

**MISSOURI DIVISION OF DEVELOPMENTAL  
DISABILITIES**

**TARGETED CASE MANAGEMENT  
FOR INDIVIDUALS WITH  
DEVELOPMENTAL DISABILITIES**

**TECHNICAL ASSISTANCE MANUAL  
For Regional Offices, County Senate Bill 40 Boards  
and Other Not-for-Profit Agencies**

Revised May 15, 2013

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## ACRONYMS

<b>CMS</b>	Centers for Medicare and Medicaid Services formerly known as Health Care Financing Administration (HCFA)
<b>DD</b>	Developmental Disability
<b>DMH</b>	Missouri Department of Mental Health
<b>Division of DD</b>	Missouri Division of Developmental Disabilities
<b>Division of DD Autism Waiver</b>	The Medicaid Home and Community Based Autism Waiver for Persons with Developmental Disabilities
<b>Division of DD Community Support Waiver</b>	The Medicaid Home and Community Based Community Waiver for Persons with Developmental Disabilities
<b>Division of DD Comprehensive Waiver</b>	The Medicaid Home and Community Based Comprehensive Waiver for Persons with Developmental Disabilities
<b>Division of DD MOCDD Waiver</b>	The Missouri Children with Developmental Disabilities Home and Community Based Waiver, known in Missouri as the Sara Jian Lopez Waiver
<b>Division of DD Partnership for Hope Waiver</b>	The Medicaid Home and Community Based Community Partnership for Hope Waiver for Persons with Developmental Disabilities
<b>FSD</b>	Family Support Division, Missouri Department of Social Services
<b>HCBS Waiver</b>	Home and Community Based Services Waiver (a specific type of Medicaid Waiver program)
<b>ICF/ID</b>	Intermediate Care Facility/Intellectual Disabilities
<b>ISP</b>	Individual Support Plan
<b>MOCABI</b>	Missouri Critical Adaptive Behavior Inventory

<b>MHD</b>	MO HealthNet Division in the Department of Social Services, the State Medicaid agency
<b>SNF</b>	Skilled Nursing Facility
<b>TCM</b>	Targeted Case Management

## I. INTRODUCTION

Targeted Case Management (TCM) for persons with developmental disabilities has been a MO HealthNet (Medicaid) service program in Missouri since January, 1991. The term ‘targeted’ means that the case management services under this program are not available to all MO HealthNet eligible people—only to those who are eligible for the services of the Missouri Division of DD (Division of DD) (42 CFR 440.169 (b)). Furthermore, only the staff of the Division of DD’s Regional Offices and certain other entities specified by the Division’s Director are eligible to provide the services. This is to assure that eligible individuals receive help from case managers who have appropriate education and specialized experience.

Case management services are broadly defined in 42 CFR 440.169 as services furnished to assist individuals in gaining access to needed medical, social, educational, and other services. In order to receive case management services, the individual must be MO HealthNet eligible under the State plan and must either reside in a community setting or be in the process of transitioning to a community setting, in accordance with 42 CFR 441.18. In the MO HealthNet service program, case management is referred to as Targeted Case Management, or TCM. The terms “case management” and “Targeted Case Management” are used interchangeably in this document to refer to Division of DD support coordination. Missouri Division of DD has used the term “service coordination” for many years to refer to case management. The Division is changing the term service coordination to support coordination, as the latter more accurately reflects the role and function of this position.

The principal service under this TCM program is referred to as support coordination or case management and the staff who provide this service are support coordinators or case managers.

Support coordination activities may take place with or without the eligible individual present. It may include contacts with others, assessments, planning and documenting on behalf of the eligible individual.

The MO HealthNet State Plan describes case management for persons with developmental disabilities as including the following components:

1. Assessment:

Assessment of the individual’s need for medical, social, educational or other services.

- a. Identifying and documenting an applicant’s need for individualized, specialized services for a developmental disability, including case management; and completing related documentation.
- b. Informing and otherwise assisting the applicant or others responsible for the applicant during the assessment process.
- c. Obtaining necessary releases, collecting records, preparing ecological and behavioral assessments, arranging other assessments as needed, and coordinating the overall assessment process to identify the comprehensive array of services and supports needed.

- d. Facilitating Individual Support Plan (ISP) development and on-going review as a member of the interdisciplinary team. Interpreting the comprehensive assessment and ISP outcomes to the individual and /or responsible others.
- e. Re-assessments of individuals' needs to medical, social, educational and other services shall be completed annually at a minimum, or more frequently as the individual's needs change.

Assessment includes such activities as:

- Collecting the individual's history;
- Identifying the needs of the individual, and completing related documentation. This which may include administration/review of formal assessment measures, for example the Missouri Critical Adaptive Behaviors Inventory (MOCABI), to assist in this process;
- 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. Planning for Services:

- a. From the ISP, developing and writing an individualized service plan which will enable the prioritized outcomes of the ISP to be attained.
- b. At a minimum, annually reviewing the ISP to ensure it continues to be appropriate to the needs of the individual and effective in achieving the prioritized outcomes in the ISP.
- c. When needed, as indicated by the individual response to the prioritized outcomes, redesigning the ISP to further promote individualized training and growth or to incorporate new outcomes.

Development [*planning*] (and periodic revision) of an individual's support plan (ISP), based on the information collected through assessment, also includes such activities as:

- Specifying the goals and actions to address the medical, social, educational, and other services needed by the eligible individual;
- Ensuring active participation of the eligible individual, and working with the individual, and/or the individual's authorized health care decision maker, and others associated with his or her support team to develop those goals and actions;
- Identifying a course of action to respond to the assessed needs of the eligible individual.

## 3. Case Coordination:

- a. Locating appropriate service providers and community resources to provide the services specified in the service plan, and coordinating these services with other staff, coordinating services with other staff, collateral agencies and providers identified in the ISP.
- b. Meeting with the individual and his or her significant others on an ongoing basis to plan, promote, assist and assure the implementation of the ISP and to guide and encourage their participation in strategies to address the prioritized outcomes identified in the ISP.

- c. Directly assist the person to access the services in the service plan, as well as any other services and resources needed to address habilitation outcomes, including crisis services. Such assistance includes advocating on the individual's behalf and being present with the individual at services and resources when advocacy or other guidance is necessary to assure the individual's access to and utilization of those services and resources.
- d. Case coordination does not include transporting the individual for any reason.

Referral and related activities [*Coordinating*], such as scheduling appointments for the individual, coordination and linking of supports, helps the eligible individual obtain needed services. These activities help link the person with the medical, social, and educational providers or other programs and services that address identified needs and achieve goals specified in the ISP.

4. Case Monitoring:

- a. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the ISP is effectively implemented and adequately addresses the needs of the eligible individual, including monitoring service delivery and progress towards outcomes specified in the ISP. These contacts may be with the individual, family members, service providers, or other entities or individuals. The activities/contacts may be conducted as frequently as necessary and include at least one annual monitoring to help determine whether the following conditions are met:
  - 1. Services are being furnished in accordance with the ISP;
  - 2. Services in the plan are adequate;
  - 3. If there are changes in the in the needs or status of the eligible individual, monitoring and follow-up activities include making the necessary adjustments in the ISP and services arrangements with providers.
- b. Monitoring service delivery to assurance individual is afforded both his or her legal and constitutional rights.
- c. In response to negative monitoring findings, intervening with the planning system and/or service delivery system to address the problem(s).
- d. Case monitoring is performed at least quarterly. At least one face-to-face contact is required annually, while three of the four quarterly contacts may be by telephone.

5. Case Documentation:

- a. Completing necessary documentation on all aspects of case management as it applies to individuals receiving case management, including case openings, assessments, plans, referrals, progress notes, contacts, due process requirements, discharge planning, and case closure.
- b. Case management includes contacts with non-eligible individuals who are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual in obtaining 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.

- c. Time spent in case management activities may consist of in-person or other contacts with the individual and all others involved or concerned with his or her care, compiling and completing necessary planning and other documentation, and travel to and from contacts and activities related specifically to the individual. Service logs will be maintained which identify the recipient, the case manager and the activity, as well as the date, units of service (5 minute increments), and place of service.

Case management services are also described in 42 CFR 440.169.

Support coordination may not be provided to individuals in an Institution for Mental Disease (IMD) who are between the ages of 22 and 64, nor to individuals who are inmates of public institutions.

Individuals qualified to receive support coordination who reside in other Medicaid qualifying institutions (ICF/DD or nursing facilities) may receive support coordination. However, the support coordination is only billable as TCM during the last 180 consecutive days of their stay while transitioning to the community. Support coordination may not be billed to Mo HealthNet as TCM for reimbursement until the individual has been discharged from the institution and has been enrolled in community services.

**Other Requirements:**

1. Case management does not include the following:
  - a. Activities not consistent with the definition of case management services under section 6502 of the Deficit Reduction Act.
  - b. The direct delivery of an underlying medical, education, social, or other service to which the eligible individual has been referred.
  - c. Activities integral to the administration of foster care programs.
2. TCM may only be billable/reimbursable for an eligible individual. An “eligible individual” is a person who is both eligible for MO HealthNet and for Division of DD Regional Office services **at the time** the services are furnished. Time spent collecting information and determining if a person is eligible for Division of DD Regional Office services, and time spent helping an individual apply for MO HealthNet is not billable as TCM.
3. TCM is only available for the cost of support coordination if there are no other third parties liable to pay for those services, including reimbursement under medical, social, educational, or other programs.
4. Individuals must be given free choice of any qualified Division of DD TCM provider entity serving the person’s county/location of residence.
5. TCM must not be used to restrict an individual’s access to other MO HealthNet services.
6. When an individual is eligible to receive support coordination that could be billed as TCM, the individual has the right to request the service not be billed to MO HealthNet.
7. An eligible individual must not be required to receive other MO HealthNet services, such as DD Home and Community Based Waiver services, as a condition of receiving support coordination that is billable as TCM.
8. An eligible individual must not be required to receive support coordination that is billable as TCM as a condition of receiving other MO HealthNet services, such as DD Home and Community Based Waiver services.

9. Payment for TCM **must not duplicate** payments made to public agencies or private entities under other program authorities for this same purpose. For example, if support coordination is billable under another program or as part of another service, it may not also be billed as TCM.
10. Individuals providing TCM may not be responsible for authorizing or denying access to other MO HealthNet services, such as DD Home and Community Based Waiver services.
11. Support coordinators may assist guardians and others in enabling an individual to gain access to needed services, but they may not be utilized to replace or fund the function of guardian, public administrator or conservator.

### **PROHIBITION AGAINST FALSE CLAIMS**

The Federal False Claims Act (Section 1902(a) (68) of the Social Security Act) requires an entity that furnishes Medicaid reimbursed items or services totaling at least \$5,000,000 annually to establish and disseminate written policies regarding the law, rights of employees to be protected as Whistleblowers, and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. The policies are to be made available to all directors, officers, administrators, managers, staff, employees, contractors, agents, students, physicians or professionals associated with the entity.

#### **References:**

Section 6032 of the Deficit Reduction Act of 2005 (Section 1902(a) (68) of the Social Security Act)

Missouri Anti-Fraud Laws Related to Health Care:

- Missouri State Statutes: 191.900-191.910
- Missouri Code of State Regulations 13 CSR 70-3.0.30

Section 1902(a) (68) of the Social Security Act relates to "Employee Education about False Claims Recovery". The False Claims Act provides that any person who knowingly presents or causes to be presented to the U.S. Government (including Medicaid program) a false or fraudulent claim for payment or approval; knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; conspires to defraud the government by getting a false or fraudulent claim paid or approved by the Government; or knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government is liable to the US Government for a civil penalty of not less than \$5,000 and not more than \$10,000 plus 3 times the amount of damages which the Government sustains because of the act of that person.

"Knowingly" or "knowing" means that a person with respect to information has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

Although the Act imposes liability only when the person acts knowingly, it does not require the person submitting the claim has actual knowledge that the claim is false. If a person acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, the person may also be found liable.

In summary, the False Claims Act imposes liability on any person who prepares and/or submits a claim to the federal government that he or she knows (or should know) is false. Following are some examples:

1. A support coordinator creates a false case note for an eligible individual or intentionally enters excessive time spent in providing coordination on a log note in order to gain credit for time worked.
2. A billing office staff alters a service code or other components of a billing record in order to get a charge to be paid by MO HealthNet, in disregard for the actual service that was provided.

If an employee becomes aware of actual or suspected fraud and abuse, he or she is required by federal and state law to report the activity. Such an employee is sometimes referred to as a Whistleblower. Federal and state laws have been enacted to protect Whistleblowers to encourage the reporting of misconduct involving false claims. This is referred to as the “qui tam” provision.

### **Reporting information to the Missouri Medicaid Audit and Compliance Unit**

Contact Missouri Medicaid Audit and Compliance (MMAC) for provider enrollment, provider review, provider self-disclosure, sanction, or participant lock-in issues at telephone number 573-751-3399. You may also contact MMAC by using the form at the following website: <http://mmac.mo.gov/contact-us/> or by mail at:

Missouri Medicaid Audit and Compliance  
P.O. Box 6500  
Jefferson City, MO 65105

### **Provider Self-Disclosures**

Providers who want to contact MMAC for self-disclosures can find the form on the following website: <http://mmac.mo.gov/providers/self-audits-self-disclosures/>

The form may either be emailed to: [mmac.financial@dss.mo.gov](mailto:mmac.financial@dss.mo.gov) or mailed to the following address:

Missouri Medicaid Audit and Compliance  
Financial Section – SELF DISCLOSURE  
P.O. Box 6500  
Jefferson City, MO 65102-6500

For additional information about MMAC, please visit the main website at: [www.mmac.mo.gov](http://www.mmac.mo.gov)

### **Reporting Medicaid Fraud:**

Contact

[Department of Social Services, Division of Legal Services — Investigations Unit](#)

DLS Hotline: 1- 877-770-8055,

DLS Fraud email: [ask.mhd@dss.mo.gov](mailto:ask.mhd@dss.mo.gov)

Or contact MMAC

MMAC Fraud Hotline: (573) 751-3285

MMAC Fraud Email: [MMAC.ReportFraud@dss.mo.gov](mailto:MMAC.ReportFraud@dss.mo.gov) .

You may also send the complaint in writing to:

**Department of Social Services**

Division of Legal Services — Investigations Unit

P.O. Box 1527

Jefferson City, MO 65109

**Reporting Medicaid Fraud as a Whistleblower:**

Section 191.907 of the Revised Statutes of Missouri allows any person who reports MO HealthNet fraud to receive a financial reward.

To report fraud, call the Medicaid Fraud Hotline toll free at **800-286-3932**, email

[Attorney.general@ago.mo.gov](mailto:Attorney.general@ago.mo.gov), or download a complaint form at:

<http://ago.mo.gov/forms/MedicaidFraudComplaintForm.pdf>

Please complete the form and mail to the following address:

**Missouri Attorney General's Office**

P.O. Box 899

Jefferson City, MO 65102

## II. PARTICIPANT ELIGIBILITY

To be eligible for TCM services provided by support coordinators of the Division of DD, of a Regional Office, an approved County Board or other not-for profit agencies, an individual must be determined to:

- Have a developmental disability as defined in 630.005 RSMo (and 9 CSR 45-2.010) and determined by a Division of DD Regional Office;
- Be eligible for MO HealthNet in order for the TCM Provider to submit claims to MO Healthnet for reimbursement ;
- Not reside in ICFs/ID or other MO HealthNet-funded nursing facilities (ICFs) unless the person has a transition plan to move into the community.

Individuals qualified to receive support coordination who reside in other Medicaid qualifying institutions (ICF/ID or nursing facilities) may receive support coordination. However, the support coordination is only billable as TCM during the last 180 consecutive days of their stay while transitioning to the community. Case management (TCM services) may not be billed to Mo HealthNet as TCM for reimbursement until the individual has been discharged from the institution and has been enrolled in community services.

As stated on page 10 of this manual, the target group of persons served through Division of DD TCM services does not include individuals who are served in Institutions for Mental Disease (IMD) who are between the ages of 22 and 64, nor to individuals who are inmates of public institutions.

The Missouri Department of Social Services, Family Support Division (FSD) is responsible for determining if individuals are eligible for MO HealthNet. Only MO HealthNet eligible individuals who are enrolled for services through Division of DD's eleven Regional Offices are eligible for

TCM that is billable to MO HealthNet. The individual must be enrolled with a Regional Office with an eligible program code on the day of service, in order to be eligible for the TCM program.

Support coordinators who initially have contact with individuals new to the Regional Office, their families or guardians must explain what to expect when they begin receiving support coordination. If the individual is eligible for Division of DD services and MO HealthNet, explain that all support coordination time spent on behalf of the person will be logged and billed to MO HealthNet, including time spent in meetings or on phone calls, making contacts, and completing documentation. A quarterly statement of all services billed to MO HealthNet is sent to a sample of participants. If an individual receives this statement, it will include any TCM charges billed by the Regional Office, County Senate Bill 40 (SB-40), or other not-for-profit TCM provider. Finally, communication must assure the person or their family or guardian that billing MO HealthNet for TCM in no way limits the person's eligibility for other MO HealthNet services or the amount of those MO HealthNet services he or she may receive.

### **III. PROVIDER ELIGIBILITY**

Other than the Division's Regional Offices only County SB-40 Boards or other not-for-profit agencies designated by the Division may provide TCM services for persons with developmental disabilities. Qualified County SB-40 Boards or other not-for-profit agencies designated by the Division to provide TCM services shall maintain an active case management agreement or intergovernmental agreement with the Division that includes the provision of case management. A not-for-profit agency is only an eligible case management provider within a county or counties where it has an active case management agreement with the County SB-40 Board in that county or has a case management agreement/contract with the Division of DD. The not-for-profit agency shall be registered with the Secretary of State.

Division of DD Regional Offices or approved County SB-40 Boards that meet the requirements set forth in 42 CFR 447.10 may serve as an Organized Health Care Delivery System (OHCDS). Otherwise, qualified providers shall not be required to provide services through an OHCDS agreement. An entity that contracts with an OHCDS to provide case management services must meet the same requirements and qualifications as apply to providers enrolled directly with the Medicaid Agency. All contracts executed by an OHCDS for case management services shall meet the applicable requirements of 42 CFR 434.6 and 45 CFR Part 74, Appendix G.

Following are conditions of eligibility for Regional Office support coordination, and for County Boards and other not-for-profit agencies enrolling in the TCM Program for persons with Developmental Disabilities.

#### **A. Qualifications of Providers**

In addition to Regional Offices, SB40 Boards and other not-for-profit TCM providers may be designated as qualified TCM providers. Support coordinators employed by these entities must meet the minimum experience and training qualifications as follows.

Support coordinators shall meet qualifications as per Division Directive 2.040 (below); 42 CFR 483.430; 9 CSR 45-3.010(1) (D); The Medicaid Waiver Manual; Person Centered

Planning Guidelines, and the TCM Contract with Missouri Division of Developmental Disabilities. Background screenings are identified in 9 CSR 10-5.190; and Support Coordinator training requirements are described in the TCM Contract.

**Missouri Division of DD Directive 2.040** indicates:

The Medicaid State Plan on file with, and approved by, the Centers for Medicare and Medicaid (CMS) requires case managers (support coordinators) employed by a provider of Targeted Case Management to have the following minimum experience and training:

1. One or more years of professional experience as (a) a registered nurse, (b) in social work, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, or speech therapy or a closely related area, or (c) in providing direct care to people who have developmental disabilities;  
AND
2. A bachelor's degree from an accredited college or university with a minimum of 24 semester hours or 36 quarter hours of credit in one or a combination of human service field specialties. Additional experience as a registered nurse may substitute on a year for year basis for a maximum of two years of required education.

These requirements are the same as are required for the Missouri state merit position of Case Manager I. Anyone who has worked for the state as a Case Manager I, or who is on the register for Case Manager I is considered to have met the requirements as a TCM case manager, also called a support coordinator.

## **B. Rate of Payment**

The reimbursement rate for TCM services will be determined in accordance with the methodology described in the State plan for TCM for persons who have developmental disabilities as approved by the Centers for Medicare and Medicaid Services (CMS).

## **C. Monitoring**

The Division of DD operates the TCM Program for persons with developmental disabilities under a cooperative agreement with Mo Department of Social Services. By the terms of this cooperative agreement, the Division of DD has agreed to monitor sub-state TCM providers for procedural compliance with laws and regulations, and with the conditions of participation. This monitoring will be performed by the Division of DD according to a protocol developed between the Division and the County Board and other not-for-profit TCM providers.

Division of DD Staff conducts reviews with TCM entities that have been delegated waiver administrative functions in the following areas:

1. Participant waiver enrollment:
  - a. Qualifications of staff;
  - b. Evidence the ISP was prepared according to guidelines;
  - c. Evidence due process and appeals processes are followed;
  - d. Accuracy of information entered in the Division's Consumer Information Management system;

- e. Evidence records are maintained for each individual receiving support coordination; and
- f. Evidence individual was provided choice of waiver service or ICF/ID service.
- 2. Participant waiver enrollment managed against approved limits.
- 3. Level of care evaluation:
  - a. Qualifications of staff;
  - b. Evidence the ICF/ID Level of Care Form was completed following the procedures;
  - c. Evidence the individual was accurately found eligible or ineligible; and
  - d. Evidence individuals were reevaluated annually by qualified staff, who followed the process; and
  - e. Evidence determinations were accurate.
- 4. Review of ISPs.
- 5. Verify proper signatures are in place for waiver documents as applicable.
- 6. Utilization management:
  - a. ISP supports waiver services that are prior authorized;
  - b. Support coordinator case notes indicate monitoring was conducted of individuals to prevent occurrences of abuse, neglect, and exploitation using risk assessment and planning;
  - c. Service authorizations accurately reflect ISP and budget plan;
  - d. ISPs are updated/reviewed at least annually, or when warranted by changes in the individual's needs;
  - e. Evidence that provider monthly reviews were done and documented in log notes;
  - f. Evidence that quarterly reviews were prepared;
  - g. Evidence services were delivered in accordance with the ISP including the type, scope, amount, duration, and frequency as specified in the plan.
- 7. Quality assurance and quality improvement activities.

#### **D. Training**

The Division of DD will offer training to support coordinators employed by the County Boards and other not-for-profit TCM providers when entities initially begin providing targeted case management, when the Division of DD TCM policies and procedures change, and on an as needed basis. All TCM providers are responsible for ensuring their staff are provided sufficient training on applicable CMS assurances, Federal and State statutes and CSRs.

#### **E. Free Choice**

Section 1915 (g) (1) of the Social Security Act requires that TCM services in no way act to restrict free choice of qualified providers. The State has assured CMS that there will be no restriction on a recipient's free choice of qualified case management providers, nor will support coordinators restrict an individual's free choice of providers of other MO HealthNet services. In any county in which a Regional Office, County Board or other not-for-profit TCM provider offers case management services, individuals and/or their guardians must be offered a choice of case management providers. This choice must be offered at least once a year at the planning meeting, but a person's reasonable request for a change in case manager must be acted upon at any time the request is made.

## **F. Service Definitions**

Support coordinators employed by these TCM entities must adhere to the definition and scope of TCM services contained in Sections V through VII of this manual.

## **IV. ADMINISTRATION OF HCBS WAIVERS**

All TCM entities may also administer certain functions related to the Home and Community based Comprehensive, Community Support, the MOCDD (Sara Jian Lopez) Waiver, the Autism Waiver, and the Partnership for Hope Waiver. Training will, in most cases, be provided by or at Regional Offices, and most requirements of the waivers themselves are explained in the MO HealthNet Program Manual. However, there are additional requirements related to the administration of these waiver programs, as follows.

### **A. Eligibility Determination**

Regional Office and County Board support coordinators may perform assessments and develop required level of care evaluations to assist in establishing eligibility for the waiver programs, but final eligibility must be determined by the Regional Offices.

### **B. Individual Support Plan**

All waiver services must be included in an approved Individual Support Plan (ISP) prior to service delivery. Furthermore, the type of plan acceptable under the waivers is an ISP developed in accordance with developmental disabilities Person Centered Planning Guidelines. ISPs may be developed by the TCM entity support coordinators, but they shall be subject to approval by the Regional Offices and review by the MO HealthNet Division. If a person or entity other than the support coordinator is designated to develop the ISP, it is the support coordinator's responsibility to ensure all required elements are in the ISP. ISPs shall also be subject to Division of DD Utilization Review processes. County Boards are encouraged to use the Division's process; however, they may use their own process if the standards equal or exceed the Division's. The Regional Office will provide technical assistance as requested.

Re-assessments of individuals' needs to medical, social, educational and other services shall be completed annually at a minimum, or more frequently as the individual's needs change.

### **C. Free Choice**

In any county in which both Regional Offices, County Boards or other not-for-profit agency TCM providers are available, free choice of TCM provider shall be offered to all eligible individuals within the specified geographic area identified in this state plan. This choice shall be formally offered upon intake by the Division and at least annually during the review of the ISP. Furthermore, an individual's request for a change of support coordinator and/or TCM provider shall be acted upon at any time during the year. The interagency agreement shall specify methods and timetable for transferring responsibility and information between the County Board, other not-for-profit agency and the Regional Office, if applicable.

Free choice of any qualified Medicaid provider of other medical care under MO HealthNet state plan.

Federal rule specifies that providers of targeted case management shall in no way limit a recipient's access to MO HealthNet services or choice of provider of MO HealthNet services.

#### **D. Further discussion of Free Choice**

Individuals and their guardians must be given free choice of all waiver and other MO HealthNet providers and services. ISPs for waived services must not restrict choice. This requires the support coordinator to give all pertinent information and not to bias individuals' free choice.

All waiver services have to be necessary to the support of the individual in the community, as determined by a planning team and approved by the Regional Office. The individual (or family or guardian) has to be informed about services available under the waiver.

The individual has to be informed about which waiver services are considered necessary to support him or her successfully and why the decision was made. This decision is reached through an assessment and planning process, with consensus the goal. Nonetheless, the individual may appeal the decision if he/she is dissatisfied, and the support coordinator will then need to explain both the informal and formal avenues of appeal.

Finally, the individual has the right to reject any or all waiver services. This may result in participation in the waiver not being feasible, but it is a choice. Termination from the waiver, following due process notification is required.

#### **E. Due Process and Notice of Right to Appeal**

Anytime an adverse action is taken or decision made related to MO HealthNet eligibility, DD Waiver Program participation, or access to specific waiver services, the individual has the right to request an appeal. Examples of adverse actions include:

- An individual is determined ineligible for MO HealthNet;
- An individual requests participation in the waiver program but is denied;
- An individual participating in the waiver is denied a waiver service; or
- The level of services an individual has received in the past is reduced without the individual's (or his/her or guardian's) agreement.

Appeals related to MO HealthNet eligibility decisions are the responsibility of the Family Support Division (see below). When the appeal concerns DD Waiver Program participation or access to waiver services, an individual has appeal rights with both the Department of Mental Health (DMH) and MO HealthNet Division (MHD).

While not required to do so, individuals are encouraged to begin with the DMH's appeal process. An individual or his representative can, however, appeal to the MHD before, during or after exhausting the DMH process. However, once the appeal process is initiated at MHD, all DMH appeal rights end regardless of whether the DMH process was begun or

completed. The individual's support coordinator needs to assist the individual with any of these processes.

### **Family Support Division Appeal Process**

If an individual is denied eligibility for MO HealthNet or his or her MO HealthNet eligibility is terminated, he or she has the right to appeal the decision to the local FSD County Office. An individual may call, write or visit the office to request a hearing. A hearing will be scheduled within 90 days after the date of the adverse action.

### **Department of Mental Health Appeal Process**

The Department of Mental Health's appeal process is also known as the Leake process and brochures about it are available at each Regional Office. In addition, the DD Waiver Program Manual contains a detailed summary of the process in Section 13. Should the individual go through the entire Leake process and disagree with the Department director's final decision, he or she may appeal to the Circuit Court, according to Chapter 536 of the Revised Statutes of Missouri (RSMo.). Should the individual making the appeal be dissatisfied at any point during or after the Leake process, he or she may make a separate appeal to the MHD. But once the appeal process begins with MHD, all appeal rights with DMH end.

### **MO HealthNet Division Appeal Process**

An individual who is MO HealthNet eligible may contact MHD to request an appeal of Division of DD Regional Office decisions related to DD Waiver Program participation and access to waiver services. The request for an appeal must be initiated within 90 days of the date of action. To request an appeal through the MO HealthNet agency, an individual may write to the MO HealthNet Division, Recipient Services Unit, P.O. Box 6500, Jefferson City, Missouri 65102-6500, or call the Recipient Services Unit at 1-800-392-2161.

### **Responsibility of the Support coordinator**

When adverse action concerning waiver eligibility or access is to be taken, the Regional Office is responsible for notifying the individual in writing at least ten days prior to any action being taken. The individual will be informed of the appeal process in the written notice. The support coordinator will assist individuals as needed in requesting an appeal and preparing for the hearing.

There are four specific types of termination where notice, even though required, does not have to be sent in advance:

1. When the individual has died, a notice that services have been terminated must be sent to the responsible party, but it requires no information on appeal rights;
2. When the support coordinator has written confirmation of a voluntary withdrawal;
3. The individual has been admitted to an institution, and is therefore no longer eligible for the Division of DD waiver services; and
4. When the support coordinator has proof of the individual's relocation to another state.

In all four situations, the notice of termination should be dated no later than the date of the adverse action.

If the adverse action concerns termination or reduction of services, the individual may request the disputed service(s) be continued until the hearing is held and a decision is made on the appeal. If the result of the agency's decision is upheld, the individual may be required to pay for the continued services. If the agency's decision is overturned, the individual will not be responsible for the cost of services.

## **V. SERVICE DEFINITIONS**

The Medicaid service program is named "Targeted Case Management". The service provided, however, is broadly described as support coordination. Under the TCM program, support coordinators are responsible for ensuring that individuals receiving supports have access to and receive services that meet their needs. The support coordinator is also responsible for monitoring the effectiveness of the services and supports being given.

The single most important element of quality support coordination is building relationships. When strong relationships are developed and trust exists between all people involved with the individual supported, the quality of supports and services improves. Yet, building relationships is not a separate and distinct activity; it is integral to each function the support coordinator performs.

For instance, when a support coordinator is developing an ISP, a relationship with the person/family naturally develops during the discovery process (the time spent finding out the person's/family's interests, hopes, dreams and goals). When a support coordinator successfully enlists the help of another organization in assisting an individual, the relationship between the person, his or her family and the support coordinator will be strengthened. The component activities, or services, of support coordination are described in this section. A definition of each service is provided below, along with examples of specific activities and documentation requirements.

### **Planning**

Planning supports has two components: Identifying the needs of the person being supported and creating an action plan that will support the person in meeting those needs. It is difficult to define precisely where "identifying needs" turns to "action planning," because both activities should be occurring continuously and interactively. Therefore, both activities are treated as one and are to be logged with one code.

### **Identifying Needs**

The support coordinator communicates with the individual with a developmental disability and his or her family; with individuals, businesses and organizations in the community; and with other collaborating agency representatives to gather and share information with which to identify needs and concerns and build partnerships in support of the individual and family.

This phase of planning involves:

- Getting to know the person being supported in order to discover how he wants to live, what he wants to learn, what works best for him and what does not;

- Getting to know the person's interests, gifts and talents;
- Obtaining information about the person by spending time with him, and by communicating with his family, friends and staff from organizations that provide supports and services; and
- Conducting formal assessments if needed, or gathering assessments from collateral information.

### **Action Planning**

In this phase of planning, the support coordinator translates information from the assessment into a plan of action by bringing together people with the information, ideas and skills necessary to support the individual and family in achieving their goals. Planning will involve collaboration with individuals and families to initiate and develop support partnerships; it will include coordinating, attending, and facilitating meetings; and the resulting support action plan must contain:

- Specific support strategies;
- Timelines for completion of each strategy, and
- The names of those responsible for each part of the support plan.

There must be a clear link between statements made in the identifying needs portion of the plan (sometimes called the personal profile) and the action or support part of the ISP.

Examples of Planning Supports (both components):

1. Gathering information from family, the individual and those that provide support for the purpose of compiling the personal profile (assessment/social history), developing outcomes and completing the action plan.
2. Interviewing an individual and/or family and performing a brief functional assessment in order to write the initial ISP.
3. Conducting the Missouri Critical Adaptive Behavior Inventory (MOCABI) or Vineland (for children) and preparing the Level of Care determination form.
4. Preparing for and attending the individual's service planning meetings.
5. Traveling to/from planning meetings (log/case note for the meeting must specify how much of the time was spent in travel). There needs to be enough information in the log/case note to connect the travel time to the service.
6. Writing the ISP and sharing the plan with those who are responsible for supports/services including the individual, family and direct support staff.
7. Completing forms as needed for the utilization review process.
8. Complete forms as needed to set up a service and/or have payment for services authorized.

Documentation: An entry in a case note, plus the planning and/or assessment document(s). The case note should indicate where the documents are located, if not kept in the same file. When the ISP is completed over a period of several days, the case note should link each activity back to the ISP.

### **Linking Resources**

Linking involves matching the unique support needs of individuals and families (identified in the ISP) with resources in the community. Linking may involve researching existing resources,

developing new resources, making referrals to collaborating agencies with information and follow-up support, writing service authorizations; and coordinating federal, state and community programs to achieve necessary supports.

Examples:

1. Scheduling assessments, appointments or other meetings on the individual's behalf.
2. Locating appropriate providers and arranging services (i.e., respite/day habilitation).
3. Arranging protective intervention when the health and safety of the person or others around the individual is threatened.
4. Communicating with the individual, providers, family members and others who provide support to develop, implement and/or revise the ISP.
5. Meeting with other health care professionals and the individual to discuss assessment results and/or treatment options to ensure that the person being supported makes informed decisions regarding their health care.
6. Completing forms or entering data into a computer, as needed to set up a service and/or have payment for services authorized. Also includes entering information into the computer to document the provision of services.
7. Includes time spent traveling to/from meetings as long as the log/case note indicates how much time was spent in travel. Note: Adding travel time to the case is not required for TCM logging systems that have a separate travel time field for the logging entry. There needs to be enough information in the log/case note to connect the travel time to the service.

Documentation: An entry in a case note. If staff makes a call to schedule an appointment for an individual, the case note needs to say who was called and for what date and time the appointment was made. If staff calls about this appointment four different times during a day, however, only one case note is needed. When writing a case note about a service immediately after performing the service, staff may include the time spent writing the note in the time for service and avoid a separate entry.

### **Service Monitoring**

An ongoing process of monitoring and assessment of the quality, timeliness and effectiveness of services and supports a person receives. This service component is intended to ensure that individuals with developmental disabilities and their families get the supports they need, when they need them, in order to see measurable improvements in their lives. This includes individuals requiring face to face contacts and quarterly contacts.

The Division of DD created a Directive for Service Monitoring. Division Directive Number 3.020 Service Monitoring Policy and Implementation Guidelines sets service monitoring standards as described in the following links:

<http://dmh.mo.gov/docs/dd/directives/3020.pdf>

<http://dmh.mo.gov/docs/dd/directives/3020appA.pdf>

<http://dmh.mo.gov/docs/dd/directives/3020appB.doc>

<http://dmh.mo.gov/docs/dd/directives/3020appC.doc>

### Frequency of Service Monitoring Contacts/Visits

#### Residential Services:

Individuals who receive funding by the Division for residential services have monthly face-to-face visits by their support coordinator to monitor health, environment/safety, exercising of

rights, services and staff, money and satisfaction with services. Residential services monitoring is completed at the service delivery site, which includes group homes, ISLs, foster homes, host/support family homes, and residential care facilities. The outcome of these visits is documented in a log note.

Individuals participating in on-site day services and employment services have quarterly face-to-face visits. If an individual receives both residential and day services or employment services, support coordinators do not have to visit the residential site during the quarterly day service or employment service visit. Individuals participating in off-site day services or employment services have quarterly face-to-face visits with at least one annual visit at the off-site or employment location where the service is received.

Individuals living in nursing homes, private ICF/DD facilities, or residential care facilities not funded by the Division of DD receive quarterly face-to-face visits by their support coordinator to monitor health, welfare, safety, and satisfaction with services documented in a log note.

#### Natural Home:

Individuals participating in on-site and off-site day services, personal assistance, career preparation services, professional assessment and monitoring, or employment services (funded by the Division of DD) have quarterly face-to-face visits to monitor health, environment/safety, exercising rights, staff and services, money and satisfaction with services documented in a log note. Employment services, career preparation services, professional assessment and monitoring, as well as off-site day services have quarterly face-to-face visits with at least one annual visit at the site of service delivery. *Note: Areas monitored are dependent on the services received.*

All other individuals receiving purchased services (transportation, counseling, therapies, adaptive equipment, respite, facility-based out of home respite, temporary residential, dental, etc.) receive at least an annual face-to-face visit and quarterly phone contacts to monitor health, environment/safety, people's rights, services and staff, money and satisfaction of services with documentation in a log note. *Note: Facility-based respite and temporary residential services receive a monthly face-to-face visit if in either service at least 30 consecutive days.*

Individuals whose only support is support coordination receive at least an annual face-to-face visit and quarterly phone contacts to assess needs for services and resources.

In addition, any waiver participant who does not receive at least one waiver service each month must receive support coordination in months waiver services are not received.

The above "frequency of visits/contracts" guideline is a **minimum standard**. It is expected that support coordinators exercise **professional judgment** and increase visits according to the individual needs of people. For individuals living in their natural homes less than quarterly contact, as outline above, may be requested by the family but must be agreed to by the support coordinator and documented in the Individual ISP.

The review with the individual must include the areas of environment/ safety, health, services and staff, money, and rights each time a person in a Division of DD-funded setting is visited/contacted. Additionally, the review must focus on:

- Whether the service is being provided as defined and if it is meeting the individual's needs. The SC should draw qualitative conclusions about the person's health and welfare status, ISP, outcomes, satisfaction, and adequacy and effectiveness of services and supports.
- Whether or not the outcomes in the person's ISP are outcomes the person wants to work toward. If not, the support coordinator should work with the person and their support team to discover what outcomes the person does want to work toward and amend the ISP accordingly;
- Documentation for the Service Monitoring visit/phone contact may be summarized in the log note or by referring to the completed Service Monitoring Tool in the log note. The log note will be entitled "Service Monitoring". The log note will also include any issues/concerns noted during the monitoring and the action taken.

Examples: Service monitoring includes time spent:

1. Conducting the review and documenting findings;
2. Communicating to all parties involved in supporting the individual regarding concerns about supports that have/have not been provided;
3. Communicating to all parties involved regarding the need to change supports and services recommended in the ISP;
4. Meeting to brainstorm and resolve issues that arise during monitoring; and
5. Traveling to/from review meetings. Log/case note entry for the meeting must specify how much time was spent in travel. There needs to be enough information in the case note to connect the travel time to the service. Also, note if the amount of travel is divided among individuals.

Note that service monitoring often leads back into planning. This is appropriate, and can logically be logged either as that or as Planning. There is only a fine line between where one stops and the other begins, and it may be logged either way.

### **Quarterly Review of Progress on ISP**

This code is to be used for individuals with purchased services funded either through Federal/State and/or County Board funds. This will involve review of progress notes written and/or submitted by the provider(s) of the purchased services. It is to be completed every three months from the implementation date of the plan. For individuals without purchased services or purchased services where provider monthly reports are not submitted (e.g., transportation and respite), use the code for Service Monitoring.

A quarterly review should include evaluating the documentation of service provision and evaluating whether the services and supports provided are helping the person attain the outcomes in the plan or at least maintaining their current level. The intent is to draw information from the provider's records.

A quarterly review may be documented in either a case note or a formal summary report. However it must adequately describe what documents were reviewed, conclusions drawn, and recommendations made. The case note should be prefaced with “Quarterly Review”. If a separate summary is completed, it should be kept with the individual record, either with the ISP or under its own heading. The quarterly report need not be long, and it does not need to duplicate information from notes or from the provider records.

A suggested Support coordinator Quarterly Review format, organized into four sections, is as follows:

1. Begin with “Quarterly Review” Dates of the review of progress.—This should be completed every three months following the implementation date of the ISP;
2. List the services reviewed and the monthly reports received;
3. Review of provider information (appended to report); and
4. Action plan, as needed, which includes identification of needed changes in service delivered to enhance or improve progress on objectives.

### **Documentation**

Much of the time a support coordinator spends in documenting can be included with the previously mentioned activities; e.g., the time spent writing an ISP can be logged under “planning”. The service code for documentation may be used when the time spent writing cannot conveniently be included with another activity. Documentation time which can be billed to MO HealthNet under the TCM program includes maintaining appropriate records in accordance with federal/state programs, policies, and procedures. This would include obtaining necessary releases and otherwise ensuring the confidentiality of all written and verbal discourse. See Section XIII, Logging and Documentation, for more information.

Examples: Writing letters, memoranda, notes, transfer summaries, and discharge summaries.

Documentation: The case note, plus the related documentation (e.g., the summary). The case note should include identifying information that assists in locating the corresponding document. For example, “transfer summary written. See summary date 1/11/12 located in the individual’s file.”

### **Transition/Transfer of Case Responsibility**

Regional Offices, County Boards, and other not-for-profit TCM agencies are to varying degrees across the state sharing support coordination responsibility. If more than one support coordination agency is operating in an area/county, individuals receiving services have a right to select any of those support coordination agencies. When an individual chooses another agency for support coordination, legitimate TCM activity associated with the transfer occurs for both agencies. For instance, transfers of files may be necessary or making contact with providers to acquaint them with the change.

Another example where there may be a case transfer from one TCM entity to another is when an individual moves to another part of the State.

For TCM activities involving support coordinators from the sending and receiving entities, the following conditions shall apply to billable services:

- During the period of case transfer, there may be billable activities from each TCM entity that are viewed as independent. In these instances, close communication between these support coordinators is essential to ensure TCM activities that will be billed by both entities are independent and not duplicative in any way. This distinction must be documented in each logging case note. For example, the sending TCM support coordinator may engage in activities specific to transferring the case to the receiving TCM entity (closing the case). The receiving TCM support coordinator may be completing activities to become more familiar with the individual and the services the person receives (opening the case).
- When TCM activities of the support coordinator from one agency cannot be distinct or independent from that of the support coordinator from the other agency, only one support coordinator may log billable TCM for the activities. This requires close communication between the two support coordinators as to who will log billable TCM and the other non-billable. For example, if both Division of DD support coordinators from the sending and receiving TCM entities attend the same planning meeting and serve the same function in support of the individual, only one support coordinator can log billable TCM and the other would log using a non-billable TCM code.
- There are two HCPCS codes in the Medicaid Information System (EMMIS) applicable to Division of DD TCM claims: G9012HI (Other Specified Case Management-5 minute unit); and G9012HITS (Other Specified Case Management-Case Transfer Follow up Services-5 minute unit).
  - Transfers When One TCM Entity Uses CIMOR for Logging and the Other Does Not  
Regional Offices, some County Boards, and other Not-for-Profit TCM agencies use CIMOR for logging. For TCM entities that utilize the CIMOR system for case management logging, the support coordinator should use logging code 000040 when completing applicable billable TCM activities associated with transferring an individual's case to a TCM entity that does not utilize CIMOR for logging. This applies no matter which way the transfer goes; until the transfer is complete. Logging the 000040 code in CIMOR (which maps to G9012HITS for claims to MO HealthNet) will generate a bill which will keep the other TCM entity's billing from failing as a duplicate service.
  - Transfers When Both TCM Entities Use CIMOR for Logging  
If both sending and receiving TCM agencies use CIMOR for logging applicable billable TCM associated with transfer of case responsibility, the support coordinators from both agencies will need to communicate to determine who will log billable case management using the 000040 code in CIMOR, while the other support coordinator would use another billable TCM code in CIMOR, to prevent TCM claims failing as a duplicate service.
  - Transfers When Neither TCM Entity Uses CIMOR for Logging  
For case transfer among County Board TCM entities that use a different system other than CIMOR for TCM logging and submitting TCM billing claims to MO HealthNet, the support coordinators from both agencies will need to communicate to determine who will log billable case management using the G9012HITS code, while the other support coordinator would use another billable TCM code, to prevent claims failing as a duplicate service.

- It is expected that the transition/transfer of case responsibility should be completed within approximately 30 days.
- Transition/Transfer of Case documentation: Enter a case note. Each case note entry must describe/justify the need for the dual support coordinator responsibility. Further, as applicable for both support coordinators submitting billable logging, explain the difference in TCM service provided and that it is not a duplication of service.

### **Individual Transition from an Institution**

Support coordinators may support an individual who is transitioning to a community living arrangement from a Title XIX (MO HealthNet) certified nursing home or habilitation center. Services may be logged not to exceed the last 180 consecutive days the person was in the Title XIX facility, but must not be billed until after the date of discharge to community services.

### **Case Closure**

Case closure involves terminating a person from the service delivery system.

Example: Completing discharge summaries or other forms for recording the individual's removal from the services delivery system. Sometimes this is done as a result of the individual's death. Although case closure services provided after the date of death should be logged, the support coordinator should prevent the service being billed to MO HealthNet by logging with a non-billable code.

Documentation: A case note, plus a discharge summary, etc., in the individual's file.

### **Non-billable Case Management Services**

Sections V through XII of this manual explain various ways support coordinators can determine for themselves what is and is not billable to MO HealthNet. Specific criteria for billable TCM must be met and documented. Such criteria are explained in later sections of this manual. Certain activities are sometimes billable and other times not. The support coordinator must learn the difference and, if the criteria are not met, log with a non-billable code.

Documentation: The case note needs to be clear as to what was done and why the non-billable code was entered.

### **DD Person Centered Planning and ISP Mentoring**

TCM agencies can use an administrative code that will allow experienced support coordinators and/or quality management staff to mentor another support coordinator by assisting with the facilitation and development of an ISP. This type of planning cannot effectively be learned using only traditional training techniques. The purpose of this administrative code is to enable the Division of DD to track time which, while not billable as TCM, is administratively necessary for assuring ISPs are developed with the necessary level of quality.

Examples: Assisting a support coordinator to facilitate a Person Centered Planning meeting and/or develop the ISP. The experienced staff may demonstrate the desired methods and techniques, then observe a return demonstration.

Time logged for this code will not be billed as TCM.

Documentation: Enter a note to describe the ISP Mentoring activity.

## VI. CRISIS TEAM ACTIVITIES

SPECIAL INSTRUCTIONS: LOGGING CRISIS TEAM ACTIVITIES for Regional Office Staff ONLY

Crisis team activities can be divided into three categories with relation to MO HealthNet covered services:

1. Support coordination “type” activities,
2. Crisis intervention activities that could be covered under one of the waiver programs, and
3. Other types of activity.

### **Support coordination “Type” Activities**

A special situation exists when the person in crisis is or could be a participant in any of the Division of DD’s three MO HealthNet Waiver programs. As explained below, crisis intervention is a service covered under each waiver program, for up to eight weeks per episode, and billable by Regional Offices. All the crisis intervention activities should be billed to the waiver. Exceptions can be made; team leaders must just understand the potential for accidental duplication and assure it does not occur.

### **Crisis Intervention Activities Coverable Under a Waiver**

On many occasions, the crisis team member will be the primary intervener. This is a direct service (crisis intervention) rather than a planning or linking function (support coordination). When the crisis team member personally provides direct care or intervention, or when the activity is strictly clinical, such as recording behaviors or coaching and instructing, the activity is a direct crisis intervention service.

Crisis intervention is a waiver service. All crisis intervention services may be billed to MO HealthNet when the individual is MO HealthNet eligible, enrolled in the DD Comprehensive, Community Support, or Sara Jian Lopez Waivers, and the service is properly authorized through the DD prior authorization system. A separate document, the Crisis Intervention Service Manual, details procedures for authorizing, logging and billing waiver crisis intervention services.

For individuals not enrolled in one of the waivers, the crisis team should log direct crisis intervention services with code 030001. This will provide a record of time spent and the service provided; however, MO HealthNet will not be billed.

## VII. DETERMINING IF AN ACTIVITY IS BILLABLE

Most of what support coordinators in the Division of DD Regional Offices, County Board, and other not-for-profit TCM providers do as routine activity qualifies as TCM and is billable. However, no list can encompass all that a support coordinator does, nor should a support coordinator’s actions be limited by such a list. Therefore, support coordinators must be able to decide for themselves if an activity is billable.

The following four points should serve as a logical guide for determining if a case manager's activity is a billable TCM service:

**1. Connect a Person to Services**

It is the intent of TCM activities to connect and maintain identified services for the individual's growth and development. TCM activity must be intended to connect a person to a service. For example, planning is needed to identify a service a person should be connected with; linking is needed to make the connection; quality enhancement is needed to be sure the person is truly connected with and benefiting from the service. A distinction must be made between connecting a person to a service and actually providing a service directly. Providing a service directly is not billable as TCM.

**2. State Plan TCM Definition**

The activity must meet the definition in the state plan. That is, it involves "planning, assessment, coordination, monitoring or related documentation to assist or ensure the person gains access to services and benefits from services." Planning Supports, Linking Resources, Quality Enhancement, and Documentation as defined in Section V meet these definitions. As defined, Linking Resources may include directly assisting the person to access services and resources, but only when advocacy is absolutely necessary to ensure the access. See Section XI for more information.

**3. Freedom of Choice**

The activity must in no way restrict the person's freedom of choice of provider, either of support coordination or of any other service, and the person must have freedom to refuse the service.

**4. MO HealthNet Eligible**

In order for the service to be billable/reimbursable the person benefitting from the activity must be eligible for MO HealthNet and part of the targeted group (eligible for Regional Office services) as defined in Section II of this manual.

**VIII. ELIGIBILITY FOR MO HEALTHNET**

Time spent assisting a person in initially applying for MO HealthNet (Missouri Medicaid) is not billable TCM. Once the person is MO HealthNet eligible, TCM received to assist the person with subsequent reinvestigations for MO HealthNet eligibility may be billable TCM. In order for TCM to be billable, the individual must have current eligibility for Division of Developmental Disabilities and be MO HealthNet-eligible on the dates the billable TCM occurred. Further, the activities must fall within the definitions for billable TCM as per this manual. The TCM documentation shall clearly describe the TCM activities associated with MO HealthNet eligibility reinvestigations.

**IX. SUPPORT INTENSITY SCALE**

Evaluator time spent in conducting/administering a Support Intensity Scale (SIS) is not billable TCM. If conducting this type of activity use a non-billable code. DMH CIMOR system for Division of DD TCM includes 000070 SIS non-billable code.

Should the primary support coordinator of an individual for whom the SIS is being completed, serve as a respondent during SIS administration - by providing TCM activities such as planning and coordinating to help the individual in gaining access to needed medical, social, educational and other services - these activities may be billable TCM. In order for TCM to be billable, the individual must have current eligibility for Division of Developmental Disabilities and be MO HealthNet-eligible on the dates the billable TCM occurred. Further, the activities fall within the definitions for billable TCM as per this manual. Documentation shall clearly describe the TCM activities that occurred during SIS administration to meet intended outcomes described above.

#### **X. ACTIVITIES WHICH MAY NOT BE BILLED AS TCM**

If a provider wants the logging system to include all of their staffs' activities, including those that are not billable, the provider may consider developing additional codes for staff to use that will be excluded by their Medicaid billing system.

Note: The Division also has a code (111111) for "non billable case management" which it uses to track support coordination activities that it does not bill to Medicaid. Providers may want to utilize this option.

Following are activities which support coordinators sometimes perform, but which but are not billable as targeted case management services.

#### **Knowledge Enrichment**

Continuing one's education and professional growth, which includes attending conferences and seminars, is a critical activity. Because it is not specifically for the benefit of one individual, it cannot be billed as targeted case management.

#### **Networking**

Networking involves developing community relationships and community support systems which benefit the lives of individuals with developmental disabilities and their families. Networking is distinguished from linking resources in that networking is not related to specific supports for a particular individual or family. Therefore, it cannot be billed as targeted case management.

#### **Direct Support**

Support coordinators sometimes provide direct support to a person such as helping him move to a new apartment or transporting him to a store or appointment or helping the person pay a bill. Any service which is "direct support" is not billable as TCM. Additional examples of non-billable services are helping a person shop, helping a person do laundry, balancing a person's checkbook, counseling, training, etc.

#### **Other Activities**

Activities that do not fall under billable support coordination must be logged with the appropriate service system code. Do not use MO HealthNet billable targeted case management codes. For example, activities logged solely as, "took Jack to pick-up his

clothes”, “transported Mary to court appointment”, “took Jim to the park”, “helped Susan move to her new apartment”, “assisted Terry with shopping”, etc. are, as stated, neither crisis intervention nor case management; rather, these descriptions indicate a direct service, which is not billable to MO HealthNet. See Sections V through X for more information on determining whether or not a service is billable

### **Crisis Intervention**

Providing support directly to an individual during a crisis situation might include data collection, oversight or instruction. However, since this is direct clinical intervention (direct support), it is not billable as targeted case management. Connecting a person with crisis intervention services, however, could be billed as targeted case management under Linking Resources.

### **Abuse Neglect Investigations**

While resolving situations of abuse or neglect may involve TCM activities such as planning and linking resources, conducting the investigation is not billable.

### **Certification Survey Function**

Attending a certification survey function such as an enhancement planning meeting is not billable unless one of the individuals being discussed is in the support coordinator’s caseload. In this case, time spent helping to plan enhancement, which will benefit this person, would be billable.

### **Utilization Review**

The time a support coordinator spends serving on the Utilization Review Committee (URC) is not billable. Time a support coordinator spends advocating to the URC on behalf of an individual may be billable.

## **XI. ACCOMPANYING AN INDIVIDUAL**

The Center for Medicare and Medicaid Services (CMS) takes the policy position that transporting an individual is a “direct service” and hence not a billable TCM activity. CMS’s position on direct service starts with the definition of TCM in the Social Security Act— “...services which will assist individuals...in gaining access to needed medical, social, educational and other services.” According to CMS, TCM is a service that connects a person with another service. Therefore, if the case manager actually provides any support to the individual, particularly involving “counseling, accompanying, or transporting,” CMS calls it a direct service, which is not billable.

Planning supports, linking resources and service monitoring, which are legitimate TCM activities, may, under certain conditions, require the support coordinator to accompany a person to explain, to advocate or otherwise intervene in, or to augment a process in which the person’s access to services is being questioned or determined. Likewise, accompanying a person into the community may be necessary for planning or linking to services, or to observe and monitor the effectiveness of the supports being provided. Actual time the support coordinator spends conducting activities that fall under the TCM service definition is billable as TCM. The time the individual is being transported by the support coordinator is a direct service and not billable under TCM.

## **XII. DETERMINING WHO IS THE PRIMARY SUPPORT COORDINATOR**

CMS assumes each person has only one support coordinator. There are various circumstances where this may not be the case, and in each instance, some actions can be billed as TCM and some cannot. [There are three instances where this may not be the case, and in each instance, some actions can be billed as TCM and some cannot.] Providers must develop a protocol for staff to control the inappropriate billing of services to MO HealthNet.

### **Multiple Agencies**

When a person is enrolled in multiple agencies, he is likely to have a “case manager” for each. If those “case managers” are performing the same activity, CMS would only consider one of them to be legitimate for payment by MO HealthNet. On the other hand, if the various “case managers” have clearly different functions, only the time spent doing the same activity would be duplicative.

For instance, individuals served through the Division of DD may have a dual diagnosis of a mental illness and receive case management from an administrative agent for the Division of Comprehensive Psychiatric Services. When conducting an activity together, the two support coordinators should determine who is primary and who is secondary. When the activities overlap, such as during a planning meeting, the secondary support coordinator must log in such a way as to suppress billing for his time in the meeting by logging a non-billable code.

Another example is the young child who may have a case manager from the Health Children and Youth program for assistance with physical health problems and a support coordinator through the Division of DD to assist with supports for mental or behavioral problems. Again, these two “case managers” need to work together, but where they are both attending the same meeting or talking with each other, one needs to be the primary support coordinator and the other the secondary.

### **Logging an Activity for someone not on your Caseload**

Support coordinators, supervisors, and other TCM-qualified staff may all log a TCM service as primary support coordinator if all the following conditions apply for the individual:

- The activity being logged is a legitimate TCM activity provided to or on behalf of a specific individual;
- The individual is eligible for TCM;
- The person performing the activity meets the qualifications to provide TCM; and
- One person is performing the activity at the time.

### **Transition/Transfer of Case Responsibility**

See the description for Transition/Transfer of Case Responsibility in Section V of this manual. This is an instance where two support coordinators from different Division of DD TCM agencies may be providing a certain amount of TCM services necessary for the individual transferring from one TCM entity to the receiving TCM provider. The need for this capability derives from the requirement that individuals be given informed free choice of service providers, including support coordinators. Transfers need to be accomplished in a timely manner: Thirty (30) days should ordinarily be sufficient.

### **XIII. LOGGING AND DOCUMENTATION**

As TCM services are provided, the support coordinator is responsible for logging the activity. The Division's information system on the CIMOR includes TCM logging screens so that support coordinators can log activities directly into the system as services are provided. The automated system also has an expandable field for entering a narrative explanation, which, in this manual, is called a **note**.

Each provider is responsible for developing their own logging system, which may be either on paper or a computer system. The provider must ensure that the system collects minimum required information specified below.

In order for TCM services to be billed to MO HealthNet, there must be an identifiable charge related to an identifiable and allowable service that was rendered by a qualified provider on behalf of an eligible person included in the target group.

#### **Required Information**

MO HealthNet State plan for case management for persons with developmental disabilities indicates providers shall maintain case records that document for all individuals receiving case management as follows:

- The name of the individual;
- Dates of case management services;
- The name of the provider agency (if relevant) and the person providing the case management service;
- The nature, content, units of case management services received and whether the goals specified in the care plan have been achieved;
- Whether the individual has declined services in the care plan;
- The need for, and occurrences of, coordination with other case managers;
- A timeline for obtaining needed services; and
- A timeline for reevaluation of the plan.

Further information on the aforementioned documentation requirements are described below and in other sections of this manual, where applicable.

Documentation requirements for TCM provided by the Department of Mental Health are found in **13 CSR 70-3.030.13**. (<http://www.sos.mo.gov/adrules/csr/current/13csr/13c70-3.pdf>).

Logging documentation shall be completed contemporaneously with the date the TCM activity was provided. For purposes of documentation, this CSR defines contemporaneous as the time the activity is performed or within 72 hours of the time the activity was completed.

The support coordinator is responsible for including the following information when a log entry is made to support a bill to MO HealthNet:

- First name, last name, and either middle initial or date of birth of the MO HealthNet participant;
- Accurate, complete, and legible case note of each service provided; DMH ID of the individual receiving service;
- Name of the support coordinator providing the logged service activity;

- Date the service was provided (month/day/year);
- Amount of time in hours and minutes required to complete each TCM activity. *Indicate any time spent in travel associated with the TCM activity (see note below);*
- Setting in which service was rendered (Service Location);
- Individual plan with regular updates;
- Progress notes;
- Discharge summaries when applicable;
- Other relevant documents referenced in the case notes such as letters, forms, quarterly reports, and plans of care.

Note Regarding travel time:

The support coordinator should indicate in the case note total amount of travel time to and from activity, or break out travel time to the activity and from the activity. Example: "ISP completed at the individual's home. Travel time to and from the person's home total was 1 hour". Or, this can be worded as "...travel time from office to the person's home was 30 minutes, and from the person's home back to the office was 30 minutes."

If a support coordinator is conducting multiple TCM functions for more than one person in a given day, the support coordinator may split the total travel time. This may involve travel to one or more locations in the course of the travel to provide billable TCM for more than one person. For example, service monitoring for more than one individual at a group home, the travel time can be equally split among the individual's for whom the service monitoring was conducted. If the travel to and from the group home was 45 minutes total to provide service monitoring for three individuals, the travel time would be 15 minutes for each person. The case note should indicate total travel time of 45 minutes was divided out equally for three persons; thus, 15 minutes travel each.

The following documentation shall be maintained and produced in the event of an audit:

- ISP with regular updates;
- Progress notes;
- Discharge summaries when applicable;
- Other relevant documents referenced in the case note such as letters, forms, quarterly reports and plans of care;
- Documents pertaining to case management assessment/reassessments should be maintained in the record and available for review.

**Notes**

As stated above, notes are the primary means of supporting TCM billing. Notes must adequately explain the service provided and this explanation must be retrievable when a question is asked, for instance, about the basis of-the claim for payment. The note should tell what action occurred and, why, and identify the parties involved. The reader should be able to infer, from the description of what and why, the benefit the individual received.

One thing the case note should always describe is what the support coordinator has done. It may also describe other observations, activities, data and descriptions. It may stand alone, or it may refer to another document produced by, or with the help of, the support coordinator. Where the case note refers to a document, it will be sufficient to state what and where the document is, and how much time was spent on it. However, if the support coordinator works on a ISP over the course of several days or weeks, he or she should enter a case note for each

day on which time was spent, saying simply: "Worked on draft of plan from planning meeting 3/16/12." This identifies both the activity and the product.

Examples of case note entries:

"Met Anne Jones, agency manager, at XYZ group home to discuss John's desire to attend a cooking class due to his interest in working in food services. This is associated with supported employment services he is receiving. Support coordinator has arranged payment for the class and transportation. Total travel time one hour."

"A phone call was made to the individual's mother, who is requesting an increase in respite hours. Support coordinator agreed to contact the team supervisor regarding her request and get back to her within a week. Support coordinator talked with team supervisor later that same day, and received approval to send a request to UR for an increase in respite to 16 hours per week. An amendment was completed to include the need for an increase in the respite. Support coordinator called the individual's mother at 4:30 p.m. that day to update her on the amendment that was completed to increase in respite hours and that the amendment to the plan will go through the Utilization Review Committee."

"Support coordinator provided service monitoring for Tom at his home. Tom's diabetes is still well controlled by diet. Medication level this month was within normal limits. Staff has been supporting him in learning about fire safety -- he was able to point out the smoke detectors in his home, test them and tell me what he would do in case of fire. Tom is adjusting to his new home well. Tom resides with two other persons who also received TCM services monitoring today. Total travel time was 1.5 hours to and from the ISL. Since all three individuals received TCM monitoring of ISL services in their home today, the travel time was equally divided for each person. Hence, total travel time associated with Tom's visit was 30 minutes."

Examples of insufficient documentation--

"Visited XYZ group home"

"Telephone call to dad"

"Saw Mary at Workshop"

ISPs and quarterly reports are always located in the individual file, so the support coordinator doesn't need to specify location in these instances. Other documents, such as medical reports, court reports, referrals, letters and other documents supported or reflected in the case notes may be in the individual's file. The support coordinator, when writing the case note covering the activity of writing or gathering these documents, should state in the case note where the other documents are located. Note that Support coordinator (or someone else) may need to be able to explain and retrieve what they were doing a year or several years after the fact.

## Quarterly Review

Quarterly reviews are required for individuals with purchased services funded by State/Federal/ or County board funds. The purpose of the report is to summarize progress or at least maintenance of the individual with the current supports.

## Some Words are Better than Others

While no manual can tell a support coordinator what to write, there are a few suggestions as to the types of action verbs that best support a MO HealthNet claim for TCM. Because of CMS's interpretation of "direct service" (see Sections VI, VII, and X), most action verbs need to focus on the service or resource being accessed, rather than on the individual who is being helped to access it.

### Indicate a billable service:

- plan, planning, make plans for...
- arrange, arrange for, facilitate
- assess or evaluate need/capacity for...
- link, connect, coordinate
- meet with, consult with
- locate or find resources/supports, etc...
- develop or set up (as in a system of support)
- intervene or persuade (a system or resource)
- negotiate, bargain
- advise, assure
- report
- explain

### Indicate a direct service:

- take, deliver, transport
- escort
- counsel
- support
- shop
- train, instruct
- interpret

## Why do we need this Documentation?

In addition to the accepted standards of practice for support coordination, which require adequate documentation to ensure continuity and progress, there are two additional reasons to document.

## MO HealthNet Recipient Services Benefit Notice

On a quarterly basis a sample of individuals who receive MO HealthNet benefits receive a notice listing every service for which a claim was submitted during that quarter, regardless of whether the claim was paid or denied by MO HealthNet. Each TCM service that is billed to MO HealthNet is reflected on this notice. Individuals are instructed by the notice to call or write the MO HealthNet Agency if they have any questions about charges reflected on the notice.

All inquiries regarding TCM services that the MO HealthNet Agency receives are referred to Division of DD. The Division must explain in writing to the individual and the MO HealthNet Agency what specific activity was performed for each charge made to MO HealthNet during the quarter in question. In order to do this, the County Board and the not-for-profit agency must keep clear documentation that is easily retrievable.

## **Audit Requirements**

State and federal auditors may also review claims for all MO HealthNet services billed by the Division or billed by provider agencies in association with a program administered by the Division of DD, such as the MO HealthNet Home and Community Based Waiver. In audit situations, the Division of DD must be able to clearly substantiate, explain and sometimes defend the activity for which a charge was made to MO HealthNet. Review periods may go back as far as five years. Often, individuals who were assigned to a case at the time services were delivered are no longer available to explain notes. Routine documentation avoids potential problems with audits.

## **XIV. BILLING REQUIREMENTS**

### **Billing Format**

Claims and adjustments must be billed electronically using MO HealthNet's website emomed.com, or send the HIPAA 5010 version of the 837P. To send HIPAA 5010 version of the 837P, providers must follow the HIPAA guidelines obtained from WPC-EDI at <http://wpc-edi.com/> and payer specific instruction from the Medicaid companion guide at <http://www.dss.mo.gov/mhd/providers/index.htm>

To obtain electronic connection specifications, providers must call MO HealthNet's fiscal agent, Wipro InfoCrossing at 573-635-3559. Providers must have their Medicaid Provider number when calling InfoCrossing.

### **Place of Service**

It is required there be a place of service code that indicates where the activity took place.

### **Unit of Service**

A TCM service unit is five minutes.

### **Time Limit for Original Claim Filing**

Claims from participating providers who request Medicaid reimbursement must be filed by the provider and must be received by the state agency with 12 months from the date of service. The counting of the 12 month time limit begins with the date of service and ends with the date of receipt.

### **Time Limitations for Resubmission of a Claim**

Claims must be submitted to MO HealthNet for payment within 12 months of the date of service. If the claim is denied or returned to the provider, the provider has 12 additional months from the date it is denied/returned, not 24 months from the date of service.

### **Service Codes**

There are internal service codes that the Division uses to document the provision of TCM services. These codes are listed below. County Boards may elect to use these codes or develop their own. Regardless of what code a County Board chooses to use, any activity that is logged must be within the scope of the activities listed below and defined in Section V. of this manual.

- 000020 Planning Supports
- 000021 Linking Resources
- 000022 Service Monitoring/Quality Enhancement
- 000023 Quarterly Review of Progress on ISPs
- 000030 Documentation
- 022001 Case Closure

All allowable TCM services are then billed to MO HealthNet under one procedure code G9012HI.

### **Transitioning from an Institution**

TCM is generally not billable for persons who reside in a Title XIX certified facility (SNF or ICF nursing home, private ICF/DD, or state operated ICF/DD) even if the service is delivered someplace else. There is an exception for persons who reside in a Title XIX certified facility whose ISP includes a plan for relocating (transitioning) to a community living arrangement. (Transition does not include moving from one institution to another.) Once a person has transitioned into the community, MO HealthNet can be billed for case management services the person receives related to relocating to the community, not to exceed the last 180 days the person resided in the facility. Billing cannot occur until after the date of discharge into the community.

### **Title XIX Placements (Ineligible Place of Residence)**

As mentioned above, some individuals who receive TCM services reside in Title XIX certified facilities, which are ICF's, SNF's or ICF/DD Facilities (both private ICFs DD and state operated habilitation centers). MO HealthNet will not reimburse TCM services for individuals who reside in these facilities, because the facility is already being paid a per diem.

[Note: An edit had been added to DMH CIMOR effective August 6, 2008. This edit checks to determine if the individual resides in a Title XIX facility on the date of the TCM service. If the individual does reside in at Title XIX facility, CIMOR will mark the service as non-billable.]

### **Title XIX Placements (Eligible Place of Residence)**

MO HealthNet will reimburse TCM services for up to 180 days for individuals who reside in institutions when the individual is transitioning from the institution to a community living arrangement such as a living arrangement funded through the waiver. For TCM providers that use CIMOR for billing, in order for a support coordinator to submit billable logging for individuals who are transitioning to the community, the 20000T code must be utilized and Service Location should designate ICF/DD, nursing facility, or skilled nursing facility. This will allow targeted case management to be billed and paid for persons who are being transitioned from a Title XIX state operated ICF/DD, private ICF/DD, or nursing home. Transition activities coded with 20000T shall not be billed to MO HealthNet until after the date of discharge into the community. Support coordinators can log applicable transition activities, while the person is residing in an ICF/DD or nursing facility, by using a non-billable code. Once the person has successfully transitioned to the community, the code can be changed to 20000T and submitted as a billable TCM claim for that date of service. Claims with the 20000T code shall only be billed for service dates up to 180 consecutive days prior to the effective date of successful transition.

This does not include persons who transition from one institution to another, for example, move from a state operated ICF/DD facility to another, or to a nursing home or private ICF/DD.

Note that Residential Care Facilities (RCFs) I & II are not Title XIX certified facilities. TCM services logged for individuals living in these facilities will be billed.

### **Quantity of Service**

The developmental disabilities billing system takes the total time a support coordinator spends on a given activity for a given individual on a given day and converts the time to tenths of an hour. A TCM service unit is five minutes. Providers must design their billing system to also bill services in five minute increments.

## **XV. ADMINISTRATION**

### **System Edits Prior to Billing**

On a semi-monthly basis, staff in DMH Information Technology Services Division (ITSD) run the TCM billing cycle and submit claims electronically to MO HealthNet. The program bills service data that has been entered to the MO HealthNet claim since the last billing cycle. Services are not added to a MO HealthNet claim until 30 days after the date of service.

Logged data is edited for:

- 1) Billable service code;
- 2) Individual is MO HealthNet eligible;
- 3) Service location.

### **These codes will not be Billed to Mo HealthNet (Regional Office non-billable codes)**

111111 Non-Billable Case Management Services  
000050 Quality Improvement  
000070 SIS Activity  
020001 Intake/Screening Admission  
395001 Consumer Advocacy  
900001 Other Community Indirect Services  
960001 Clinical Services Supports  
960003 Personal Plan Mentoring  
970001 Staff Development  
120001 Psychosocial Evaluation

### **Service Location**

MO HealthNet requires each claim to include a "place of service". In CIMOR DMH support coordinators must indicate a service location, the table below lists the available service locations.

#### **Service Location**

- Home
- Intermediate Care Facility/Developmental Disabilities
- Office
- Custodial Care Facility

- Nursing facility
- Skilled Nursing Facility
- Other Place of Service