case Management services by qualified CM's as described in **Subsections 6.1.1, 6.1.2, and 6.1.3** of this policy;
- c. Ensure supervision of HIV CM by qualified supervisors as described in **Subsections 6.1.4 and 6.1.5** of this policy;
- d. Enroll each physical site with NC Medicaid as a provider of HIV Case Management services in accordance with §1902(a)(23) of the Social Security Act;
- e. Meet applicable state and federal laws governing the participation of providers in the Medicaid program;
- f. Maintain certification as a qualified provider of HIV Case Management services;
- g. Demonstrate compliance with initial and ongoing certification processes;
- h. Demonstrate compliance with the monitoring and evaluation of case management records through a quality improvement plan;
- i. Allow NC Medicaid, or DHHS designated contractor, to review beneficiary records and inspect agency operation and financial records;
- j. Notify NC Medicaid, or DHHS designated contractor, of proposed changes, such as business owner or name change, address or telephone number change, or plans for business dissolution within 30 calendar days of proposed change, and no later than five business days of the actual change; and
- k. Within one year of enrollment with Medicaid as a provider, the provider must have achieved national accreditation with at least one of the designated accrediting agencies. Designated accrediting agencies are the following: Accreditation Commission for Health Care (ACHC), Commission on Accreditation of Rehabilitation Facilities (CARF), Community Health Accreditation Partner (CHAP), Council on Accreditation (COA), Public Health Accreditation Board (PHAB), The Joint Commission, and Utilization Review Accreditation Commission (URAC).

6.2.2 Certification and Decertification Process

NC Medicaid, or DHHS designated contractor, is responsible for certifying qualified HIV Case Management providers to render services in accordance with professionally recognized standards, and as specified by this policy, and also for

decertifying those HIV Case Management agencies that fail to render services in accordance with professionally recognized standards, and as specified by this policy.

6.2.3 Initial Certification

A provider shall comply with all the requirements specified below. The initial certification is valid for one year. Submit a complete and signed application to NC Medicaid, or DHHS designated contractor, that includes the following information as identified under Administrative, Case Management and Human Resource Requirements.

a. Administrative Requirements

1. A list of counties to be served;
2. Hours of operation, the agency shall maintain regularly scheduled hours of operation;
3. Emergency after hours' response plan;
4. A list of potential community resources for the entire service area;
5. A copy of Articles of Incorporation, unless the agency is a local government unit;
6. The agency shall meet the following requirements:
 - A have a physical business site at the time of application. The business site must be verified by a site visit. This site must not be in a private residence or vehicle.
 - B submit a copy of the agency's organizational chart.
 - C submit a list of persons who have five percent or more ownership in all, or any one agency.
 - D apply, obtain, and maintain access to the NCCCN, Inc's web-based applications (providers certified prior to 12/1/2017 shall have 6 consecutive months to comply with this requirement).
 - E submit a business plan that provides specific information for development costs and projected monthly revenue and expense statement for the 12 months subsequent to the approval of the application, and an actual revenue and expense statement for the 12 months preceding the application date. This plan:
 - i. includes assumed consumer base, services, revenues and expenses;
 - ii. outlines management of initial expenses;
 - iii. identifies the individuals responsible for the operation of the agency and shall include their respective resumes;
 - iv. shows a program development enhancement timetable; and
 - v. includes existing financial resources.
 - F have computer capability to meet the following criteria:
 - i. Comply with Information Technology standards required by NC Medicaid, inclusive of maintenance of electronic records;
 - ii. Meet HIPAA requirements for safety and security of all data;

- iii. Perform data analysis, inclusive of tracking and trending of outcome metrics;
 - iv. Comply with electronic billing requirements.
 - v. Comply with requirements for Electronic Funds Transfer (EFT); and
 - vi. Communicate with the CCNC Network or the primary care provider on a monthly basis as defined in **Subsection 5.5** of the HIV Case Management policy.
- G Comply with the completion of a precertification onsite visit.
- H Meet all applicable state and federal licensure and certification requirements.
7. The agency shall have the following written policies that are unique to the organization.
- A confidentiality policy, to include a copy of the informed consent form;
 - B beneficiary grievance policy;
 - C beneficiary rights policy;
 - D non-discrimination policy;
 - E code of ethics policy;
 - F conflict of interest policy;
 - G electronic records policy;
 - H medical records policy, to include record retention, safeguard of records against loss, tampering, defacement or use of, and secure transportation of, records;
 - I policy to assure the beneficiary's freedom of choice among providers;
 - J transfer and discharge policy; and
 - K identification of abuse, neglect, and exploitation policy.
- b. **Case Management Requirements**
1. A description of the core components described in **Subsection 5.6** of the HIV Case Management policy, including the title and position of the individuals who will perform those functions. Applicable Full Time Employees (FTEs) or functions must be documented to meet requirements;
 2. A quality improvement plan, including but not limited to plans for:
 - A measuring beneficiary health outcomes;
 - B the monitoring and evaluation of case management records (refer to **Subsection 7.5** of this policy);
 - C tracking and reporting complaints and how they are resolved;
 - D conducting statistical studies including cost and utilization studies;
 - E assuring accuracy with claims and service records; and

F assuring that the provider and staff meet the qualifications set forth in this policy.

c. **Human Resource Requirements**

1. human resource policies unique to the organization to include, process for validation of credentials, continuing education requirements, and criminal background check on all employees;
2. plan for providing case management if the agency has insufficient case management staff to cover caseload;
3. plan for delegation of management authority for the operation of the agency and services;
4. plan for utilizing the services of volunteers, including supervision requirements for maintaining beneficiary confidentiality;
5. The agency shall submit the following:
 - A a copy of the supervision and training plan;
 - B a copy of the CM orientation plan and an annual in-service education plan for the CM;
 - C a copy of the agency's plan for networking with the CCNC Program or the primary care provider;
 - D a copy of the agency's plan for tracking the CMs demonstrated skills, abilities, competencies and knowledge.
6. The agency shall meet the following requirements:
 - A Be owned and operated by individual(s) that have not been convicted of a felony charge related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct.
 - B Be owned and operated by individual(s) that have not been convicted of a felony charge related to the neglect or abuse of a beneficiary in connection with the delivery of health care services.
 - C Employ qualified and trained CMs and supervisors, or contract with an agency or individual to provide case management or supervision, who meets the qualifications as described in **Subsection 6.1**.

Applications that do not meet the above criteria after 90 days will be returned to the provider as incomplete and no further action must be required by NC Medicaid, or DHHS designated contractor.

6.2.4 Recertification

The recertification is valid for two years, unless otherwise specified. To be recertified, a provider shall:

- a. Submit a complete and signed Recertification Application to NC Medicaid or DHHS designated contractor, within 60 calendar days of receipt.
- b. Submit copies of all items in **Subsection 6.2.3** that have changed since the initial certification.
- c. Submit copies of all HIV CM and supervisor credentials.
- d. Submit annual summary, or summaries, of quality improvement activities to include outcome metrics.

- e. Submit to a recertification on-site visit, including a review of beneficiary records or other clinical and business documentation as needed.

Applications that do not meet the above criteria after 90 days will be returned to the agency as incomplete and no further action shall be required by NC Medicaid, DHHS designated contractor.

Note: NC Medicaid, or DHHS designated contractor, shall provide a provisional recertification for a period of six months, if site visits show evidence of noncompliance with policy requirements. This will allow an opportunity for program monitoring as outlined in **Subsections 6.2.5, 7.5 and 7.6** to occur.

6.2.5 Decertification

If any one of the following conditions is substantiated, the provider may be decertified by NC Medicaid, or DHHS designated contractor, and dis-enrolled by NC Medicaid. This list is not all inclusive.

- a. Failure to provide core service components.
- b. Fraudulent billing practices.
- c. Owner(s) being convicted of a felony charge.
- d. Failure to develop, submit, and implement a written plan of correction to resolve unmet program requirements cited by NC Medicaid, or DHHS designated contractor; to make recommended corrections; or both within 30 calendar days.
- e. Falsification of records.
- f. Violation of a beneficiary's confidentiality.
- g. Employment of staff who do not meet the criteria stated in **Subsection 6.1**.
- h. Failure of staff to complete NC Medicaid, or DHHS designated contractor, mandatory basic training within 90 days of their employment date.
- i. Failure of staff to obtain required continuing educational units (CEU), as specified in **Subsection 6.1**.
- j. Failure to provide case management staff with supervision to meet the beneficiaries' needs.
- k. Failure to submit any required documentation within the time frame designated by this policy, NC Medicaid or DHHS designated contractor, or both.
- l. Failure to provide documentation as specified in **Subsection 7.5** that is sufficient to support the provider's billing.
- m. Failure to implement and enforce a quality improvement program.
- n. Failure to notify NC Medicaid, or DHHS designated contractor, within 30 calendar days of proposed changes, or five business days of actual changes, of any changes in agency name, director or ownership, mailing address, and telephone number(s), resulting in NC Medicaid or DHHS designated contractors, inability to contact the provider.
- o. Failure to comply with all applicable federal and state laws, regulations, state reimbursement plan, and policies governing the services authorized under the Medicaid program.

- p. Failure of a provider to enroll any beneficiaries within four months of certification.
- q. Failure of a provider to achieve or maintain the requirements for certification as defined in **Subsection 6.2** of this policy.

When NC Medicaid, or NC Medicaid's designated agent, notifies a Medicaid-enrolled provider that he is no longer certified to provide HIV Case Management services, the provider may request a reconsideration review in accordance with 10A NCAC 22F.0402.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, its divisions or its fiscal agent.

7.2 Coordination of Care

The HIV CM shall coordinate the beneficiaries care by means of communication with the CCNC Network or the beneficiary's primary care physician. Furthermore, the CM shall facilitate coordination of service delivery when multiple providers or programs are involved in care provision in order to ensure the appropriate use of resources, beneficiaries' freedom of choice, and the avoidance of duplication of efforts and services.

HIV Case Management beneficiaries shall not receive other case management services that are Medicaid reimbursed, including but not limited to the following:

- a. Community Alternatives Programs (CAP), including CAP for disabled adults (CAP/DA/Choice Option), CAP for children (CAP/C), and CAP for the intellectually and developmentally disabled (CAP/IDD);
- b. At-risk case management for adults and children who are at risk of abuse, neglect, or exploitation; or
- c. Targeted case management and community supports for the intellectually developmentally disabled (Enhanced Mental Health and Substance Abuse Services).

Payments for targeted case management shall not duplicate payments under other program authorities (such as child welfare and foster care services).

7.3 Transfer

HIV Case Management agencies shall have written policies governing transfers between case management providers. The receiving agency may elect to:

- a. accept the beneficiary as an ongoing beneficiary and accept copies of all the previous agency's forms (with the exception of the consent forms, which the receiving agency shall obtain upon transfer); or
- b. accept the beneficiary as a new beneficiary and complete all new forms.

Both providers shall:

- a. plan a transition date in accordance with the beneficiary's wishes or as required by medical necessity;
- b. communicate with local department of social services Medicaid staff when transitioning between counties; and
- c. the discharging agency shall complete a discharge summary within seven business days of discharge.

7.4 Beneficiary Record Documentation Requirements

7.4.1 Record Retention

All providers shall keep and maintain all financial, medical, and other records such as periodic records documented in progress note, policies and quality improvement activities, etc., necessary to fully disclose the nature and extent of services furnished to Medicaid and NCHC beneficiaries and claimed for reimbursement. This must include the historical documentation of all corrections made to assessments and plans of care. These records must be retained for a period of not less than six years from the last date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements as referenced in 10A NCAC 22F .017 and 10A NCAC 22F.0601.

The provider shall promptly retrieve the records and make them available for review by NC Medicaid or agents acting on behalf of NC Medicaid for claims review, audit, medical record review, or other examination during the retention period specified above. When a case management provider closes, the provider shall provide the following information in writing to NC Medicaid or DHHS designated contractor within 30 calendar days of the closing date:

- a. physical location of the records (hard copy and electronic);
- b. name of contact person;
- c. contact person's telephone number.

7.5 Documentation Requirements

The beneficiary record identifies the name of the case management provider and beneficiary. At a minimum, the provider shall maintain the following documents within the beneficiary's record:

- a. intake forms (the provider shall incorporate proof of HIV status within the medical record within 15 calendar days of intake);
- b. assessments;
- c. written attestation that all records are properly and safely stored and available as per **Subsection 7.4.1**.
- d. care plans with documented timelines for obtaining services;
- e. progress notes*;
- f. medication sheet
- g. contact sheets for resource development and coordination of service delivery;
- h. discharge notification and discharge summary, as applicable;

- i. beneficiary consent form(s) that address release of information, consent for case management, and beneficiaries' rights and responsibilities; and
- j. Physician or attending practitioner's written order for HIV CM services must be obtained prior to initiation of case management services. The Primary Care Physician's written order is required for HIV CM services to continue beyond two consecutive months. These orders must indicate diagnosis and attest to the medical necessity for HIV Case Management.

*Progress notes must include the following, at a minimum:

- 1. documentation of case management activities that directly foster achievement of goals identified in the care plan;
- 2. the place of service delivery;
- 3. the date of service;
- 4. the nature, extent, and duration of time (duration of time is defined as one unit of service equals 15 minutes), to include the start and end time of the activity, in addition to the number of minutes and units;
- 5. the CMs legal signature, including first and last name with title or initials (if applicable) indicating licensure or certification;
- 6. statements that reflect individualized care;
- 7. quarterly updates in the care plan which include documentation of communication with the primary care physician;
- 8. documentation of all contacts, both direct and indirect, with the beneficiary;
- 9. documentation of all contacts with the beneficiary's support network, providers, and other participants in the plan of care;
- 10. documentation indicating if the beneficiary has declined services specified in the care plan; and
- 11. documentation regarding achievement of care plan goals.

7.6 Documentation Time Frame Requirements

- a. The initial assessment must be completed within five business days of the referral date. Annual reassessments must be conducted at least every 12 months and as needed secondary to unanticipated events or changes in the beneficiary's status.
- b. The care plan must be completed within five business days of the assessment and reassessment completion date.
- c. Progress notes must be documented and incorporated into the record **within 24 hours of contact**. The progress note must be timed and dated as to the time of the contact. The progress note must be signed per **Subsection 7.5.e.5**.
- d. The contact sheet, which details a list of all service providers, family contacts, and other informal support persons, must be completed with the care plan and reviewed and updated as needed, at least every three months.
- e. The beneficiary shall be contacted within 30 calendar days of the care plan completion date to monitor the beneficiary's progress. Thereafter, at least one contact with the beneficiary, beneficiary's support network, providers, and other participants, shall be made and documented at least every three months.
- f. The care plan must be reviewed at least every three months. Changes must be made as needed, and documented.
- g. Each beneficiary shall be surveyed annually to assess satisfaction with case management services and coordination.

- h. A written notice of termination or change in HIV Case Management services must be forwarded to the beneficiary at a minimum of seven business days prior to termination or change.
- i. The provider shall document any deviations from the above (a through h) in the progress notes.

7.6.1 Electronic Records

An HIV Case Management provider may store clinical records, including those documents referenced in **Subsection 7.5**, electronically (i.e., on disk, microfilm, or optical imaging systems). Providers using electronic storage systems are subject to the following recordkeeping requirements.

- a. The provider shall keep electronic clinical records and electronic billing documentation for a minimum of six years.
- b. The provider shall promptly retrieve the records and make them available for review by NC Medicaid or agents acting on behalf of NC Medicaid for claims review, audit, medical record review, or other examination during the retention period specified above. Upon request, the provider shall supply electronic copies of all the signed documents referenced in **Subsection 7.5** to support services billed to the Medicaid program.
- c. With respect to claims review, audit, or other examination, the provider shall present clinical records along with the equipment necessary to read them.
- d. The provision for storing records electronically does not remove the requirement for retaining records for six years from the last date of service. Providers unable to maintain the historical documentation electronically shall maintain hard copies for the specified retention period.
- e. The provider shall ensure that all documentation with electronic signatures is consistent with state regulations (GS § 66-58.5) and the provider's policy.

7.7 Quality Improvement Plan

The provider shall develop and implement an internal quality improvement policy and program. The policy must include, but not be limited to the following:

- a. the person who is responsible for the quality improvement program;
- b. the process to measure quality of case management services and making improvements;
- c. method to review ten percent sampling of records at least every three months;
- d. method to review administrative review of the case management program;
- e. method to develop and measure key indicators, review of results;
- f. method to survey beneficiary satisfaction at least annually;
- g. the procedure to develop a corrective action plan for identified problems; and
- h. the procedure for follow-up to ensure that identified problems have been corrected.

Expected -outcomes of HIV Case Management for persons living with HIV include:

- a. early access to and maintenance of comprehensive health care and social services;
- b. improved integration of services provided across a variety of settings;
- c. enhanced continuity of care;
- d. prevention of disease transmission and delay of HIV progression;
- e. increased knowledge of HIV disease;
- f. greater participation in and optimal use of the health and social service system;

- g. reinforcement of positive health behaviors;
- h. personal empowerment; and
- i. an improved quality of life.

7.8 Quality Assurance Site Visits

A newly certified provider will be provided with two quality assurance (QA) site visits, to be completed within the first year following certification. The QA site visits are initiated by NC Medicaid or DHHS designated contractor, after the provider is certified. The purpose of the site visits includes the following:

- a. Technical assistance and consultation. The program consultant will conduct medical record reviews and compare NC Medicaid billing records with the provider's documentation. The consultant will provide guidance based on the review and the questions raised by the provider staff.
- b. Review of staff qualifications and documented training. Resumes of supervisors and CMs are reviewed for compliance with the criteria found in **Subsections 6.1.1, 6.1.2, 6.1.3 and 6.1.4 and 6.1.5.**
- c. Review of case management services, adherence to core service components and related documentation. Program consultants from NC Medicaid, or DHHS designated contractor, conduct a chart review of 10% of the active and closed caseload or 10 beneficiary records, whichever is fewer. Closed caseload is defined as those charts that were created before the last recertification or fourth QA visit.
- d. Investigate complaints. The program consultant shall investigate complaints from all referral sources including but not limited to: NC Medicaid's Program Integrity unit; the beneficiary; and other provider agencies.
- e. Ensure implementation of policy requirements which include quality improvement activities. Compliance with quality improvement activities must be measured against the provider's unique policy. The provider shall be required to provide documentation to support their quality improvement activities.

Note: The responsibility for all recommended corrections, changes or improvements remains with the provider.

Failure to adhere to policy requirements will result in decertification or a provisional recertification or a referral to NC Medicaid Program Integrity Program.

If unmet program requirements are noted during any site visits, the provider shall submit a written plan of correction to NC Medicaid, or DHHS designated contractor, upon request within 30 calendar days. Upon review of the corrective plan of action, quality assurance visits will be scheduled as deemed necessary by NC Medicaid, or DHHS designated contractor, to determine if corrective action has taken place and the service is compliant with all the program's requirements.

7.9 Requests to Expand

Provider expansion requests must meet each of the following criteria:

- a. Expansion requests for additional county coverage must be submitted to NC Medicaid or-DHHS designated contractor.
- b. A new physical site must be obtained if the area listed in the expansion request is more than 60 miles from the agency's existing office.

Note: The expansion site must not be in a private residence or vehicle.

- c. If establishment of a new site is required, at least one CM shall be designated for the new site. CMs covering the expansion area shall meet the qualifications described in **Subsections 6.1.1, 6.1.2 and 6.1.3.**
- d. The provider shall enroll with Medicaid for any new site. A separate provider number will be issued.
- e. The provider shall provide a resource list for the proposed area to be served.
- f. The provider is meeting beneficiaries' needs as evidenced by having received no significant citations or corrective actions related to care delivery during the past 18 months.
- g. The provider is compliant with all applicable federal and state laws, regulations, state reimbursement plan, and policies governing the services authorized under the Medicaid program.

Expansion applications that do not meet the above criteria after 90 days will be returned to the agency as incomplete and no further action shall be required by NC Medicaid, or DHHS designated contractor.

8.0 Policy Implementation/Revision Information

Original Effective Date: May 1, 1994

Revision Information:

Date	Section Revised	Change
11/07/2006	Sections detailed below	Initial Promulgation of current coverage
11/07/2006	1.0	Description of the service made consistent with CMS definition. Deletes Intake as a “core service component.”
11/07/2006	3.2	Redefines specific documentation criteria for meeting medical necessity
11/07/2006	5.3.1	Defines areas to be assessed consistent with CMS definition.
11/07/2006	6.0	Establishes criteria for Certification, Recertification, Decertification, and Technical Assistance Site Visits.
11/07/2006	6.3.1	Establishes new qualifications for HIV Case Manager. It adds having a bachelor’s in any field with 1 year experience in counseling or in a related human services field. It eliminates the “high school prepared” category.
11/07/2006	6.3.2	Establishes new qualifications for HIV Case Manager Supervisor. It adds having a bachelor’s in any field with 1 year experience in counseling or in a related human services field.
11/07/2006	6.4.2	Increases the number of required CEUS to 20 hours annually.
11/07/2006	6.5	Establishes criteria for Expansion Requests
11/07/2006	7.3	Establishes criteria for Transfers
11/07/2006	7.5	Adds additional documentation requirements.
11/07/2006	7.6	Establishes stricter criteria for documentation time frame requirements
11/07/2006	7.6.1	Establishes criteria for Electronic Records
11/07/2006	7.7	Establishes criteria for provider to develop and implement an internal quality assurance program.
11/07/2006	All sections and attachment(s)	Relevant application of EPSDT criteria is discussed
10/01/2009	5.4 and Attachment A, Section D	PAG notified of unit limitation. Provider may not bill in excess of 16 units per month per recipient.
02/23/2010		PAG notified of changes in policy since 11/7/2006. Based on proposed policy changes effective 10/1/2010
10/01/2010	All sections and attachment(s)	Wording change to reflect termination of MOA with DPH.
10/01/2010	1.0	Adds the requirement that recipients must establish and maintain a medical home with either CCNC or a primary care physician.
10/01/2010	4.2.2	Increases the number of “non-covered activities.”

Date	Section Revised	Change
10/01/2010	5.2	Defines role of CCNC as medical home.
10/01/2010	5.2	Establishes criteria for MD order for initiation of services, continuation beyond two months
10/01/2010	5.3	Adds monitoring criteria for monthly contact with primary care physician.
10/01/2010	5.3.2	Adds the role of CCNC in the process of Care Planning.
10/01/2010	5.3.4	Adds the role of CCNC in the process of monitoring.
10/01/2010	5.4	Establishes requirement for MD order for services beyond 2 months or maximum 32 units.
10/01/2010	6.1	Adds more requirements to become certified including, provider must have 3 years of providing or managing HIV Case Management programs; must obtain national accreditation and must secure a performance bond.
10/01/2010	6.2	Increases the criteria required to become certified including the submission of a business plan, and the agency must possess certain computer capabilities and adds the number of policies they must submit.
10/01/2010	6.2.2	Changes the recertification cycle from 3 to 2 years and includes potential for a provisional recertification for a six month period.
10/01/2010	6.2.3	Renames and adds criteria for Quality Assurance Site Visits.
10/01/2010	6.2.4	Adds criteria for Decertification and changes time requirement for enrolling recipients.
10/01/2010	6.3	Adds additional requirements for case managers and supervisors regarding amount and type of experience and skills and knowledge they must possess.
10/01/2010	6.4.1	Adds requirement that case manager must attend basic training before the agency can bill for their work.
10/01/2010	6.4.2	Lists topics that must be included in annual training CEUs and lists possible training resources.
10/01/2010	7.6	Establishes requirement that Progress Notes shall be documented and incorporated into the record within 24 hours of contact.
10/01/2010	7.7	Changes name and adds additional requirements for Quality Improvement Plan
10/01/2010	Attachment B	Adds a table of Key Indicators for Quality Improvement.
03/12/2012	All sections and attachment(s)	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 12B under Session Law 2011-145, § 10.41.(b)
03/12/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
06/01/2013	6.1.1	Deleted, "Twelve months of those two years must include experience with HIV+ persons."

Date	Section Revised	Change
06/01/2013	6.1.3	Item “a” reworded to, “Basic knowledge of HIV disease, prevention and treatment techniques. The case manager shall have documented proof within one year of their hire date that they possess this knowledge. The knowledge should be based on current clinical practice, defined as standards of practice prevalent from their date of hire through the date of verification. The basic knowledge shall include: methods of transmission and treatment, common definitions, general knowledge of medications used to treat HIV and barriers to medication and treatment compliance.”
06/01/2013	6.1.4	Deleted, “Twelve months of those three years must include experience with HIV+ persons.”
06/01/2013	All sections and attachment(s)	Replaced “recipient” with “beneficiary.”
10/01/2015	All Sections and Attachment	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/01/2018	All sections and attachment(s)	Replaced CCNC references with “CCNC Program”, “CCNC Network”, or “NCCCN, Inc.”.
03/01/2018	All sections and attachment(s)	Deleted “the provider certified prior to 10/1/2010 shall have two years to be in compliance”.
03/01/2018	3.2.1.b and 7.5.j	Add the requirement of the referring physician to indicate a diagnosis when authorizing services.
03/01/2018	5.3	Deleted “maximum of 32 units”.
03/01/2018	5.3	Clarify language to specify the ongoing written order must come specifically from a beneficiary's Primary Care Physician.
03/01/2018	5.3 and 5.5	Added requirement for agencies to use DMA-3155 or similar medical home communication tracker.
03/01/2018	5.4	Deleted the requirement for agencies to secure Carolina Access authorization and the language, “and can assist the providers in linking beneficiaries to a primary care provider.”
03/01/2018	5.5	Deleted “CD4 T-cell counts” and “Viral load”.
03/01/2018	5.6.1.e	Deleted “Social Status”.
03/01/2018	5.6.4	Deleted “Examples of monitoring and follow-up activities include but are not limited to the following: reporting to the beneficiary’s medical home regarding the beneficiaries’ status, reassessments and discharge or terminations.”
03/01/2018	6.1.2 and 6.1.5	Replaced “service” with “care” and added “referral, linkage and resource development” and “discharge or termination”.
03/01/2018	6.1.7.2	Reduced continuing education units from “20” to “twelve” and clinical hours from “10” to “six”.
03/01/2018	6.1.7.2	Deleted “medical management and care”

Date	Section Revised	Change
03/01/2018	6.2.1. k	Added accreditation bodies “Accreditation Commission for Health Care (ACHC), Community Health Accreditation Partner (CHAP), Council on Accreditation (COA), Public Health Accreditation Board (PHAB), The Joint Commission (TJC)”.
03/01/2018	6.2.1. 1	Remove requirement for a performance bond.
03/01/2018	5.6.2 and 6.2.3	Added requirement to apply, obtain, and maintain access to the NCCCN, Inc’s web-based applications. Providers certified prior to 12/1/2017 shall have 6 months to comply with this requirement.
03/01/2018	7.8	Reduced number of initial quality assurance visits from “four” to “two”.
03/01/2018	7.8.c	Added language to cap records to be reviewed at a maximum of 10.
03/01/2018	5.4 and 7.5. j	Added language to specify requirements, regarding who is allowed to refer and authorize services.
03/01/2018	Attachment A	Replaced “B20” with “ICD-10-CM Codes reflecting highest level of medical necessity for HIV Case Management”.
03/01/2018	Attachment B	Removed from Policy
03/01/2018	7.7.e and 7.8.e	Deleted references to Attachment B.
03/15/2019	Table of Contents	Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”
03/15/2019	All Sections and Attachments	Updated policy template language.
01/15/2020	Table of Contents	Updated policy template language, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.”
01/15/2020	Attachment A	Added, “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines”.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

ICD-10-CM Code(s)
ICD-10-CM Codes reflecting highest level of medical necessity for HIV Case Management

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

CPT Code(s)
G9012

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
1 unit = 15 minutes.

F. Place of Service

Acceptable places of service include offices and the beneficiary's primary private residence.
Beneficiaries may also reside in adult care homes.

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

There is a limit of 16 units per calendar month per beneficiary.

The provision of HIV Case Management is based on a one to one interaction between the CM and the beneficiary. The provider shall not bill for units of service that represent billing for more than one beneficiary during any specified period of the day.

Providers shall accept Medicaid and NCHC payments for HIV Case Management services as payment in full.

HIV Case Management cannot be billed on the same day as any CAP service, including Choice Option. This also applies to behavioral health (intellectual developmental delay) case management, and at-risk case management for adults or children.

HIV Case Management shall not be billed when a beneficiary is institutionalized, excluding the date of admission and the date of discharge. Refer to **Subsection 4.2.1.**