MONTANA HEALTHCARE PROGRAMS NOTICE

June 13, 2017

Targeted Case Management

Policy Clarification of Activities Billed as Targeted Case Management

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

Targeted Case Management - Services that assist members eligible under the Medicaid State Plan in gaining access to needed medical, social, educational, and other services.

Allowable TCM Components (CFR 440.169)

1. **Comprehensive assessment and periodic reassessment of member's needs** to determine the need for any medical, educational, social, or other services. These assessment activities include the following:

    a. Taking member history.
    b. Identifying the needs of the member 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 member.

2. **Development (and periodic revision) of a specific care plan** based on the information collected through the assessment and includes the following:

    a. Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible member.
    b. Includes activities such as ensuring the active participation of the eligible member and working with the member (or the member'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 member.

3. **Referral and related activities** (such as scheduling appointments for the member) to help the eligible member obtain needed services, including activities that help link the member 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 member. These activities and contacts may be with the member, family members, service providers, or other entities or individuals and conducted as frequently as necessary. This includes at least one annual monitoring to help determine whether the following conditions are met:

    a. Services are being furnished in accordance with the member's care plan.

b. Services in the care plan are adequate.
c. There are changes in the needs or status of the eligible member. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Transitioning to Community (CFR 440.169; Olmstead Act) - All Medicaid-eligible members transitioning to the community, can receive targeted case management services during the last 180 consecutive days of a Medicaid-eligible member's institutional stay.

To facilitate a successful transition to community living, the following must occur:

- The amount, duration, and scope of the targeted case management activities must be documented in a member's plan of care, including targeted case management activities prior to and post-discharge.
- Targeted case management activities must be coordinated with and must not duplicate institutional discharge planning. These services may be reimbursed at the same time as transitional targeted case management services if services are distinctly different and are not duplicative. Targeted case management may not be reimbursed outside of a bundled rate when it is a required component of the service and has already been calculated into the institutional reimbursement rate. Please see service specific requirements to determine if targeted case management may be billed concurrently with an institutional stay.

Medication Management Appointments - The Department recognizes that targeted case management is a distinct and separate service from medication monitoring performed by a qualified licensed professional provider. The mere presence of the targeted case manager in the medical care setting does not constitute an integral component of medication management.

- Montana Medicaid will reimburse for targeted case management during a medication management meeting only when the targeted case manager attends, provides, and documents a service that meets one or more of the four components of targeted case management defined above.
- The location of these components is not restricted. Therefore, targeted case managers are allowed to perform these core components in a medical care setting.
- Eligibility for reimbursement is contingent upon meeting case note requirements, as well as documenting the targeted case management component provided to the member.

Targeted Case Manager's Role during Crises - The targeted 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 the crisis. CFR 42.441.18, Subpart (c) states targeted case management does not include the direct service of the crisis. As long as the crisis plan does not identify the case manager as the primary responder to the member's crisis, which would then become a direct service, it is appropriate for the targeted 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

- Targeted case management services do not include the completion of a Medicaid benefits application.
- Targeted case management services do not include activities that are an integral and inseparable omponent of another covered Medicaid Service.
- Targeted case management does not include services that constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible member has been referred.

- Targeted case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, the activities for which a member may be eligible that are integral to the administration of another other nonmedical program such as a guardianship, child welfare/child protective services, foster care,

parole, probation, or special education programs 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 42.441.17(4)).

- Targeted case management services will not be furnished to the following otherwise qualified members:
  - ✓ who reside in a Medicaid certified IMD except for the time period required to assist in transition to community services;
  - ✓ who reside in a Medicaid certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or nursing facility, except for the time period required to assist in transition to community services; and
  - ✓ who receive case management services under a home and community-based waiver program authorized under Section 1915c of the Social Security Act.

Other Provisions

Single Medicaid Targeted Case Manager - Medicaid targeted case management services will only reimburse for a single (one) Medicaid targeted case manager. If the services **are not duplicative** and the following conditions are met, a member can temporarily receive targeted case management services from more than one targeted case management service provider:

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

Freedom of Choice - Members must have the free choice of any qualified provider. Information regarding provider qualifications can be found in the specific targeted case management program ARMS and manuals.

No Gate Keeping - Providers of targeted case management services are prohibited from serving as gatekeepers under Medicaid. Providers cannot act to restrict a member's access to other care and services furnished by Medicaid. A provider of targeted 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 cannot compel a member to receive targeted case management services by conditioning the receipt of other Medicaid services or the receipt of other Medicaid services on the receipt of targeted case management services.

Right to Refuse Targeted Case Management - Members have the right to refuse targeted case management services. If a member declines services in the care plan, it must be documented in the case notes.

Case Records - The federal regulations for targeted case management impose documentation requirements and state providers must maintain case records documenting the following for all members receiving targeted case management:

- The name of the member.
- Dates of the targeted case management services.
- The name of the provider agency (if relevant).
- The person chosen by the member to provide the targeted case management services.

- The nature, content, units of the targeted case management services received and whether goals in the care plan have been achieved.
- The length of service, as well as the time services began and ended for each targeted case management service provided.
- Whether the member has declined services in the care plan.
- Timelines for providing services and reassessment.
- 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://mtrules.org/.

The provider must maintain records that specify the medical necessity of each targeted 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 targeted case management services must be billed in 15-minute unit increments. Billing, except as otherwise provided in this policy, must be conducted in accordance with your program's specific ARMS, manuals, and/or the provider's contract with the Department.

- A billing unit is based on a 15-minute unit increment.
- Only four 15-minute units can be billed for a 60-minute hour.
- A provider cannot bill for a service of less than 8 minutes if it is the only targeted case management service provided that day.
- The actual minutes billed for any one targeted case manager in a work day cannot exceed the work hours of that targeted case manager.
- If any 15-minute targeted case management service is performed for 7 minutes or less on the same day as another 15-minute targeted case management service that was also performed for 7 minutes or less, and the total time of the two is 14 minutes, then providers must bill for one unit of service.
- Three separate targeted case management services of 7 minutes each, equaling a total of 21 minutes, must be billed as one 15-minute unit of service.
- The expectation is that a provider's targeted case management 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, the situations will be highlighted for review.
- Providers must maintain records that fully demonstrate the extent, nature, and medical necessity of services and items provided to Medicaid members. The records must support the fee charged or payment sought for the services and items, and demonstrate compliance with all applicable requirements.
- Providers can locate the specific program's ARMS regarding any 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 targeted case management services that 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 Targeted 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.dhcs.ca.gov/Documents/Attachment%202.pdf.

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.

Contact Information

If you have any questions, please contact:

Developmental Disabilities	Catherine Murphy (406) 444-1716
Children with Special Healthcare Needs	Katharine Bevan (406) 444-0950
Children's Mental Health	Aaron Hahm (406) 444-6962
High Risk Pregnant Women	Katharine Bevan (406) 444-0950
Adult Mental Health	Barbara Graziano (406) 444-9330
Substance Abuse	Jackie Jandt (406) 444-9596

For additional information, contact Montana Provider Relations at (800) 624-3958 or (406) 442-1837 or email MTPRHelpdesk@conduent.com.

Visit the Montana Healthcare Programs Provider Information website at www.medicaidprovider.mt.gov.