



Section: Clinical Practices	Policy Name: Complex Case Management	Policy Number: MHL 12.07
Owner: Director of Clinical Quality	Reviewed By: Moira Kean	Total Pages: 3
Required By: <input type="checkbox"/> BBA <input type="checkbox"/> MDHHS <input checked="" type="checkbox"/> NCQA <input checked="" type="checkbox"/> Other (please specify): ___ MHL ___	Final Approval By: <i>Moira Kean</i>	Date Approved: Jun 4, 2020
Application: <input checked="" type="checkbox"/> SWMBH Staff/Ops <input type="checkbox"/> Participant CMHSPs <input type="checkbox"/> SUD Providers <input checked="" type="checkbox"/> MH/IDD Providers <input type="checkbox"/> Other (please specify): _____	Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Healthy Michigan _____ <input type="checkbox"/> SUD Block Grant <input type="checkbox"/> SUD Medicaid <input checked="" type="checkbox"/> MI Health Link	Effective Date: 6/1/2020

Policy: The overall goal of Complex Case Management (CCM) is to help members regain optimum health or improved functional capability in the right setting and in a cost-effective manner while supporting and enhancing the overall goal of improving care under the standards of best practice driving quality-based outcomes. It involves comprehensive assessment of the member’s condition; determination of available benefits and resources; and development and implementation of a case management plan with patient-centered goals, monitoring and follow-up.

Purpose: To organize and coordinate services for members with multiple or complex conditions helping members obtain access to care and services and coordinating care by identifying and coordinating member’s needs.

Scope: Integrated Health Care and Utilization Management may be affected by this policy.

Responsibilities: Integrated Healthcare Specialist or Care Manager II or II will fulfill the policy as written.

Definitions:

- A. Integrated Healthcare Specialist: Registered Nurse (RN), Licensed Master Social Work (LMSW).
- B. Care Manager II or Care Manager III: Licensed Master Social Work (LMSW), Limited License Psychologist (LLP), Licensed Professional Counselor (LPC), or Registered Nurse (RN) is required.

Standards and Guidelines:

- A. The organization has a process for collecting data from existing databases and proactive data mining is conducted utilizing programmed reports. Some data access is collected in collaboration with demonstration partners.



- B. The organization uses data at its disposal (i.e., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, referrals and demographics) to identify members with multiple or complex conditions without discrimination. In addition, the organization has a process for facilitating the receipt of referrals via email, fax or phone.
- C. CCM is an opt-out program; all eligible members have the right to participate or to decline participation.
- D. CCM documentation system includes automated features that provide accurate date, time and user ID. Automated features also include prompts and reminders for follow up assessments.
- E. CCM systems are supported by evidence-based clinical guidelines or algorithms with automatic documentation and automated prompts for follow up.
- F. CCM process documentation and details are included in Southwest Michigan Behavioral Health's (SWMBH) Complex Case Management procedure 12.7.1.
- G. Each CCM file will be documented according to SWMBH Complex Case Management procedure's guidelines.
- H. Each CCM file will document that SWMBH completed the necessary ongoing management according to the CCM procedure.
- I. SWMBH will evaluate member experience with the CCM program minimally on an annual basis; and will review member complaints at MI Health Link (MHL) Committee meetings as they are identified.
- J. SWMBH will evaluate the effectiveness of the CCM program annually.

Effectiveness Criteria:

Inpatient and Emergency Room utilization 6months prior to CCM, during CCM and 6 months post CCM will be analyzed.

WHODAS scores at baseline, quarterly and at discharge will be analyzed to assess for functional improvement.

References: NCQA Standards – QI 8 Complex Case Management

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	5/16/2015		unknown	unknown
1	11/15/2016		Unknown	unknown
2	5/21/20		Made edits to reflect 2020 NCQA standards	Sarah Green






MHL 12.07 Complex Case Management

Final Audit Report

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