Case Management References

Case Management Scenarios		
***Note**: Although not an exhaustive list, these scenarios are meant to help providers distinguish between the types of services that are and are **NOT** billable under Case Management. The non-billable scenarios listed include activities that **should be conducted**, when appropriate, but **cannot be billed** under Case Management.*		
	Billable	**Non-Billable**
Connection	• Actively helping patients apply for Medi-Cal • Completing the Coordinated Entry System Survey Packet including housing assessments (e.g., Vulnerability Index - Service Prioritization Decision Assistance Tool for adults, VI-FSPDAT for families, or the Next Step Tool for youth); and linking patients to housing resources. • Transferring Medi-Cal benefits for patients who have moved, from the previous county of residence to Los Angeles County. • Linking patients to community resources such as food and clothing assistance.	• Providing transportation for patients to scheduled appointments. **Providers should arrange transportation for patients to and from appointments and attend scheduled appointments, if patient consent is given, but time spent traveling to and from appointments is non-billable (except for in Residential Treatment, which is covered in the day rate and Perinatal patients in the Perinatal Services Network).**
Coordination	• Identifying a referral agency by using the Service and Bed Availability Tool (SBAT) and scheduling an appointment for a level of care transition (e.g., from Intensive Outpatient or ASAM 2.1 to Low Intensity Residential or ASAM 3.1, etc.). • Coordinating action plans with mental health providers to ensure patients are provided complementary services.	• Documenting case management activities in Miscellaneous Notes, including information regarding recent primary care and specialist visits, emergency room visits, auxiliary treatment services (e.g., dialysis), and any community resources received. **Although providers are expected to conduct these activities, time spent performing these activities are non-billable.**
Communication	• Entering and updating data into the Treatment Court Probation eXChange (TCPX), Drug Court Management Information System (DCMIS), and Clarity Homeless Management Information System (HMIS). • Data entry into Probation Department's web-based reporting system for JJCPA referrals • Time spent communicating with service providers, county workers, judges, etc., either face-to-face or by phone (e.g., meeting with patient and doctor during a primary care visit). • Following up with other agencies regarding scheduled services and/or services received by patients. • Providing written or verbal status reports to health and mental health providers, and county partners (e.g., Department of Children and Family Services, Probation Department).	• Entering data into Sage (pre-authorizations, authorizations, progress notes, etc.). • Attempting, but not successfully contacting service providers either by phone or face-to-face. **Providers should only bill for Case Management if they are successful in communicating with other service providers on the patients' behalf.**

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Case Management Checklist			
***Note**: This checklist is a reference tool for use during Case Management sessions to ensure that core functions of case management, and their respective activities, are being performed. This is not meant to be an exhaustive list of case management activities. This table is intended to offer examples of activities that should be covered in sessions, when applicable, and can be billed as Case Management.*			
Topics		**Potential Activities**	**Performed in session? (Y/N)**
Connection	**Establishing & Maintaining Benefit**	Actively help patients to apply for and maintain health and public benefits (e.g., Medi-Cal, My Health LA, General Relief, Perinatal, Housing, etc.).	
		Transfer Medi-Cal benefits from the previous county of residence to Los Angeles County for patients who have moved.	
	Community Resources	Link patients to community resources and services (e.g., transportation, food and clothing assistance, family planning services, legal assistance, educational services, vocational services, etc.)	
Coordination	**Transitions in SUD LOC's**	Facilitate necessary transitions in substance use disorder levels of care (e.g., initiating referrals to the next level of care, coordinating with and forwarding necessary documentation to the accepting treatment agency, etc.).	
	Health Services	Coordinate care with physical health, community health clinics and providers, and mental health providers to ensure a coordinated approach to whole person health service delivery.	
	Social Services	Coordinate activities with state, County and community (e.g., DPSS, DCFS, Probation, Superior Courts, Housing Providers, etc.) entities.	
Communication	**Other Health Providers**	Communicate face-to-face or by phone with physical health, community health clinics and providers, and mental health providers	
	Service Partners	Communicate face-to-face or by phone with Department of Public Social Services (DPSS) workers, Department of Children and Family Services (DCFS) social workers, Department of Mental Health (DMH) workers, Probation Officers, Housing Providers, etc.	
	Advocacy	Advocate for patients with health/social service providers, County and community partners, and others in the best interests of patients.	

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