

**Billing Guidelines
for
Targeted Case Management (TCM)**

Effective: November 1, 2011

Billing Guidelines for Service Coordination funded by Medicaid as Targeted Case Management (TCM)

1. Service Coordination funded by Medicaid as TCM:

Service coordination is defined §2.553 of rules governing Service Coordination for Individuals with Mental Retardation (40 TAC Chapter 2, Subchapter L).

Service coordination funded by Medicaid as TCM includes:

- Basic Service Coordination: Service Coordination performed in accordance with 40 TAC Chapter 2, Subchapter L, for a Medicaid-eligible individual who has been assessed as having more than one need and who is not residing in an ICF, including a state supported living center (SSLC) or enrolled in a Medicaid waiver program.
- Service Coordination – HCS or TxHmL Program: Service Coordination for individuals enrolled in the Home and Community-based Services (HCS) program or Texas Home Living (TxHmL) program in accordance with 40 TAC Chapter 9, Subchapter D or Subchapter N.

If an individual is a Medicaid recipient and eligible for service coordination, the local authority (LA) determines frequency, duration and intensity of the service coordination that the individual will receive. The LA must document in the individual's plan of services and supports or person-directed plan (PDP) the results from the evaluation including the individual's choices and outcomes (or legally authorized representative (LAR), on the individual's behalf); the specific services and supports to be provided by community providers; and the frequency, duration and intensity of service coordination.

Service coordination must be provided in accordance with the individual's plan of services and supports. If an individual's needs change, the LA must consult with the individual (or LAR, on the individual's behalf) and revise the individual's plan, as appropriate, and/or adjust the frequency, duration and intensity of service coordination. The LA may provide crisis prevention and management prior to documenting the service in the individual's PDP or plan of services and supports. The LA terminates service coordination for an individual if the individual (or the LAR on the individual's behalf) no longer desires service coordination or the individual no longer meets the eligibility criteria for service coordination as set forth in §2.554 of rules governing Service Coordination for Individuals with Mental Retardation (40 TAC Chapter 2, Subchapter L).

2. Definitions:

- a) **Collateral** -- Any person directly associated with helping an individual achieve, or potentially helping an individual achieve, an outcome identified in the individual's plan of services and supports or PDP. For example, collateral may be a provider, teacher, family member, or neighbor.
- b) **Individual** – A Medicaid recipient who has been determined eligible for service coordination.
- c) **Telemedicine** – For purposes of Medicaid, telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient) that states may choose to cover. This definition is modeled on Medicare's definition of telehealth services located at 42 CFR 410.78. Note that the Federal Medicaid statute (Title XIX of the Social Security Act) does not recognize telemedicine as a distinct service.

3. Required activities:

- a) Provision of service coordination.
- b) Develop the PDP or plan of services and supports using person-directed planning that is consistent with the DADS' *Person Directed Planning Guidelines* and that describes:
 - the individual's desired outcomes;
 - the services and supports, including service coordination services, to be provided to the individual; and
 - the frequency (which must be at least every 90 days) and duration of service coordination to be provided to the individual.

4. Prohibited activities:

- a) The LA staff person providing service coordination may not perform a provider function for the LA's provider operations.
- b) The LA staff person providing service coordination may not be a "relative" of the individual or have the same residence as the individual. ("Relative" is defined in §2.253 of rules governing Service Coordination for Individuals with Mental Retardation (40 TAC Chapter 2, Subchapter L).)

5. Encounter System:

Service coordination funded by Medicaid as TCM is reimbursed by encounter. There are two types of encounters as follows:

- a) Comprehensive encounter (Type A): A face-to-face contact with an individual to provide service coordination.

The comprehensive encounter is limited to one billable encounter per individual per calendar month. DADS will not authorize payment for a comprehensive encounter that exceeds the cap of one encounter per individual per calendar month.

- b) Supportive encounter (Type B): A face-to-face, telephone, or telemedicine contact with an individual or with a collateral on the individual's behalf to provide service coordination. An LA is allowed up to three Type B encounters per calendar month for each Type A encounter that has occurred within the calendar month.

The Type B encounters are not limited to three per individual. Rather, the allowed Type B encounters may be delivered to any individual who needs a Type B encounter. These Type B encounters are allowable as long as the individual who received the Type B encounter also received a Type A encounter that same month. For example, Sam and Mary receive a Type A encounter in June. It is allowable for the LA to bill for one Type B encounter for Sam in June and five Type B encounters for Mary in June.

Payment for an individual's Type B encounter is contingent on that individual having a Type A encounter within the same calendar month.

Within the calendar month, the Type A encounter does not have to occur on a date before any of the Type B encounters occur.

6. Annual Cap of Type B Encounters:

The annual cap for Type B encounters is calculated as the number of payable Type A encounter claims for the state fiscal year multiplied by three.

7. Monthly and End of Fiscal Year Calculations and Recoupment:

The Texas Medicaid and Healthcare Partnership (TMHP) will perform a monthly calculation process in which Type B encounters without a Type A encounter for the previous month are recouped. Multiple Type A encounters billed in a previous month for a given individual will be recouped. Recouped means that TMHP will deduct the owed amount from future encounter claim payments. *Please note:* Recoupments are only for claims in Paid status.

At the end of the state fiscal year, TMHP will perform another calculation process in which it matches the number of Type A encounters multiplied by three to the total number of Type B encounters in the system for the LA (this is not tied to a particular individual but is based solely on the number of Type A encounters multiplied by the number of Type B encounters). *Example:* If an LA bills 1000 Type A encounters, it is allowed up to 3000 Type B encounters per year.

DADS will provide each LA a monthly report which will include the total number of Type A and Type B encounters. This should help each LA track the number of Type A encounters to the number of Type B encounters.

8. Eligibility for Service Coordination funded by Medicaid as TCM:

To receive service coordination funded by Medicaid as TCM, an individual must meet the criteria described in §2.555(b) of rules governing Service Coordination for Individuals with Mental Retardation (40 TAC Chapter 2, Subchapter L).

9. Reference document, law, rule, policy, etc.:

- a) Medicaid Provider Agreement For The Provision Of Mental Retardation Service Coordination
- b) Current Performance Contract
- c) 40 TAC Chapter 2, Subchapter L (Service Coordination for Individuals with Mental Retardation)
- d) 1 TAC Chapter 355, Subchapter F (Reimbursement Methodology for Programs Serving Persons with Mental Illness and Mental Retardation)

10. Qualified Provider of Service Coordination funded by Medicaid as TCM:

Only an entity designated as an LA by the executive commissioner of the Texas Health and Human Services Commission in accordance with Texas Health and Safety Code, §533.035, is a qualified provider of service coordination funded by Medicaid as TCM.

11. Qualified Service Coordinator:

A qualified service coordinator:

- must be an LA employee who meets the qualification requirements described in §2.559 of rules governing Service Coordination for Individuals with Mental Retardation (40 TAC Chapter 2, Subchapter L); and
- may not be excluded from participation in federal health care programs.

12. Clarifications:

- a) This service may not include transportation provided by the service coordinator.
- b) Service coordination funded by Medicaid as TCM may be provided to a Medicaid recipient who resides in a nursing facility licensed in accordance with Texas Health and Safety Code, Chapter 242, and who has been determined through a preadmission screening and resident review (PASRR) assessment to be eligible for specialized services.
- c) The documented need for multiple services is considered “two or more documented needs” as referenced in §2.554(a)(1) of rules governing Service Coordination for Individuals with Mental Retardation (40 TAC Chapter 2, Subchapter L).

- d) Meeting(s) for the purpose of the discovery process - Identifying the individual's wants, needs, and desires for services/supports as part of the service planning process and the actual service planning team meeting where the plan of services and supports or PDP is developed or revised are allowable activities as long as the documentation clearly evidences that these activities were part of the service planning process.
- e) This service includes the coordination and monitoring of participation in a non-medical program for a specific individual who is eligible for service coordination funded by Medicaid as TCM.

13. Data Warehouse Reporting Requirements:

- a) Appropriate Encounter Services and Grid Codes – refer to DADS FYs 2010 & 2011 Performance Contract, Attachment F (amended 9-1-2010). Applicable grid code 0351, Basic Service Coordination and Service Coordination for individual's enrolled in HCS or TxHmL.
- b) Critical Encounter Fields – Enc_Type_Cd must be **F**, Face to Face, **T**, Telephone, or **E** Telemedicine (effective 9-1-2010). An Encounter Type value **T** is not sufficient **on its own** to produce or support an R014 assignment. Recipient_Cds **1-7** will be allowed for valid encounters (effective 9-1-2010) but values **2**, collateral, Not Specified, **5**, collateral, family member or LAR only, or **7**, collateral, waiver provider only are not sufficient **on their own** to produce or support an R014 assignment.
- c) If crisis prevention and management is provided, the Crisis data field must be **Y**.

14. Documentation necessary for verification:

- a) A progress note or other documentation verifying the service was provided on the specified date.
 - I) The progress note includes a legible, written narrative for each encounter that describes the service and, at least every 90 days, includes information pertaining to the individual's progress toward outcomes or goals. The written narrative includes:
 - name of individual;
 - type of service coordination activity provided (e.g., assessment, service planning and coordination, monitoring, or crisis prevention and management);
 - date service coordination encounter occurred (month, day, year);
 - place of encounter;
 - actual begin time and duration of encounter;
 - detailed description of the encounter;
 - for a supportive encounter (Type B), the name of person with whom the contact occurred and the relationship the person has with the individual and whether the contact is face-to-face, by telephone, or telemedicine;
 - name and title of the service coordinator; and
 - signature of service coordinator (including credentials or job title as appropriate).
 - II) Elements noted above do not necessarily have to be contained within the narrative describing the encounter as long as they are contained within the progress note that also contains the narrative (e.g., billing strip).
 - III) The following are unacceptable as a description of the encounter in a written narrative:
 - ditto marks;
 - references to other written narratives or progress notes using words or symbols;
 - non-specific statements such as "had a good day," "did OK," or "no problem today;"
 - statements that are repeated, photocopied or are otherwise identical to other written narratives, including "fill in the blank" statements;
 - a list of preprinted activities, such as a schedule or "check off" sheet;
 - a data collection sheet; and
 - a medication log.

- b) Sufficient documentation to demonstrate eligibility for service coordination (e.g., Assessment indicating multiple needs, or IPC CARE Screen C72, or needs list) that is consistent with the period of time being reported.
- c) PDP or plan of services and supports in effect for the month of service reported.
- d) Evidence of the server code of the LA employee providing the service.

15. Service Claim Requirements:

An LA must submit an electronic service claim for TCM that meets the requirements specified by TMHP.

16. Billable Activity:

The only billable activities for service coordination funded by Medicaid as TCM are:

- interacting or observing face-to-face with an individual to provide service coordination;
- interacting by telephone, or telemedicine with an individual to provide service coordination;
- interacting face-to-face, by telephone, or telemedicine with a collateral to provide service coordination;
- participating in service planning team meetings;
- participating in the development of the PDP or plan of services and supports for an individual; and
- participating in the development of the individual plan of care (IPC) for an individual enrolled in HCS or TxHmL.

17. Activity Not Billable:

Certain activities by a service coordinator do not constitute billable activity. These activities include, but are not limited to:

- traveling by a service coordinator;
- documenting the delivery of service coordination funded by Medicaid as TCM (for example, writing written narratives, completing forms and entering data);
- reviewing an individual's written record; and
- drafting an individual's PDP, plan of services and supports, or IPC.