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)~~ (DODD), 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) "Medically necessary" for the purposes of this rule means services and activities that are of an appropriate type, amount, duration, scope and intensity which are also appropriate to the individual's health and welfare needs, living arrangement, circumstances or expected outcomes.

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

(7) "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.

(8) "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~~ DODD, 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~~ DODD.

(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~~ DODD.

(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 and with respect to the direct delivery of foster care services, including but not limited to those 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) 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)~~ (CBDD) services.

(E) Qualified providers.

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

~~(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.

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

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

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

(3) 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);

(4) 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;

(5) 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.

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(G) Reimbursement and claims submission.

(1) Each ~~CBMRDD~~CBDD 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~~ CBDD shall bill ~~ODMRDD~~ DODD its usual and customary charge for a TCM covered service. TCM services will be reimbursed the lesser of the ~~CBMRDD's~~ CBDD's usual and customary charge or the rate found in appendix A to this rule. Without regard to the rate of reimbursement that may be identified in appendix A to this rule, no provider of TCM shall receive reimbursement at a rate in excess of the rate in the federally approved state plan amendment.

(2) Each ~~CBMRDD~~CBDD is responsible for instituting collection efforts against third parties liable for the payment of TCM services as required by rule

5101:3-1-08 of the Administrative Code. The ~~CBMRDD~~CBDD must maintain sufficient documentation to substantiate collection activities and any payments received. Sufficient documentation includes a written confirmation every twelve months from any known possible third party, if applicable, which states that the TCM service is not covered under that program or policy.

(3) If any of the TCM services provided by a ~~CBMRDD~~ CBDD are paid or attributable to another federal program, the costs of such services should be allocated in accordance with OMB Circular A-87.

(4) A ~~CBMRDD~~ CBDD 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.

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

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

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

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

(9) Records relating to TCM services shall be made available to ~~ODMRDD~~ DODD, 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.

(10) 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.

(11) 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.

(12) A ~~CBMRDD~~ CBDD shall not submit claims in excess of twenty-six units per day per service and support administrator (SSA) unless the service(s) associated with such claims is considered medically necessary as defined in paragraph (B)(5) of this rule. A ~~CBMRDD~~CBDD is required to maintain sufficient documentation to track the units per day per SSA.

(13) Where a ~~CBMRDD~~ CBDD submits claims in excess of the established limit as described in paragraph (G)(12) of this rule, the ~~CBMRDD~~ CBDD must also submit an attestation that the service(s) associated with such claims is considered medically necessary as defined in paragraph (B)(5) of this rule. Such claims for the specific SSA are to be submitted separately from all other TCM claims according to ~~ODMRDD~~ DODD specifications.

(H) Record requests and retention.

(1) ~~CBMRDD~~ CBDD 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~~ DODD 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~~DODD 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~~DODD, shall furnish to ~~ODMRDD~~DODD, ODJFS, CMS, and the medicaid fraud control unit or their designees any records related to the administration and/or provision of TCM services.

(2) ~~ODMRDD~~DODD will conduct a retrospective program review for units that exceed the established limit as defined in paragraph (G)(12) of this rule to determine if the service(s) associated with such claims is considered medically necessary as defined in paragraph (B)(5) of this rule.

(3) ODJFS will monitor the activities of ~~ODMRDD~~DODD, 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 .

(4) 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~~ CBDD.

(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~~ CBDDs 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~~DODD, and/or ODJFS, and the ~~CBMRDD~~CBDD 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.

(K) Nonfederal share.

(1) A ~~CBMRDD~~CBDD is responsible for payment of the nonfederal share of medicaid expenditures in accordance with section 5126.057 of the Revised

Code. A ~~CBMRDD~~CBDD shall provide this nonfederal share prior to the ~~CBMRDD~~ CBDD receiving payment.

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