

November 24, 2010

# Montana Health Care Programs Notice

## Targeted Case Management

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### Policy Clarification of Activities Billed as Targeted Case Management (TCM)

The following provides clarification for allowable reimbursable components for Medicaid State Plan Targeted Case Management Programs: Substance Abuse or Dependency; Developmental Disabilities; Children with Special Health Care Needs; Youth with Severe Emotional Disturbance; Adults with Severe Disabling Mental Illness; and High-Risk Pregnant Women.

**Targeted Case Management (TCM)** – Services that assist individuals eligible under the Medicaid State Plan in gaining access to needed medical, social, educational and other services.

#### Allowable TCM Components

1. **Comprehensive assessment and periodic reassessment of individual needs**, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:
  - a. Taking client history.
  - b. Identifying the needs of the individual, and completing related documentation.
  - c. Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.
2. **Development (and periodic revision) of a specific care plan** based on the information collected through the assessment, that includes the following:
  - a. Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.
  - b. Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.
  - c. Identifies a course of action to respond to the assessed needs of the eligible individual.
3. **Referral and related activities** (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
4. **Monitoring and follow-up activities**, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:

- a. Services are being furnished in accordance with the individual's care plan.
- b. Services in the care plan are adequate.
- c. There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

**Transitioning to Community** – All Medicaid-eligible individuals transitioning to the community, except individuals in a Psychiatric Residential Treatment Facility, Administrative Rule of Montana (ARM) 37.87.807, Case Management Services, Covered Services, may be provided case management services during the last 180 consecutive days of a Medicaid-eligible person's institutional stay.

The amount, duration, and scope of the case management activities will be documented in an individual's plan of care, which includes case management activities prior to and post-discharge, to facilitate a successful transition to community living. Case management activities must be coordinated with and must not duplicate institutional discharge planning, which may be reimbursed at the same time as transitional case management services if services are distinctly different and are not duplicative.

**Medication Management Appointments** – Consistent with established State and Federal regulation, the following are allowed TCM components: assessment; care planning; referral and related activities; and monitoring and follow-up activities.

1. The location of these components is not restricted. Therefore, case managers are allowed to perform these core components in a medical care setting.
2. The Department recognizes that TCM is a distinct and separate service from medication monitoring performed by a physician. The mere presence of the case manager in the medical care setting does not constitute an integral component of medication management. Montana Medicaid will reimburse for TCM when the provider attends a medication management meeting with a recipient, provided that the case management component is documented and meets one or more of the four components of case management defined in ARM 37.86.3301, Case Management Services, General Definitions.
3. Eligibility for reimbursement is contingent upon meeting case note requirements documenting the case management component provided to the client.

**Case Manager's Role During Crises** – The case manager's function includes assisting the family in anticipating and describing the crises they may experience; as well as developing a crisis plan to address these crises. CFR 42.441.18, Subpart (c) states TCM does not include the direct service. As long as the crisis plan does not identify the case manager as the primary responder to the individual's crisis, which would then become a direct service, it is appropriate for the case manager to be available to assist the family in activating the resources they identified in the crisis plan already developed.

### **Unallowable Case Management Activities**

The following activities may not be billed as TCM and are not reimbursable as a unit of TCM:

- Non-Medicaid individuals can receive outreach, application, and referral activities; however, these activities are not allowable as case management services, rather they are an administrative function.

- Direct medical services including counseling or the transportation or escort of consumers;
- Duplicate payments that are made to public agencies or private entities under the State Plan and other program authorities;
- The writing, recording, or entering case notes for the consumer's file;
- Coordination of the investigation of any suspected abuse, neglect, and/or exploitation cases;
- Travel to and from client activities; and
- Any service less than 8 minutes duration if it is the only service provided that day and any service that does not incorporate the allowable TCM components, even if written into the individualized care plan.

**Direct Service Delivery Restriction** – Case management does not include services that constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including foster care program services such as, but not limited to, the following foster care services:

1. Research gathering and completion of documentation required by the foster care program.
2. Assessing adoption placements.
3. Recruiting or interviewing potential foster care parents.
4. Serving legal papers.
5. Home investigations.
6. Providing transportation.
7. Administering foster care subsidies.
8. Making placement arrangements.

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, the activities for which an individual may be eligible that are integral to the administration of another nonmedical program such as a guardianship, child welfare/child protective services, parole, probation, or special education program except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Act (Code of Federal Regulations (CFR) 42.441.18(c) and 42.441.18(4)).

### **Other Provisions**

**Single Medicaid Targeted Case Manager** – Medicaid TCM services will only be reimbursed for a single (one) Medicaid TCM provider. If the services **are not duplicative** and the following conditions are met, an individual may temporarily receive TCM services from more than one TCM service provider:

- If an individual is pregnant and there is a need for more than one targeted case manager due to the complexity of the client situation, e.g., a high-risk pregnant woman who is also developmentally delayed, mentally ill, or abusing drugs or alcohol; or
- A child who is in receipt of non-Medicaid funded case management services through ARM 37.34.207, Developmental Disabilities Program, Part C of IDEA, or services through ARM 37.34.206, Family and Education, Support Services, may also receive non-duplicated Medicaid Children With Special Health Needs State Plan TCM services; and

- Documentation requirements are met in ARM 37.85.414, Maintenance of Records and Auditing, and ARM 37.85.410, Determination for Medical Necessity.

**Freedom of Choice** – Individuals must have the free choice of any qualified provider. Refer to the specific case management program for provider qualifications.

**No Gate Keeping** – Providers of case management services are prohibited from serving as gatekeepers under Medicaid. Providers may not in any manner act to restrict an individual’s access to other care and services furnished by Medicaid. A provider of case management services who provides other Medicaid-funded services must implement a structure to avoid conflicts of interest and any forms of self-serving interests. Providers may not compel an individual to receive case management services, condition on the receipt of other Medicaid services or the receipt of other Medicaid services on the receipt of case management services.

**Right to Refuse Case Management** – Individuals have the right to refuse case management services. If an individual declines services in the care plan, it must be documented in the case notes. Case managers cannot condition the receipt of case management services on the receipt of other services.

**Case Records** – The Federal case management rule imposes new documentation requirements. Providers must maintain case records that document the following for all individuals receiving case management:

- The name of the individual;
- Dates of the case management services;
- The name of the provider agency (if relevant);
- The person chosen by the individual to provide the case management services;
- The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
- Whether the individual has declined services in the care plan;
- Timelines for providing services and reassessment; and
- The need for, and occurrences of, coordination with other programs’ case managers.

The Department’s ARM 37.85.414, Maintenance of Records and Auditing, and ARM 37.85.410, Determination for Medical Necessity, must be followed, and can be found at:

<http://www.dphhs.mt.gov/legalresources/administrativerules/title37/chapter85.pdf>

The provider must maintain records that specify the medical necessity of each case management service. The records must also document the time spent or the **time treatment began and ended** for each procedure billed to the nearest minute.

**15-Minute Unit** – Medicaid case management services must be billed in unit increments of 15 minutes. Billing, except as otherwise provided in this policy, must be conducted in accordance with your program’s specific Administrative Rules, manuals, and/or your contract with the Department. **Billing**

and subsequent reimbursement for services are subject to ARM 37.85.414, Maintenance of Records and Auditing, and ARM 37.85.410, Determination of Medical Necessity, and apply to billing units.

- A billing unit is based on a 15-minute unit increment.
- Only four 15-minute units may be billed for a 60-minute hour.
- A provider may not bill for a service of less than 8 minutes if it is the only service provided that day.
- The actual minutes billed for any one case manager in a work day may not exceed the work hours of that case manager.
- If any case management 15-minute service is performed for 7 minutes or less than 7 minutes on the same day as another 15-minute service that was also performed for 7 minutes or less, and the total time of the two is 8 minutes or greater, then providers must bill for one unit of service.
- Three separate case management services of 7 minutes, equaling 21 total timed minutes, must be billed as one 15-minute unit of service.
- The expectation is that a provider’s direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations will be highlighted for review.
- Providers must maintain records which fully demonstrate the extent, nature, and medical necessity of services and items provided to Medicaid recipients. The records must support the fee charged or payment sought for the services and items, and demonstrate compliance with all applicable requirements.
- You can locate your program’s Administrative Rules regarding specific documentation requirements at:  
<http://www.dphhs.mt.gov/legalresources/administrativerules/title37/armtitle37.shtml>

Units	Time
1	Is equal to 8 minutes, but less than 23 minutes
2	Greater than or equal to 23 minutes, but less than 38 minutes
3	Greater than or equal to 38 minutes, but less than 53 minutes
4	Greater than or equal to 53 minutes, but less than 68 minutes
5	Greater than or equal to 68 minutes, but less than 83 minutes
6	Greater than or equal to 83 minutes, but less than 98 minutes
7	Greater than or equal to 98 minutes, but less than 113 minutes
8	Greater than or equal to 113 minutes, but less than 128 minutes

**Resources:**

Federal Targeted Case Management Rule History: On December 4, 2007, the Centers for Medicare and Medicaid Services (CMS) published the interim final rule *Optional State Plan Case Management Services*, CMS-2237-IFC, for Medicaid-funded TCM services, which includes case management services. The rule became effective March 3, 2008. A partial moratorium was imposed until April 1, 2009, and extended to July 1, 2009. On May 6, 2009, a proposed rule to rescind certain provisions of the December 4, 2007, interim final rule was published to solicit public comments and was effective July 1, 2009.

Optional State Plan Case Management Services, Interim Final Rule, December 4, 2007, RIN 0938-AO50, CFR Parts 431, 440, and 441, CMS-2237-IFC, viewable at:  
<https://www.cms.gov/MedicaidGenInfo/Downloads/CMS2237IFC.pdf>

Partial Rescission of Case Management Services Interim Final Rule, May 6, 2009, RIN 0938-AP75, 42 CFR Parts 431, 433, 440 and 441, CMS-2287-P2; CMS-2213-P2; CMS-2237-P, viewable at:  
<http://www.regulations.gov/search/Regs/home.html#documentDetail?R=CMS-2009-0037-0002>

Rescission of School-Based Administration/Transportation Final Rule, Outpatient Hospital Services Final Rule, and Partial Rescission of Case Management Interim Final Rule, June 30, 2009, 42 CFR Parts 431, 433, 440 and 441, CMS-2287-F2; CMS-2213-F2; CMS-2237-F, RIN 0938-AP75, viewable at: <http://edocket.access.gpo.gov/2009/pdf/E9-15204.pdf>

**Medicaid Program Manager Contact Information:**

Developmental Disabilities Case Management	Tim Plaska (406) 444-3878
Children’s Mental Health Case Management	Jamie Stolte (406) 444-7392
High-Risk Pregnant Women Case Management	Ann Buss (406) 444-4119
Adult Mental Health Case Management	Marcia Armstrong (406) 444-2878
Children with Special Health Needs Case Management	Ann Buss (406) 444-4119
Substance Abuse or Dependency Case Management	Jackie Jandt (406) 444-9656

**Contact Information**

For claims questions or additional information, contact Provider Relations:

**Provider Relations toll-free in- and out-of-state: 1-800-624-3958**

**Helena: (406) 442-1837**

**E-mail: [MTPRHelpdesk@ACS-inc.com](mailto:MTPRHelpdesk@ACS-inc.com)**

Visit the Provider Information website:

**<http://medicaidprovider.hhs.mt.gov/>**