



## ADMINISTRATIVE RULES OF MONTANA



### **37.86.3305 CASE MANAGEMENT SERVICES, GENERAL PROVISIONS**

- (1) Case management services assure healthy outcomes by assisting recipients to access needed services and by coordinating between all agencies and providers responsible for service delivery. A case management plan sets goals for meeting a client's needs and where appropriate the needs of the client's caregivers and identifies the means for implementing those goals with emphasis on the self-sufficiency of the client and caregivers in obtaining services.
- (2) Case management services are available to persons who are determined by the department or its designees in accordance with this subchapter to be within the covered groups set forth in ARM 37.86.3306.
- (3) Receipt of case management services does not restrict a client's right to receive other Montana Medicaid services from any certified Medicaid provider.
- (4) Case management services cannot duplicate any other Medicaid service or other services available to the client.
- (5) Case management services must be delivered by a case manager whose primary responsibility is the delivery of case management services to one or more of the populations identified in ARM 37.86.3306. Exceptions to this requirement may be approved by the department or its designee.
- (6) Except as otherwise provided for in this subchapter, a client may select a case management service provider and other service providers whose services are received with the assistance of case management.
- (7) A client in accordance with the following criteria may temporarily receive case management services from more than one case management service provider if:
  - (a) there is need for more than one case manager to manage the provision of services to the client;
  - (b) there is a single coordinated individualized plan for case management of the provision of services;
  - (c) there is a lead case management provider;
  - (d) there is an agreement as to which case management services provider will bill Medicaid; and
  - (e) the plan of care contains the following:
    - (i) designation of the lead case management service provider;
    - (ii) justification for the use of more than one case management service provider;

- (iii) specification of roles and responsibilities each case management service provider is to undertake;
  - (iv) documentation of all the case management services provided on behalf of the client, including those not reimbursed by Medicaid;
  - (v) assurances of nonduplication of case management services; and
  - (vi) strategies for reducing case management to a single service provider.
- (8) Medicaid reimbursement for case management services except as provided in ARM 37.86.3902, is only available for the case management services provided by the lead case management provider.
- (9) Decisions as to which case management provider is to be the lead case management provider for a client, except as provided in ARM 37.86.3902, are made locally. If there is disagreement that cannot be resolved locally, the department contacts for each program involved are to make the necessary decision.
- (10) A case management plan must be developed jointly by the case manager and the client and where appropriate the client's caregivers.
  - (a) The plan should be signed by the client and where appropriate the client's caregivers. If the plan is not signed, the reason for the lack of signature must be documented.
  - (b) Refusal to sign the plan will not result in a denial of case management services.
  - (c) A case management plan for a minor or for an adult who is subject to full guardianship must be signed by the parents or guardian.

**Authorizing statute(s):** Sec. 53-6-113, MCA

**Implementing statute(s):** Sec. 53-6-101, MCA

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**History:** NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1994 MAR p. 3201, Eff. 12/23/94; AMD, 1997 MAR p. 898, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.