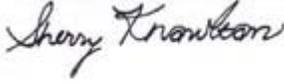


	MEDICAL ASSISTANCE BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE	
	SUBJECT Medical Case Management Recordkeeping Forms	BY  Sherry Knowlton Deputy Secretary for Medical Assistance Programs
NUMBER:	99-94-11	
ISSUE DATE:	July 6, 1994	
EFFECTIVE DATE:	May 1, 1994	

PURPOSE:

The purpose of this bulletin is to inform medical case management providers of the forms they may use for documenting medical case management services.

SCOPE:

This bulletin is applicable to all medical case managers enrolled in the Medical Assistance (MA) Program, who render medical case management services to MA eligible individuals under 21 years of age.

BACKGROUND/DISCUSSION:

Under the provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), all MA eligible recipients under the age of 21 are eligible for medically necessary expanded services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The Health Care Financing Administration recently clarified that the expansion included medically necessary case management. (Detailed information concerning these services can be found in MA Bulletin number 99-94-08.) In order to comply with the federal mandate, the Department is adding case management services to the fee schedule effective May 1, 1994.

PROCEDURE:

As part of the case management services, the case manager should use the Service Coordination Plan Form (MA 399) and the Case Management Activity Log Form (MA 400). Example copies of the forms are attached. The two forms will be valuable tools to document case management services provided to clients and should facilitate record keeping.

The forms are not to be submitted to the Department, as is required for targeted case management services, but should be retained in the recipient's file.

Forms MA 399 and MA 400 may be ordered on the MA 300X order form.

INSTRUCTIONS FOR COMPLETING SERVICE COORDINATION PLAN FORMS – FORM MA 399

(PLEASE USE BLACK INK OR TYPE)

Client's Control Number – Enter the recipient control number from the targeted Case Management Approval Notice.

Recipient Number – Enter the 10-digit recipient number as it appears on the client's Pennsylvania ACCESS card.

Case Manager's Name – Enter the full name of the case manager chosen by the client.

MAID Number – Enter the seven-digit ID number assigned to the case manager by the Office of Medical Assistance Programs.

Physician's Name – Enter the full name of the client's primary care physician.

MAID Number/License Number – Enter the seven-digit ID number assigned to the physician by the Office of Medical Assistance Programs. If not a medical assistance enrolled provider, enter the physician's professional license number.

Phone Number – Enter the physician's three-digit area code and seven-digit telephone number.

Date Physician's Plan Reviewed – Enter date (m,d,y) that the physician's plan of care is reviewed and updated. (Required every six months.)

Dates Care Plan (SCP) Reviewed – Enter date (m,d,y) the service plan is reviewed. Required monthly, or more often, if needed.

Long Term Goals – Based on physician's plan of care, and needs of client, state goals to be achieved with service plan.

Need/Problem – State all need(s)/problem(s) to be resolved, identified through the client's assessment. Items identified should include medical, socioeconomic, psychological/emotional needs.

Action Required (1) – Describe action(s)/step(s) required to alleviate or assist client with problem. **State potential or actual provider or community resource to be used for accomplishment of action.**

Goal – State goal to be accomplished by action.

Target Date – Enter date on which completion of goal is anticipated.

Result – Describe the result of action(s) taken. State whether the need/problem was resolved or whether an alternative action is needed. To be done either at time of monthly review or on target date noted (whichever comes first).

Date Revised/Completed (2) – Enter date action (service) is revised or completed. If action is changed to accomplish a more effective outcome to client, list change as a new need/problem and identify the number of the new need/problem in this block.

Approved by Client: Initials/Date – Client's initials and date initialed by client. If client is unable to initial, parent or legal representative may do so.

Approved by Case Manager: Signature/Date – Case manager's signature and date signed by case manager.

INSTRUCTIONS FOR COMPLETING CASE MANAGEMENT ACTIVITY LOG – FORM MA 400

(PLEASE COMPLETE USING BLACK INK OR TYPE)

If more than one log is submitted, number pages appropriately in the right-hand corner.

Submitted by – Enter full name of case manager.

MAID Number – Enter seven-digit ID number assigned to provider by Office of Medical Assistance Programs.

For Period – Enter month, day, year for beginning date of service; enter month, day, year for service period ended. All dates must pertain to the same calendar month.

Client's Name – Enter client's full name. Use separate activity log for each client receiving services.

Recipient Number – Enter the ten-digit recipient number of the client as it appears on the client's Pennsylvania ACCESS card.

USE AS MANY LINES AS NEEDED TO DESCRIBE AN ACTIVITY.

Date of Service – Enter day, month, year service was provided.

Time of Service – Enter time of day service began to time of day service ended.

Minutes – Enter total number of minutes service was provided.

Place of Service – Enter location where service was provided "ie" office, client's home, hospital outpatient area.

Description of Nature of Service – Give a brief description of purpose of service.

Total Minutes This Report Period – Enter total number of minutes services were provided for report period designated in "for period".

Cumulative Units This Report Period – One unit is defined as 15 minutes. Divide total number of minutes for report period by 15 to obtain number of cumulative units for report period.

Signature of Case Manager/Date – Must be signed and dated by case manager providing services to client.

Forward DPW copy with invoice at the end of the month. Maintain case manager copy in client's file.

ATTACHMENTS:

- Service Coordination Plan Form (MA 399)
- Case Management Activity Log Form (MA 400)

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Division of Outpatient Programs
P.O. Box 8046
Harrisburg, PA 17105-8600

1-800-537-8862

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.