ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Targeted Case Management**

DATE: **October 1, 2012**

SUBJECT: **Provider Manual Update Transmittal TCM-2-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
204.000	3-1-08	204.000	10-1-12
212.200	3-1-08	212.200	10-1-12
212.410	3-1-08	212.410	10-1-12
213.000	3-1-08	213.000	10-1-12
214.000	3-1-08	214.000	10-1-12
216.000	3-1-08	216.000	10-1-12
217.100	3-1-08	217.100	10-1-12
218.100	3-1-08	218.100	10-1-12
218.200	3-1-08	218.200	10-1-12
218.300	3-1-08	218.300	10-1-12
220.000	3-1-08	220.000	10-1-12
250.100	3-1-08	250.100	10-1-12

Explanation of Updates

Section 204.000 is updated to reformat and clarify qualifications for Targeted Case Management (TCM) providers for beneficiaries age sixty (60) and older in Arkansas.

Sections 212.200 and 212.410 are updated to change DHHS to DHS.

Section 213.000 is updated to include assistance with or arrangement for assistance with applications and paperwork as covered services.

Section 214.000 is updated to remove completion of paperwork from the list of excluded services.

Section 216.000 is updated to include time spent recording documentation as a billable service.

Section 217.100 is updated to change DHHS to DHS.

Section 218.100 is updated to include further details regarding the TCM assessment and service plan development.

Section 218.200 is updated to clarify service management and referral and linkage services.

Section 218.300 is updated to clarify activities for service monitoring and service plan updating.

Section 220.000 is updated to change the amount of services available for beneficiaries age 21 and older to 50 hours per SFY.

Section 250.100 is updated to include referral and linkage services in billing documentation example.

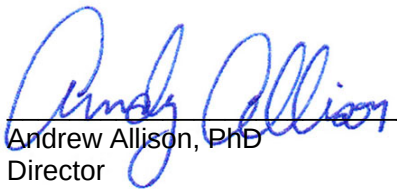
The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-6453 (Local); 1-800-482-5850, extension 2-6453 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.



Andrew Allison, PhD
Director

204.000 Participation Requirements for Providers of Targeted Case Management for Beneficiaries Age Sixty (60) and Older 10-1-12

Providers of targeted case management who are restricted to serving persons sixty (60) years of age and older must be certified by the Division of Aging and Adult Services as an organization qualified to provide targeted case management services.

In order to be certified by the Division of Aging and Adult Services, the provider must meet the following qualifications:

A. Be located in the state of Arkansas

B. Be licensed as a Class A or Class B Home Health Agency by the Arkansas Division of Health or a unit of state government or an agency

C. Be able to demonstrate one year of experience in performing case management services (experience must be within the past 3 years)

D. Be able to demonstrate one year of experience in working specifically with individuals in the targeted group (experience must be within the past 3 years)

E. Have an administrative capacity to insure quality of services in accordance with state and federal requirements

F. Have the financial management capacity and system that provides documentation of services and costs

G. Have the capacity to document and maintain individual case records in accordance with state and federal requirements

H. Be able to demonstrate that the provider has current liability coverage

I. Employ qualified case managers who:

1. Reside in or near the area of responsibility; and
2. Are licensed in the state of Arkansas as a social worker (Licensed Master Social Worker or Licensed Social Worker), a registered nurse or a licensed practical nurse; or
3. Have a bachelor's degree from an accredited institution in a health and human services field, plus two years' experience in the delivery of human services to the elderly; or
4. Have performed satisfactorily as a case manager serving the targeted population for a period of two (2) years (experience must be within the past 3 years).

A copy of the current certification must accompany the provider application and Medicaid contract.

212.200 Beneficiaries Age Twenty-One (21) and Younger Eligible for Developmental Disabilities Services 10-1-12

This target population consists of beneficiaries who are age twenty-one (21) and younger and who:

A. Experience developmental delays

B. Have a diagnosed physical or mental condition with a high probability of resulting in developmental delay

C. Are determined to be at risk of having substantial developmental delay if early intervention services are not provided and

D. Are diagnosed as having a developmental disability which is attributable to mental retardation, cerebral palsy, epilepsy, autism or any other medical condition considered closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or requires treatment and services similar to those required for such persons.

DDS certified case managers enrolled as Medicaid targeted case managers must obtain written verification that any beneficiary they wish to bill for has been certified as eligible to receive services from the Division of Developmental Disabilities Services. This documentation must be obtained from the DDS service coordinator responsible for the beneficiary's county of residence and must be maintained in the beneficiary's record. Providers may request a list of DDS service coordinators and their locations from the local DHS county office.

212.410 Regulations for ElderChoices Program Case Management 10-1-12

A. A plan of care developed by the DHS RN for the ElderChoices Program replaces any other plan of care. The ElderChoices plan of care must include all appropriate ElderChoices services and certain non-waiver services appropriate for the beneficiary.

B. If services are currently provided to an ElderChoices client, the provider must report these services to the DHS RN. Before beginning or revising services to an ElderChoices client, the DHS RN must be contacted to ensure that the plan of care is revised and approved. All changes in service or client circumstances must be reported to the DHS RN immediately. Certain services provided to an ElderChoices client that are not included in the plan of care may be subject to recoupment by the Medicaid Program.

C. An ElderChoices plan of care may not be revised by anyone other than the DHS RN. All services, regardless of the funding source, must be documented by the TCM provider in the beneficiary's TCM case file. Non-Medicaid funded services, such as food stamps, housing, etc., must be included in the overall TCM assessment and on the TCM service plan. These type services that are not required on the waiver plan of care may be implemented without prior approval by the DHS RN.

D. If a temporary situation arises based on a filled position becoming temporarily vacant and the hiring of the position is in process, a case manager may exceed the maximum of 70 active cases for no more than 60 consecutive days. The maximum number of active cases during a temporary situation, as described above, may not exceed 90 Medicaid beneficiaries. If the TCM agency temporarily stops accepting referrals, written notification must be sent to the DHS RN with an effective date. Once referrals are being accepted again, written notification must be sent to the DHS RN with an effective date. This will ensure all TCM agencies are fairly represented and it will avoid unnecessary referrals, which would ultimately delay services being provided to the beneficiary.

213.000 Covered Case Management Services 10-1-12

The following provides examples of case management services that are covered by Arkansas Medicaid. The list includes but is not limited to:

A. Assessment of the eligible individual to determine service needs

This assessment process refers to assessing the individual's service needs to assist in accessing services that currently may or may not be in place. It does not refer to a medical assessment or replace any eligibility requirement for any Medicaid program.

B. Development or assisting in the development of an individualized care plan, specific to the beneficiary's needs

This is a service plan that meets the requirements of the TCM program. It does not replace any required plan of care or service plan for a Medicaid waiver program or any other Medicaid program.

C. Referral(s) to help the beneficiary obtain needed services

D. Monitoring and follow-up contacts

E. Scheduling appointments related to gaining access to medical, social, educational and other services appropriate to the beneficiary's needs

This includes, but is not limited to, medical appointments, transportation services and appointments with DHS.

F. Face to face or telephone contacts with the beneficiary and/or other individuals for the purpose of assisting in the beneficiary's needs being met

1. Communications through FAX or email are covered when the purpose of the communication is to gather information from an individual other than the beneficiary AND the purpose of the communication meets the TCM service definition.
2. Billable communication is limited to time spent sending emails and/or faxes. Receiving faxes and/or emails is not a billable TCM service. Hard copies of emails and faxes must be maintained in the beneficiary's file for audit purposes by the Arkansas Medicaid Program or its representatives. Documentation must support all claims for Medicaid reimbursement, as is currently required by the Medicaid Program.
3. Communications through fax or email is not billable when communication is with the beneficiary.

G. Assisting in or arranging for assistance in the completion of an application for types of assistance

1. The time the case manager spends gathering information and documents required by the application for assistance is a covered TCM service.
2. Documentation in the case file must support all activities for which Medicaid is billed.

H. Conferencing with others, on behalf of the applicant, to assist in the application process for accessing services is covered

These type contacts must be documented.

I. Referral for energy assistance

J. Referral for legal assistance

K. Referral for emergency housing

214.000 Exclusions 10-1-12

Services that are not appropriate for targeted case management services and <u>are not covered</u> by the Arkansas Medicaid Program include, but are not limited to:

A. Targeted case management services provided to beneficiaries who are receiving case management services through the DDS Alternative Community Services (DDS ACS) Waiver Program

B. The actual **provision** of services or treatment. Examples include, but are not limited to:

1. Training in daily living skills
2. Training in work skills, social skills and/or exercise
3. Grooming and other personal care services
4. Training in housekeeping, laundry, cooking
5. Transportation services (Arranging for transportation for a beneficiary is covered.)
6. Counseling and/or crisis intervention services
7. Contacts made by the TCM to vendors verifying that services or goods, such as wheelchairs, air conditioners, canes, commodities, etc. are available or ready for delivery
8. Delivery of services or goods, such as wheelchairs, air conditioners, canes commodities, etc.
9. Inspection of services or goods, such as wheelchairs, wheelchair ramps, air conditioners, installation of air conditioners, commodities, etc.

C. Services that go beyond assisting individuals in gaining access to needed services. Examples include, but are not limited to:

1. Supervisory activities, including supervisory duties required in other programs such as personal care and home health
2. Paying bills and/or balancing the beneficiary's checkbook
3. Delivering application forms, paper work, evaluations and reports.
4. Observing a beneficiary receiving a service, e.g., physical therapy, speech therapy, classroom instruction
5. Escorting beneficiaries to scheduled medical appointments
6. Attending meetings, conferences or court hearings to provide information regarding the beneficiary and/or the beneficiary's family
7. Home visits to observe the beneficiary and family's interactions or the condition of the home for child or adult protection purposes
8. Verifying Medicaid eligibility through telephone calls, AEVCS, or by any other means
9. Travel and/or waiting time
10. Administrative activities associated with Medicaid eligibility determination, application processing, and verification of status of pending application, telephone calls requesting information regarding steps in the application process

    Follow-up calls on pending applications are not a targeted case management function. These calls are not covered.
11. Attending meetings, hearings, appeals, conferences, and/or court hearings to provide information regarding the beneficiary and/or the beneficiary's family

    This includes staffing for personal care. Information shared between two departments of the same agency in order to best serve the beneficiary is the responsibility of the agency providing care. This service is not part of case management.

12. Nursing services, checking blood pressure, post operative care, etc. Case managers must refer a beneficiary to a home health agency or other appropriate agency for such care and monitoring.

    Time spent making a referral is covered.

13. Training, accessing resource information, any activity associated with gaining knowledge on community services available in the area of responsibility

    This is the responsibility of the TCM agency and the targeted case manager in order to successfully provide the TCM service.

14. Staffing meetings

15. Medicaid eligibility determinations, Medicaid intake processing, Medicaid preadmission screening for inpatient care, and prior authorization for Medicaid services and utilization review

16. Medicaid outreach (methods to inform or persuade beneficiaries or potential beneficiaries to enter into care through the Medicaid system

17. Client outreach in which a provider attempts to contact potential recipients of a service, including TCM

    The attempt to contact individuals who may or may not be eligible for case management services or other Medicaid services is not considered a coverable TCM service.

D. Case management services that duplicate services provided by public agencies or private entities under other program authorities for the same purpose.

   For example, targeted case management services provided to foster children duplicate services provided by a public agency and are therefore not covered.

E. Case management services that duplicate integral and inseparable parts of other Medicaid or Medicare services, e.g., Home Health, Rehabilitative Services for Persons with Mental Illness (RSPMI) and Children's Medical Services, when provided on the same date of service

F. Case management services provided to inpatients

   Discharge planning is a service required of physicians, other practitioners and inpatient facilities. Case management is not a covered service for any date the beneficiary is an inpatient of a facility or institution. These facilities include, but are not limited to, acute care hospitals, rehabilitative hospitals, inpatient psychiatric facilities, nursing homes and residential treatment facilities.

G. Case management services provided while transporting a beneficiary

216.000 Documentation in Beneficiary Files 10-1-12

The targeted case manager must develop and maintain sufficient written documentation to support each service for which billing is made. Written description of services provided must emphasize how the goals and objectives of the service plan are being met or are not being met. All entries in a beneficiary's file must be signed and dated by the targeted case manager who provided the service, along with the individual's title. The documentation must be kept in the beneficiary's case file.

Documentation must consist of, at a minimum, material that includes:

A. The prescription for targeted case management services

B. The dates of the Child Health Services/EPSDT screens for beneficiaries under the age of twenty-one (21) ineligible for DDS ACS waiver services

C. When applicable, a copy of the original and all updates of the beneficiary's individualized education plan (IEP)

D. The specific services rendered

E. The type of service rendered: assessment, service management and/or monitoring

F. The type of contact: face to face or telephone

G. The date and actual clock time for the service rendered

This must include the start time and the stop time for each TCM service.

H. The beneficiary's name and Medicaid number

I. The name of the provider agency, if applicable, and person providing the service

The targeted case manager providing the service must initial each entry in the case file. If the process is automated and all records are computerized, no signature is required. However, there must be an agreement or process in place showing the responsible party for each entry.

J. The place of service (Where the service took place: e.g. office, home)

K. The number of units billed

L. Updates describing the nature and extent of the referral for services delivered

M. For non-DDS ACS beneficiaries under the age of twenty-one (21), a copy of the original and all updates, of the beneficiary's service plan

N. DDS beneficiary's certification of eligibility for DDS services

O. Description of how TCM and other in-home services are meeting beneficiary's needs

P. Progress notes on beneficiary's conditions, whether deteriorating or improving and the reasons for the change

1. While the targeted case manager may not be considered a medical professional, progress notes are intended to describe a beneficiary's overall condition, including any changes since the last contact, the reason for the change, etc.

2. This requirement is not asking the targeted case manager to diagnose, treat, or offer medical opinions. However, the targeted case manager must record information provided by the beneficiary or others on behalf of the beneficiary that pertains to the service plan goals and progress toward those goals.

Q. Process for tracking the date the beneficiary is due for reevaluation by the Division of County Operations

The tracking is to avoid a beneficiary's case from being closed unnecessarily.

1. The TCM agency may establish a tickler system that meets the requirements of the TCM program.

2. The Medicaid Program has not established a specific tickler system that must be uniformly used by all providers.

R. Documentation, as described above, is required each time a TCM function is provided for which Medicaid reimbursement will be requested. Time spent recording required documentation is a billable TCM service.

217.100 Requirements for Time Records and the Tickler System 10-1-12

Each TCM must maintain a tickler system for tracking purposes.

A. The tickler system must track and notify of the following activities:

1. Each active TCM beneficiary
2. Expiration date of any Medicaid waiver plan of care applicable to a given beneficiary
3. Medicaid eligibility date
4. The beneficiary's case reevaluation date, as established by DHS, Division of County Operations

B. It is the responsibility of the case manager to maintain a tickler system, as described above, for those beneficiaries in their specific caseload. However, the record keeping requirements and documentation requirements must be maintained in the beneficiary's file.

218.100 Assessment/Service Plan Development 10-1-12

This component is an annual face-to-face contact with the beneficiary and contact with other professionals, caregivers or other parties on behalf of the beneficiary. Assessment is performed for the purpose of collecting information about the beneficiary's situation and functioning and to determine and identify the beneficiary's problems and needs.

The TCM assessment is a comprehensive assessment that includes medical, social, educational, and other services. It goes beyond the assessment process used in determining eligibility for the 1915(c) waiver program. It addresses all facets of the individual's everyday life in determining how any problem or need might be met and what services are available in the individual's community.

For TCM beneficiaries age 21 and over, the maximum units allowed for this service may not exceed twelve (12) units per assessment/service plan visit.

This component includes activities that focus on needs identification. Activities, at a minimum, include:

A. The assessment of an eligible beneficiary to determine the need for any medical, educational, social and other services. Specific assessment activities include:

1. Taking beneficiary history
2. Identifying the needs of the beneficiary
3. Completing related documentation
4. Gathering information from other sources, such as family members, medical providers and educators, if necessary, to form a complete assessment of the Medicaid eligible beneficiary

B. An assessment may be completed between annual assessments, if the TCM deems it necessary.

1. Documentation in the beneficiary's case file must support the assessment, such as life-changing diagnoses, major changes in circumstances, death of a spouse, change in primary caregiver, etc.

2. Any time an assessment is completed, the circumstances resulting in a new assessment rather than a monitoring visit must be documented and must support the activity billed to Medicaid.

3. **For beneficiaries age twenty one and older, reassessments performed between annual assessment visits are limited to eight (8) units per reassessment.** Documentation in the beneficiary's case file must support the reassessment, such as a life-changing diagnosis, major changes in circumstances, death of a spouse, change in a primary caregiver, etc. Any time an assessment is completed, the circumstances resulting in a new assessment rather than a monitoring visit must be documented and must support the activity billed to Medicaid.

C. Service plan development builds on the information collected through the assessment phase and includes ensuring the active participation of the Medicaid-eligible beneficiary or their authorized representative. The goals and actions in the care plan must address medical, social, education, and other services needed by the Medicaid-eligible beneficiary. Service plans must:

1. Be specific and explain each service needed by the beneficiary
2. Include all services, regardless of payment source
3. Include support services available to the beneficiary from family, community, church or other support systems and what needs are met by these resources
4. Identify immediate, short term and long term ongoing needs as well as how these needs/goals will be met
5. Assess the beneficiary's individualized need for services and identify each service to be provided along with goals

NOTE: The TCM service plan is a comprehensive care plan that includes medical, social, educational, and other services that have been identified and included on the service plan for purposes in meeting the identified goals. The TCM service plan goes beyond the ElderChoices waiver plan of care developed by the DHS RN. The TCM service plan addresses all facets of the individual's everyday life in determining how any problem or need will be met and what services are available in the individual's community.

D. The assessment and the service plan may be accomplished at the same time, during the same visit, or separately.

1. However, for the assessment and the service plan for beneficiaries age 21 and over, **the total time in completing the assessment and developing the service plan may not exceed 12 units per beneficiary, regardless of whether the two are completed on the same date of service or different dates of service.**

2. **For beneficiaries age 21 and over, the total time spent on the assessment and service plan development process may not exceed 12 units.**

NOTE: Annual reassessments and service plan development are allowed, in fact, encouraged. This policy does not prohibit annual reassessments and service plan development. Reassessments may be conducted any time the case manager deems it appropriate, however, when reassessments are performed more frequently than annually, justification for conducting a full reassessment, rather than a monitoring visit, must be included in the documentation contained in the case record.

TCM service plans must be renewed, at least, annually.

This component includes activities that help link Medicaid eligible beneficiaries with medical, social, educational providers and/or other programs and services that are capable of addressing identified needs and achieving goals specified in the service plan. For example, making referrals to providers for needed services and scheduling appointments may be considered case management. This component details:

A. Functions and processes that include contacting service providers selected by the beneficiary and negotiation for the delivery of services identified in the service plan. Contacts with the beneficiary and/or professionals, caregivers or other parties on behalf of the beneficiary may be a part of service management.

B. For beneficiaries participating in an HCBS waiver program, the transfer of information to the DHS RN via the AAS-9511, AAS-9510, or other communication form is not a covered service.

This activity is required but it is considered administrative paperwork and is not a billable TCM activity.

See Section 262.100 for the appropriate procedure code.

218.300 Service Monitoring/Service Plan Updating 10-1-12

This component includes activities and contacts that are necessary to ensure the TCM care plan is effectively implemented and adequately addressing the needs of the Medicaid-eligible beneficiary.

The maximum units allowed for this service may not exceed four (4) units per monitoring visit when providers are dealing with beneficiaries age 21 and over.

A. The activities and contacts may be with the Medicaid-eligible beneficiary, family members, providers or other entities.

B. They may be as frequent as necessary, within established Medicaid maximum allowable limitations, to help determine such things as:

1. Whether services are being furnished in accordance with a Medicaid eligible beneficiary's plan of care
2. The adequacy of the services in the plan of care
3. Changes in the needs or status of the Medicaid-eligible beneficiary

C. Monitoring is allowed through regular contacts with service providers at least every other month to verify that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contacts with the beneficiary, at least monthly, that the beneficiary continues to participate in the service plan and is satisfied with services.

1. A face to face monitoring contact with the beneficiary must be completed once every three months. Required contacts with the service providers may be conducted through face to face contact or by telephone. Communication with service providers by email or fax are allowed as described in Section 213.000, F.1.
2. A face to face contact is not considered a covered monitoring contact unless the required monitoring form is completed according to instructions, dated, signed by the targeted case manager, and filed in the beneficiary's case record.

D. Updating includes:

1. Reexamining the beneficiary's needs
2. Identifying changes that have occurred since the previous assessment

3. Identifying hospitalizations or other extended absences from the home

4. Altering the TCM service plan

5. Measuring the beneficiary's progress toward service plan goals. Service plans should not be updated more than quarterly unless there is a significant change in the beneficiary's needs.

Monitoring and follow-up activities include making necessary adjustments in the TCM care plan and service arrangements with providers, according to established program guidelines.

Face to face monitoring contacts must be completed as often as deemed necessary, based on the professional judgment of the TCM, but no less frequent than established in Medicaid TCM program policy.

E. Non-Covered Services include:

1. The updating of a tickler system

2. A case management agency is not allowed to monitor or update an activity when the service being monitored or updated is provided to the beneficiary by the same agency.

3. However, the same agency is allowed to be both the TCM agency and the agency providing a direct service, such as personal care, home delivered meals, or PERS.

4. However, the agency is not allowed to bill for a TCM monitoring contact when monitoring the **quality of care or the quality of the service** provided by the same agency or when the purpose of the contact is to monitor the progress of a service being in place, delivered, having started, effective date, etc.

5. In addition, TCM is not allowed when monitoring is required through the direct service policy, such as with PERS providers.

6. Monitoring the PERS service is a part of the certification policy for all PERS providers. Additional monitoring of the PERS service by a TCM is not a covered TCM service.

F. Examples of case monitoring and service plan updating are shown below:

1. Example # 1

   Provider "A" has been chosen by the beneficiary to provide home delivered meals. The beneficiary has also chosen provider "A" for case management services. Case management by provider "A" may not be billed for any activity associated with the provision of home delivered meals. It is the responsibility of the direct service provider to ensure quality services are provided. In this example, the home delivered meal provider is responsible for ensuring meals are delivered timely and to the beneficiary's satisfaction. Case management activity does not include monitoring the provision of home delivered meals by the same agency.

   This same policy applies to any service where the case management agency is the same agency providing the in-home service.

2. Example # 2

   Provider "B" has been chosen by the beneficiary to provide personal care. The beneficiary has also chosen provider "B" for targeted case management services. Case management by provider "B" may not be billed for any activity associated with the quality of the personal care services being provided by the same agency. It is the responsibility of the direct service provider to ensure quality services are provided.

In this example, the personal care provider is responsible for ensuring personal care services are provided to the satisfaction of the beneficiary and according to the plan of care (POC) that includes the personal care service. This includes whether or not the aide performs the duties assigned, arrives timely, stays the assigned period of time, is courteous and meets the requirements established for the Personal Care Program by the Arkansas Medicaid Program.

G. A TCM provider is allowed to bill a monitoring contact when the monitoring is for the purpose of verifying the services included on the POC are sufficient based on the beneficiary's current condition. This is also true when the case manager is contacted by the beneficiary.

1. If the monitoring contact is billed, based on this purpose, documentation must support the reason for the contact, the results of the contact and any changes requested to the POC.

a. **NOTE:** This type activity, when based on the beneficiary's condition and the sufficiency of the services in place, may be billed regardless of whether or not the case manager and the direct service provider are the same agency.

b. If the monitoring contact, whether initiated by the case manager or the beneficiary, is not addressing **quality of care**, the monitoring contact is billable, if it meets the definition described in this manual.

2. The same policy applies to the personal emergency response system (PERS) service. The TCM provider may test the PERS unit when completing a monitoring visit, if the PERS unit is not provided by the same agency as the TCM service.

a. Since the PERS providers are required to test their units monthly, if they choose to meet that requirement by having their targeted case managers test the units while in the home, this is not considered a covered TCM service.

b. It does, however, meet the requirement established for the PERS providers, if results of the testing are documented by the PERS provider and available for audit.

H. All requests from case managers to increase or decrease services or change service providers will be verified by the DHS RN and justified by the DHS RN prior to any changes being made to the waiver plan of care. This applies when the beneficiary is a participant in a home and community based waiver program.

See Section 262.100 for the appropriate procedure code and modifier.

220.000 Benefit Limits 10-1-12

Based on the state fiscal year (SFY) July through June, beneficiaries age twenty-one (21) and older are limited to fifty (50) hours (200 units) of targeted case management services per year.

Regardless of the overall SFY benefit limit, each waiver plan of care must specify the number of units being authorized and documentation must reflect how those units are utilized. Utilization must be reasonable, documented, and justified in the case record, based on the beneficiary's overall medical condition, support services available to the beneficiary, and in-home services currently in place.

If a TCM beneficiary is also a home and community based waiver beneficiary, such as ElderChoices, the waiver plan of care supersedes any other plan of care. Therefore, the number of units authorized on the waiver plan of care may not be exceeded unless prior approved by the DHS RN. **Approval will not be granted after the services are already provided**.

For audit purposes, the authorization must be in writing, placed in the beneficiary's file, and available for auditors.

250.100 Method of Reimbursement 10-1-12

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time the service is provided and upon accurate completeness of the claim filed for the service. The provider is responsible for verifying the beneficiary is eligible for Medicaid prior to rendering services.

Targeted case management services must be billed on a per unit basis, as reflected in a daily total, per beneficiary, per TCM service. One unit equals 15 minutes.

One (1) unit = 5 - 15 minutes
Two (2) units = 16 - 30 minutes
Three (3) units = 31 - 45 minutes
Four (4) units = 46 - 60 minutes

Providers must accumulatively bill for a single date of service. Providers are not allowed accumulatively bill for spanning dates of service. For example, a targeted case manager may make several referrals on behalf of a beneficiary on Monday and then again on Tuesday. The targeted case manager is allowed to bill for the total amount of time spent on Monday and the total amount of time spent on Tuesday, but is not allowed to bill for the total amount of time spent both days as a single date of service.

All billing must reflect a daily total, per TCM service, based on the established procedure codes. No rounding is allowed.

A. **Example 1**:

Case management documents reflect:

10:00 a.m. to 10:02 a.m.: Scheduled food stamp appointment and reviewed list of required information with the county eligibility worker. (Referral and Linkage)

11:00 a.m. to 11:06 a.m.: Contacted beneficiary's daughter and verified hospitalization dates of service and discussed any change in beneficiary's condition and any additional services needed. (Service Monitoring)

1:30 p.m. to 1:36 p.m.: Called DHS RN and reported hospitalization of client and conversation with client's daughter (also sent 9511).

TOTAL BILLING: 6 minutes (1 unit) (CALL TO DHS RN AND ADMINISTRATIVE PAPERWORK IS NOT BILLABLE. Two minute Referral and Linkage does not equal a unit, therefore, is not billable.)

B. **Example 2:**

Case management documentation reflects:

8:30 a.m. to 8:36 a.m.: Contacted beneficiary and discussed need for diapers and durable medical equipment, as requested by DHS RN. Also scheduled home visit. (Referral and Linkage)

10:00 a.m. to 10:02 a.m.: Scheduled transportation for eligible client. (Referral and Linkage)

10:30 a.m. to 11:00 a.m.: Delivered diapers and 3 pronged cane to eligible client.

TOTAL BILLING: 8 minutes (1 unit). (DELIVERY OF DIAPERS AND CANE IS NOT BILLABLE.)

C. Example 3:

8:15 a.m. to 8:20 a.m.: Telephone call to DHS County Office to verify status of pending food stamp application.

9:00 a.m. to 9:15 a.m.: Telephone call to applicant to report information regarding pending application. Client has no food and asks case manager about local Food Pantry. Case Manager contacts food pantry and arranges for food to be delivered to client's home. (Referral and Linkage)

9:15 a.m. to 9:16 a.m.: Telephone call to city staff to see if commodities were in and ready for distribution.

TOTAL BILLING: 15 minutes for Referral and Linkage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Targeted Populations:

TCM services, when prescribed by a physician or other medical professional designated by the Division of Medical Services, are available to beneficiaries age 60 and older, including participants in the ElderChoices 1915(c) waiver program who:

- have limited functional capabilities in two or more ADLs or IADLs, resulting in a need for coordination of multiple services and/or other resources; OR
- are in a situation or condition which poses imminent risk of death or serious bodily harm and one who demonstrates the lack of mental capacity to comprehend the nature and consequences of remaining in that situation or condition.

___ Case-management services will be made available for up to ____ consecutive days of a covered stay in a medical institution for individuals age 21 and over transitioning from an institution to a community setting. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_x_ Entire State
___ Only in the following geographic areas: [Specify areas]

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_x_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Targeted Case Management includes the following assistance:

❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:

- taking client history;
- identifying the individual's needs and completing related documentation; and
- 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;

Assessments/Reassessments are required, at least, annually.

❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:

- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- 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; and
- identifies a course of action to respond to the assessed needs of the eligible individual;

Care Plans must be renewed, at least, annually.

❖ 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, 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; and

❖ Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, 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 determine whether the following conditions are met:

    1. services are being furnished in accordance with the individual's care plan;
    2. services in the care plan are adequate; and
    3. changes in the needs or status of the individual are reflected in the care plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers, according to established program guidelines.

The maximum units allowed for this service may not exceed four (4) units per monitoring visit.

Monitoring visits may be as frequent as necessary, within established Medicaid maximum allowable limitations.

Monitoring is allowed through regular contacts with service providers at least every other month to verify that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contacts with the beneficiary, at least monthly, that the beneficiary continues to participate in the service plan and is satisfied with services.

Face to face monitoring contacts must be completed as often as deemed necessary, based on the professional judgment of the TCM, but no less frequent than established in Medicaid TCM program policy.

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Case management providers must be certified by the Division of Aging and Adult Services on an annual basis, unless approved otherwise by the Division of Medical Services, based on performance evaluations or other approved data.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

In order to be certified by the Division of Aging and Adult Services, the provider must meet the following qualifications:

A. Be located in the state of Arkansas

B. Be licensed as a Class A or Class B Home Health Agency by the Arkansas Division of Health, or a unit of state government or an agency

C. Is able to demonstrate one year of experience in performing case management services (experience must be within the past 3 years);

D. Be able to demonstrate one year of experience in working specifically with individuals in the targeted group (experience must be within the past 3 years);

E. Have an administrative capacity to insure quality of services in accordance with state and federal requirements

F. Have the financial management capacity and system that provides documentation of services and costs

G. Have the capacity to document and maintain individual case records in accordance with state and federal requirements

H. Be able to demonstrate that the provider has current liability coverage, and

I. Employ qualified case managers who must:

1. Reside in or near the area of responsibility; and
2. Be licensed in the state of Arkansas as a social worker (Licensed Master Social Worker or Licensed Social Worker), a registered nurse or a licensed practical nurse; or
3. Have a bachelor's degree from an accredited institution in a health and human services field, plus two years experience in the delivery of human services to the elderly.
4. Have performed satisfactorily as a case manager serving the targeted group for a period of two (2) years (experience must be within the past 3 years).

A copy of the current certification must accompany the provider application and Medicaid contract.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Freedom of choice (42 CFR 441.18(a)(1):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.

2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

N/A Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):

At a minimum, providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

In addition, TCM services are limited to a maximum of 50 hours (200 15-minute units) per SFY.

19. Case Management Services

A. Pregnant Women

Reimbursement is a **fee for service**.

19. Case Management Services (continued)

B. Persons Sixty years of Age and Older

TCM services, when prescribed by a physician or other medical professional designated by the Division of Medical Services, are available to beneficiaries age 60 and older, including individuals participating in the ElderChoices 1915 (c) waiver, who:

- have limited functional capabilities in two or more ADLs or IADLs, resulting in a need for coordination of multiple services and/or other resources; OR
- are in a situation or condition which poses imminent risk of death or serious bodily harm and one who demonstrates the lack of mental capacity to comprehend the nature and consequences of remaining in that situation or condition.

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure. Case management services are billed on a per unit basis. One unit equals 15 minutes.

The agency's targeted case management fee schedule rates were set as of October 1, 2012 and are effective for services on or after that date. All targeted case management fee schedule rates are published on the agency's website (www.medicaid.state.ar.us). A uniform rate for these services is paid to all governmental and non-governmental providers unless otherwise indicated in the state plan.

Cost per 15 minute unit = $7.50