

February 12, 2009

Montana Healthcare Programs Notice

Residential Treatment Center, Mental Health Center, Targeted Case Management—Mental Health

Allowable Expenses for Targeted Case Management (TCM) Services in a Psychiatric Residential Treatment Facility (PRTF)

This document is for in- and out-of-state PRTFs and Mental Health Centers (MHCs) to outline allowable expenses for TCM services provided to youth while in a PRTF starting March 1, 2009. A PRTF may provide TCM services directly to their clients or work with an MHC licensed in Montana to provide TCM services to SED youth. Similarities exist between MHC TCM services and PRTF discharge planning responsibilities. PRTFs will not be allowed to bill for all MHC TCM services if provided in-house (see Section I). If the PRTF works with an MHC for TCM services, the PRTF may reimburse the MHC for some or all of the MHC TCM activities (see Section I). A PRTF may provide TCM services differently for each youth in their facility. For difficult to place youth, it is recommended the PRTF work with an MHC for TCM services.

The department makes the following recommendations:

- The PRTF decides how TCM services will be provided to youth shortly after admission to the PRTF.
- MHC TCM services should be left open when a youth is admitted to a PRTF, with the reason documented in the youth's medical record.
- When a youth is admitted to a PRTF, MHCs with an open TCM authorization should not close the authorization with First Health.
- If the PRTF is providing TCM services, referrals for services needed on discharge should be made no less than 30 days before discharge.

Section I. Allowable TCM Expenses for Youth in a PRTF

- A. If a PRTF provides TCM services directly versus working with an MHC to provide TCM services to a youth in their facility:
1. Allowable TCM expenses include services listed in Section II, C, 1), 2), 3) and 4). If these services are provided for the purpose of discharge planning only;
 2. TCM services provided by a PRTF must be provided by a registered nurse, social worker, or other appropriately qualified personnel;
 3. TCM services provided by the PRTF must be documented in the youth's medical record to support allowable expenses tracked in 15 minute units;
 4. The PRTF will keep a record of TCM services provided by the PRTF in units per client for the cost report.

- B. If a PRTF is working with an MHC to provide TCM services, the PRTF will inform the TCM which services in Section II they will reimburse the MHC to provide:
1. The MHC will submit their claims directly to the PRTF for payment.
 2. The PRTF will keep MHC TCM claims for their records and track these expenses for the cost report.

Section II. MHC - TCM Services (four core areas covered)

A. Assessment and Periodic Reassessment:

1. Intake assessment and reassessment by reviewing the TCM care plan every 90 days;
2. TCM assessment to determine the needed medical, educational, social or other services;
3. TCM assessment should be comprehensive and include the youth's strengths and preferences;
4. TCM assessment activities include taking client history, identifying needs and completing related documentation and gathering information from other sources, if necessary.

B. TCM Care Management Planning:

1. Based on the information collected in the assessment, the TCM care plan specifies the goals and actions needed to address the medical, social, educational and/or other services needs;
2. TCM care plan should include the active participation of the youth and/or family in the development of goals in response to the assessed need;
3. TCM advocates for treatment in the least restrictive environment;
4. TCM care plan goals and objectives are measurable;
5. TCM care plan is a strengths-based recovery plan;
6. TCM care plan includes a transition plan for youth 16.5 years of age and older;
7. TCM care plan includes a crisis plan for youth/family and identifies treatment team member roles;
8. TCM care plan includes a viable discharge plan with clear criteria for discharge from TCM services;
9. TCM care plan focuses on youth and family gaining independence from TCM services.

C. Referral and Related Activities:

1. TCM assists youth to obtain needed services;
2. TCM activities help link youth with needed medical, social, educational and other services to achieve goals specified in the TCM care plan;
3. TCM assists the youth and family to access natural and community supports and activities;

4. TCM assists with completion of requests for room and board for group care, foster care, or other supplemental services through CMHB regional staff;
5. TCM convenes treatment team meetings.

D. Monitoring and Follow-up Activities:

1. Includes activities that ensure the TCM care plan is effectively implemented and adequately addresses the needs of the youth;
2. Includes contacts with the youth, family members, providers and others;
3. Activities may be conducted in-person or over-the-phone as frequently as necessary to help determine that the services are being furnished in accordance with the TCM care plan;
4. Monitoring for changes in the needs or status of the youth and making necessary adjustments to the TCM care plan and services.

Section III. PRTF Discharge Planning Requirements, Per CFR 42 Part 482.43

Subpart C Basic Hospital Functions

The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.

(a) Standard: Identification of patients in need of discharge planning. The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

(b) Standard: Discharge planning evaluation.

- (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.
- (2) Registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.
- (3) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.
- (4) The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.
- (5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

Section IV. PRTF Discharge Planning Requirements, Per JCAHO (Paraphrased):

P.C. 15.10

Provision of Care, Treatment, and Services: A process addresses the needs for continuing care, treatment, and services after discharge or transfer that includes:

1. The reason(s) for transfer or discharge;
2. The conditions under which transfer or discharge can occur;
3. Shifting responsibility for a client's care from one clinician, organization, program, or service to another;
4. Mechanisms for internal and external transfer;
5. Accountability and responsibility for the client's safety during transfer for both the organization initiating the transfer and the organization receiving the client;
6. When needs are identified for which the organization does not directly provide services, the organization refers clients to an outside source.

P.C. 15.20:

The transfer or discharge of a client to another level of care, treatment, and services, different professionals, or different settings is based on the client's assessed needs and the organization's capabilities and includes the following:

1. The client's needs for continuing care to meet psychosocial needs are identified;
2. Clients are told in a timely manner of the need to plan for discharge or transfer to another organization or level of care;
3. Planning for transfer or discharge involves the client and all appropriate licensed independent practitioners, staff, and family members involved in the client's care, treatment, and services;
4. When the client is transferred, information is provided to the client that includes the reason for the transfer and alternatives if any;
5. The discharge planning process is initiated early in the care, treatment, and services process;
6. The client is provided information that includes the reason for the discharge and the anticipated need for continued care, treatment, and services after discharge;
7. Before discharge, the organization arranges for or helps the family arrange for services needed to meet the client's needs after discharge;
8. Discharge instructions in a form the client can understand are given to the client and/or those responsible for providing continuing care.

P.C. 15.30:

When clients are transferred or discharged, appropriate information related to the care, treatment, and services provided is exchanged with other service providers.

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

Visit the Provider Information website:

<http://www.mtmedicaid.org>