

May 1, 2008

Montana Healthcare Programs Notice

Case Management and Targeted Case Management Providers

New Rules for Case Management

The Centers for Medicare and Medicaid Services (CMS) published the interim final rule for Medicaid-funded Targeted Case Management (TCM) services, which includes case management services, under Medicaid (CMS-223-IFC). Effective March 3, 2008, the new federal rule changes how Medicaid will reimburse Targeted Case Management and case management activities, hereafter referred to as case management. The rule changes the way case management is performed in order to be reimbursed by Medicaid. CMS has indicated all claims filed with a date of service on or after April 1, 2008, must be in compliance with the federal rule. The State has been working with CMS regarding implementation details of the new rule. The state will provide Targeted Case Management rule interpretations as they become available from the federal government. The entire federal rule can be reviewed at: <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/07-5903.htm>.

The Department is revising state case management administrative rules that govern billing for and reimbursement of Medicaid case management services. These necessary rule changes are being adopted through the state administrative rule process. We project the rules will be effective September 1, 2008.

The changes required for Medicaid case management services, by the federal rule, are outlined below.

- **Waivers.** For case management services delivered under Medicaid-funded home and community based waivers requiring waiver renewals from March 2008 through March 2010, CMS has granted a delay in the federal TCM rule implementation for waiver case management until March 2010. Providers of home and community case management services will receive information regarding TCM rule compliance from their specific Medicaid home and community program.
- **Single case manager.** Medicaid case management services must be provided by a single (one) Medicaid case management provider, which includes a comprehensive assessment and care plan. The Department will only reimburse one Medicaid case manager for an individual's services.
- **15-minute unit.** Medicaid case management services must be billed in increments of 15 minutes, referred to as a 15-minute unit, on or after April 1, 2008. 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 the Department's administrative

rules, Maintenance of Records and Auditing, 37.85.414, and Determination of Medical Necessity, 37.85.410, and apply to billing units. State case management administrative rules are being revised, with an expected effective date of September 1, 2008, to reflect the following 15-minute unit billing requirements for case management services:

- 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, equalling 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.

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

You can locate your program’s administrative rules regarding specific documentation requirements at: <http://www.dphhs.mt.gov/legalresources/administrativerules/title37/armtitle37.shtml>.

- **Definition of Case Management.** The new federal rule defines the term “case management services” to mean services that will “assist individuals eligible under the State Plan in gaining access to needed medical, social, educational, and other services” and to include the following components: 1) assessment and periodic reassessment, 2) develop-

ment and periodic revision of a specific care plan, 3) referral and related activities, and 4) monitoring and follow-up activities.

1. Assessment and periodic reassessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Assessment should be comprehensive and address all needs of the individual, including an individual's strengths and preferences, and consider the individual's physical and social environment. CMS is not putting forth federal standards for the frequency of reassessment, but they should be conducted at least annually. Assessment activities include: taking client history; identifying the needs of the individual and completing related documentation; 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 an assessment or reassessment, that specifies the goals and actions to address the medical, social, education, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual and others to develop those goals and identify a course of action to respond to the assessed needs of the eligible individual. The care plan also must be comprehensive to address these needs. An individual may decline to receive case management services or services in the care plan to address these needs. If an individual declines services listed in the care plan, this must be documented in the individual's case record.
3. Referral and related activities (such as scheduling appointments) to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, 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. Transportation, escort and child care services are not included in referral and related activities.
4. Monitoring and follow-up activities include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. These activities may be with the individual, family members, providers or other entities or individuals. Monitoring should occur no less frequency than annually. These activities may be conducted in person or over the phone as frequently as necessary to help determine whether: the services are being furnished in accordance with the individual's care plan; the services in the care plan are adequate to meet the needs of the individual; there are changes in the needs or status of the individual. If there are changes in the needs or status of the individual, monitoring and follow-up activities include making necessary adjustments in the care plan and services.

*Note: Case management does not include Medicaid determination and redetermination activities. These activities are not direct case management service, but are a Medicaid administrative function. These are potentially billable services to the Department with contracted providers.

- **Right to refuse case management.** Individuals have the right to refuse case management services and must be informed of their right to refuse case management. *Note: The state is currently considering the best method to inform individuals, and specific Medicaid programs will be communicating this method with their providers.
- **Freedom of choice.** Individuals must have the free choice of any qualified provider. Please refer to the specific case management program for information on 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 that provides other Medicaid funded services must implement a structure to avoid conflicts of interest and any forms of self serving interests.
- **Transportation.** Transportation or escort services may not be billed as case management. These are considered direct services.
- **Case records.** The federal case management rule imposes new documentation requirements. Providers must maintain case records that document for all individuals receiving case management the following: 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 case managers of other programs.

The Department's records administrative rules, 37.85.414 and 37.85.410, must also 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.

- **Transitioning to community.** Individuals transitioning to the community may be provided case management services. Case management may be reimbursed for services up to 60 days prior to an institutional discharge if the institutional stay was more than 180 days. For institutional stays of less than 180 days, case management may be reimbursed for up to 14 days. The time period that case management is provided in an institution must not exceed an individual's length of stay.

The provider may not bill for transitional case management services until after the individual has been discharged from the institution and enrolled in community services. Payment for case management services will not be made if an individual does not enroll in community services.

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. An institution's discharge planning activities can be reimbursed at the same time as transitional case management services if services are distinctly different and are not duplicative.

Medicaid Program Manager Contact Information

Youth Mental Health Case Management

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Developmental Disabilities

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Children with Special Health Care Needs

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Youth and Adult Substance Abuse or Dependency

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High Risk Pregnant Women

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Adult Mental Health Case Management

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Elderly & Physically Disabled Waiver

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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>