5101:3-48-01 **Medicaid coverage of targeted case management services provided to individuals with mental retardation and developmental disabilities.**

(A) Purpose.

(1) This rule specifies the conditions for medicaid payment of targeted case management (TCM), which is comprised of those activities described in section 5126.15 of the Revised Code and in rule 5123:2-1-11 of the Administrative Code, but only to the extent that they are listed in paragraph (D) of this rule as reimbursable activities for medicaid eligible individuals with mental retardation and/or a developmental disability.

(2) The department of mental retardation and developmental disabilities (ODMRDD), through an interagency agreement with the department of job and family services (ODJFS), administers the TCM program on a daily basis in accordance with section 5111.91 of the Revised Code.

(B) Definitions.

(1) "IEP" means an individualized education program and has the same meaning as described in rule 3301-51-07 of the Administrative Code.

(2) "Institution" means a nursing facility, an intermediate care facility for the mentally retarded (ICF/MR), a state-operated intermediate care facility for the mentally retarded (ICF/MR) or a medical institution.

(3) "ISP" means an individualized service plan as defined in rule 5123:2-1-11 of the Administrative Code.

(4) "Major unusual incident" (MUI) has the same meaning as defined in rule 5123:2-17-02 of the Administrative Code.

(5) "Service and support administration" has the same meaning as described in section 5126.15 of the Revised Code.

(6) "Targeted case management" means services which will assist individuals in gaining access to needed medical, social, educational and other services as described in this rule in accordance with section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)(2)) as effective January 1, 2006. Targeted case management is also referred to as medicaid case management.

(7) "Unusual incident" has the same meaning as defined in rule 5123:2-17-02 of the

Administrative Code.

(C) Eligible individuals.

(1) Individuals eligible for medicaid coverage of TCM services are:

(a) Medicaid eligible individuals, regardless of age, who are enrolled on home and community-based service (HCBS) waivers administered by the ODMRDD, and

(b) All other medicaid eligible individuals, age three or above, who are determined to have mental retardation or other developmental disability according to section 5126.01 of the Revised Code.

(D) Reimbursable activities.

(1) Medicaid services listed in paragraph (D) are reimbursable only if provided to or on behalf of a medicaid eligible individual as defined in paragraph (C) of this rule and by qualified providers as defined in paragraph (E) of this rule. Payment for targeted case management services may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Medicaid reimbursable TCM services are:

(a) Assessment. Activities reimbursable under the assessment category are limited to the following:

(i) Activities performed to make arrangements to obtain from therapists and appropriately qualified persons the initial and on-going assessments of an eligible individual's need for any medical, educational, social, and other services.

(ii) Eligibility assessment activities that provide the basis for the recommendation of an eligible individual's need for HCBS waiver services administered by ODMRDD.

(iii) Activities related to recommending an eligible individual's initial and on-going need for services and associated costs for those individuals eligible for HCBS waiver services administered by ODMRDD.

(b) Care planning. Activities reimbursable under the care planning category

are limited to the following:

(i) Activities related to ensuring the active participation of the eligible individual and working with the eligible individual and others to develop goals and identify a course of action to respond to the assessed needs of the eligible individual. These activities result in the development, monitoring, and on-going revision of an individualized service plan (ISP).

(c) Referral and linkage. Activities reimbursable under the referral and linkage category are limited to the following:

(i) Activities that help link eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services.

(d) Monitoring and follow-up. Activities reimbursable under the monitoring and follow-up category are limited to the following:

(i) Activities and contacts that are necessary to ensure that the ISP is effectively implemented and adequately addresses the needs of the eligible individual.

(ii) Conducting quality assurance reviews on behalf of a specific eligible individual and incorporating the results of quality assurance reviews into amendments of an ISP.

(iii) Reviewing the individual trends and patterns resulting from reports of investigations of unusual incidents and MUIs and integrating prevention plans into amendments of an ISP.

(iv) Ensuring that services are provided in accordance with the ISP and ISP services are effectively coordinated through communication with service providers.

(v) Activities and contacts that are necessary to ensure that guardians and eligible individuals receive appropriate notification and communication related to unusual incidents and MUIs.

(e) State hearings: Activities reimbursable under the state hearing category are limited to the following:

(i) Activities performed to assist an eligible individual in preparing for a state hearing related to the reduction, termination or denial of a service on an ISP.

(2) Coverage exclusions.

(a) Activities performed on behalf of an eligible individual residing in an institution are not billable for medicaid TCM reimbursement except for the last one hundred eighty consecutive days of residence when the activities are related to moving the eligible individual from an institution to a non-institutional community setting.

(b) Emergency intervention services as described in paragraph (Q) of rule 5123:2-1-11 of the Administrative Code. This does not preclude those activities covered in paragraph D(1) of this rule when responding to an emergency and provided by a certified or registered service and support administrator.

(c) Conducting investigations of abuse, neglect, unusual incidents, or major unusual incidents.

(d) The provision of direct services (medical, educational, vocational, transportation, or social services) to which the eligible individual has been referred.

(e) Services provided to individuals who have been determined to not have mental retardation or another developmental disability according to section 5126.01 of the Revised Code, except for individuals eligible for coverage of TCM services pursuant to paragraph (C)(1)(a) of this rule.

(f) Conducting quality assurance systems reviews.

(g) Conducting quality assurance reviews for an eligible individual for whom the service and support administrator serves as the single point of accountability.

(h) Payment or coverage for establishing budgets for services outside of the scope of individual assessment and care planning.

(i) Activities related to the development, monitoring or implementation of an individualized education program (IEP).

(j) Services provided to groups of individuals.

(k) Habilitation management as defined in rule 5123:2-1-11 of the Administrative Code.

(l) Eligibility determinations for county board of mental retardation and developmental disabilities (CBMRDD) services.

(m) Activities excluded from coverage as described in paragraph (A)(iii) of section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)(2)) as effective January 1, 2006.

(E) Qualified providers.

(1) Qualified providers of medicaid TCM services are CBMRDD as established under Chapter 5126. of the Revised Code. Only those eligible activities as defined in this rule performed by CBMRDD employees or CBMRDD sub-contractors meeting the registration or certification standards contained in rule 5123:2-5-02 of the Administrative Code are eligible for payment.

(F) Documentation requirements.

(1) To receive medicaid reimbursement for TCM activities provided under this rule, documentation must include, but is not limited to, the following elements:

(a) The date that the activity was provided, including the year;

(b) The name of the person for whom the activity was provided;

(c) A description of the activity provided and location of the activity delivery (may be in case notes or a coded system with a corresponding key);

(d) The duration in minutes or time in/time out of the activity provided. Duration in minutes is acceptable if the provider's schedule is maintained on file;

(e) The identification of the activity provider by signature or initials on each entry of service delivery. Each documentation recording sheet must contain a legend that indicates the service provider's name (typed or printed), title, signature, and initials to correspond with each entry's identifying signature or initials.

(G) Reimbursement and claims submission.

(1) Each CBMRDD shall maintain a current fee schedule of usual and customary charges. Records of fee schedules must be maintained for a period of six years. The CBMRDD shall bill ODMRDD its usual and customary charge for a TCM covered service. TCM services will be reimbursed the lesser of the CBMRDD's usual and customary charge or the rate ~~.~~ found in appendix A of this rule ~~for the cost of doing business (CODB) region in which the service is delivered~~.

(2) Each CBMRDD is responsible for instituting collection efforts against third ~~party liability companies for~~ parties liable for the payment of TCM services. The CBMRDD must maintain sufficient documentation to substantiate collection activities and any payments received. CBMRDDs shall not alter or adjust usual and customary rates charged to the medicaid program if such adjustments will result in a direct or indirect charge for costs of uncompensated care being charged to the medicaid program.

(a) If a CBMRDD extends the TCM benefit to individuals whom may also be receiving case management services as a component of another state and/or federal program, then the costs of any part of such services which are reimbursable under another state and/or federally funded program shall be allocated in accordance with "OMB Circular A-87" (as in effect January 1, 2006) or any related or successor guidance or regulations regarding allocation of costs among federally funded programs under an approved cost allocation plan.

(3) CBMRDDs are required to submit claims to ODMRDD within three hundred thirty days from the date of service in accordance with the format specified by ODMRDD. Failure to submit claims within the specified three hundred thirty days may result in the CBMRDD not being reimbursed for such claims. The CBMRDD shall have no recourse to recover such non-reimbursed claims.

(4) Medicaid reimbursement for TCM services shall constitute payment in full. Medicaid recipients may not be billed for medicaid covered services.

(5) In the event a fiscal review reveals that an overpayment has been made, and/or there is a disallowance of medicaid payments, the amount of the overpayment and/or disallowance shall be recovered from the CBMRDD no later than sixty days from the date that the state notifies the CBMRDD of the overpayment in accordance with 42 CFR 433.300 to 433.322 as in effect on January 1, 2006.

(6) Payment for TCM services must not duplicate payments made to CBMRDD under other programs.

(7) To support the provision of providing TCM through fee for service, utilization review procedures will be incorporated to assure compliance with "42 CFR Part 456" as in effect on January 1, 2006.

(8) Records relating to TCM services shall be made available to ODMRDD, ODJFS, centers for medicare and medicaid services (CMS) or any of their representatives to verify actual units of service provided are in compliance with federal requirements and are adequately supported.

(9) For the purpose of this rule, a unit of service is equivalent to fifteen minutes. Minutes of service provided to a specific eligible individual can be accrued over one calendar day. The number of units that may be billed during a day is equivalent to the total number of minutes of TCM provided during the day for a specific individual divided by fifteen plus one additional unit if the remaining number of minutes is eight or greater minutes.

(10) Billable units of service are those tasks/contacts made with the eligible individual or on behalf of the eligible individual. Activities which are not performed on behalf of or are not specific to an eligible individual are not billable.

(H) Record requests and retention.

(1) CBMRDD shall make available all records including but not limited to work papers, supporting reports, medical reports, progress notes, charges, journals, ledgers, computer tapes, computer disks, and fiscal reports for review by representatives from ODJFS, ODJFS' designee, CMS, or ODMRDD at the discretion and request of these representatives.

(2) Documentation will be retained for a period of six years from the date of receipt of final payment or until such time as a lawsuit or audit finding has been resolved, whichever is longer. The records shall be provided to ODJFS or its designee upon request in a timely manner. Records produced electronically must be produced at the provider's expense, in the format specific by state or federal authorities.

(I) Monitoring, compliance and sanctions.

(1) ODMRDD shall conduct periodic monitoring and compliance reviews related to TCM as authorized by the Revised Code. Reviews may consist of, but are not limited to, physical inspections of records and sites where services are provided, interviews of providers, recipients, and administrators. Qualified providers as defined in paragraph (E) of this rule, in accordance with the medicaid provider agreement and ODMRDD, shall furnish to ODMRDD, ODJFS, CMS, and the medicaid fraud control unit or their designees any records related to the administration and/or provision of TCM services.

(2) Annually, ODMRDD will conduct a ~~post review of one hundred per cent of paid claims that exceed twenty-four units (six hours) of service provision in a given day to a specific individual.~~ retrospective prior authorization post claim review of one hundred per cent of paid claims that exceed the total number of units that could be billed for a specific provider, based on standard hours of operation. ODMRDD will review data and documentation for appropriate and efficient utilization by ~~county board and by service and support administrator.~~ provider. A referral to the accreditation unit will occur should a plan of correction be needed to address utilization efficiency or appropriateness.

(3) ODJFS will monitor the activities of ODMRDD, as necessary, to ensure that funding applicable to the TCM program is used for authorized purposes in compliance with laws, regulations, and the provisions of the interagency agreement .

(J) Due process.

(1) Medicaid eligible individuals whose TCM services either affect the provision of services or whose TCM services are affected by any decision may appeal that decision at a medicaid state fair hearing. CBMRDDs must provide notice to the individual of their right to request a state fair hearing.

(2) If an eligible individual requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of ODMRDD, and/or ODJFS, and the CBMRDD is required during the hearing proceedings to justify the decision under appeal.

(3) All rules related to medicaid due process shall be interpreted in a manner consistent with section 1.11 of the Revised Code, which requires that they be liberally construed in order to promote their objective and assist the individual in obtaining justice. All rules relating to the right to a hearing and limitations on that right shall be interpreted in favor of the right to a hearing.

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Certification

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