Brain Injury Services
Case Management Services

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DEFINITIONS

“Authorized Representative” means a person who is authorized to conduct the personal or financial affairs for an individual who is eighteen (18) years of age or older. Parents and other caretaker relatives are able to act on behalf of persons under eighteen (18) years of age.

“Brain Injury” or “Traumatic Brain Injury” (TBI) means, for purposes of this program, brain damage due to a blunt blow to the head; a penetrating head injury; injury resulting in compression to the brain; severe whiplash causing internal damage to the brain; or head injury secondary to an explosion.

“Brain Injury Services Case Management” (BIS CM) means those targeted case management services provided under the state plan to target those with severe TBI.

“Caregiver" means a person who helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Unpaid or informal caregivers include relatives, friends, or others who volunteer to help. Paid or formal caregivers provide services in exchange for payment for the services rendered.

“Case management” means a service that includes the following activities:

- Assessing and planning services
- Linking the individual to services and supports identified in the individual support plan; assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources.
- Coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration.
- Making collateral contacts to promote the implementation of the individual support plan and community integration.
- Monitoring the individual to assess ongoing progress and ensuring that authorized services are delivered; and
- Educating and counseling the individual, family, or legal representative to guide them to develop supportive relationships that promote the individual support plan for the direct benefit of the individual.

“Centers for Medicare & Medicaid Services” (CMS) means the federal agency that administers the Medicare, Medicaid, and State Child Health Insurance programs.

“Certified Brain Injury Specialist” (CBIS) means a certification through The Academy of Certified Brain Injury Specialists that includes 500 hours of direct work with individuals, giving staff ample experience in the core disciplines of behavior, speech, cognitive challenges, physical therapy, and community reintegration. Certification is valid per CBIS requirements, requiring staff to renew their status and stay current with treatment issues

and protocols in the process. For more information see https://www.biausa.org/professionals/acbis.

“Commission on Accreditation of Rehabilitation Facilities (CARF)” means the independent, nonprofit accreditor of health and human services. Through accreditation, CARF assists service providers in improving the quality of their services, demonstrating value, and meeting organizational and program standards. The accreditation process applies sets of standards to service areas and business practices during an on-site survey.

“Commonwealth Coordinated Care Plus (CCC Plus) Program” means the Department’s mandatory integrated care initiative for certain qualifying individuals, including dual eligible individuals and individuals receiving long term services or supports (LTSS). The CCC Plus program includes individuals who receive services through Nursing Facility (NF) care, or from the Department’s home and community-based services (HCBS) 1915(c) waivers.

“Commonwealth Coordinated Care Plus (CCC Plus) Waiver” means the Department’s Home and Community Based waiver that covers a range of community support services offered to older adults, individuals who have a disability, and individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled nursing care. The individuals, in the absence of services approved under this waiver, would require admission to a Nursing Facility, or a prolonged stay in a hospital or specialized care Nursing Facility. The CCC Plus Waiver has two benefit plans: the standard benefit plan and the technology assisted benefit plan. Individuals who are enrolled in the technology assisted benefit plan are technology dependent and have experienced loss of a vital body function, and require substantial and ongoing skilled nursing care. Individuals in this waiver are eligible to participate in the CCC Plus program.
“Critical Incident” means any incident that threatens or impacts the well-being of the member. Critical incidents shall include, but are not limited to, the following incidents: medication errors, theft, suspected physical or mental abuse or neglect, financial exploitation, and sentinel events.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

“DMAS” means the Virginia Department of Medical Assistance Services. DMAS is the state Medicaid agency that is responsible for administering the Medicaid and CHIP programs.

“Enhanced Benefits” means benefits that the Contractor may choose to offer outside of the required covered services. Enhanced benefits are not considered in the development of the Contractor’s capitation rate.

“Enrollment (DMAS Managed Care Program)” means the assignment of an individual to receive healthcare coverage through a DMAS contracted managed care plan. This does not include attaining eligibility for the Medicaid program.

“Enrollment (Waiver)” means the process whereby an individual has been determined to meet the eligibility requirements (financial and functional and medical/nursing) for a service and the approving entity has verified the availability of services for that individual. It is used to define the entry of an individual into a HCBS waiver, effective the first day a waiver service is rendered. This does not include attaining eligibility for the Medicaid program.

"Face-to-face contact" means an in-person meeting between the case manager and the individual and family/caregiver, as appropriate, for the purpose of assessing the individual's status and determining satisfaction with services, including the need for additional services and supports.

“Facility” means, for the purpose of coordinating services between the community and facility, an acute care hospital, freestanding psychiatric hospital, long term care hospital, psychiatric or addictions focused residential treatment facility or nursing facility.

"Family" means the unpaid people who live with or provide care to the member, and may include a parent, a legal guardian, a spouse, children, relatives, a foster family, or in-laws but shall not include persons who are compensated to care for the individual.

“FAMIS” means Virginia's Children’s Health Insurance Program (CHIP). FAMIS stands for Family Access to Medical Insurance Security. FAMIS is a separate federal program from Medicaid. FAMIS members are not eligible for Medicaid and are not eligible for certain EPSDT specialized services (Ex: Personal Care, and Residential Treatment) when enrolled in a FAMIS managed care organization.

"Functional Impairment” means impairments which are typically classified as difficulty completing basic activities of daily living (e.g., dressing, grooming, getting in and out of bed) and instrumental activities of daily living (e.g., preparing meals, managing finances, housework).

“Home” means a place of temporary or permanent residence, not including a hospital, ICF/ID, nursing facility, or licensed residential care facility.

“Home and Community Based Services (HCBS)” or "waiver services" means the range of community services approved by CMS pursuant to § 1915(c) of the Social Security Act to be offered to persons as an alternative to institutionalization. They provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

"Immediate family member" means spouses, parents (as "parent" is defined in this section), children (biological, adoptive, foster, step,) and siblings of the individual in the waiver.

"Individual" means the Commonwealth's citizen, including a child, who meets the income and resource standards in order to be eligible for Medicaid-covered services, has a diagnosis of brain injury, and is eligible for the BIS CM service.

“Individual Service Plan” (ISP) means a comprehensive, person-centered plan that sets out the supports and actions to be taken during the year by each provider, as detailed in each provider's plan for supports to achieve desired outcomes and goals. The ISP shall be developed collaboratively by the individual, the individual's family/caregiver as appropriate, providers, the case manager, and other interested parties chosen by the individual.

“Managed Care Plan or Managed Care Organization (MCO)” means an organization which offers Managed Care health insurance plans (MCHIP), as defined by Virginia Code § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for eligible members. The Virginia Department of Medical Assistance Services (DMAS) is transitioning to Cardinal Care, a unifying brand encompassing all health coverage programs for Medicaid members. Cardinal Care will combine Virginia’s two existing managed care programs – Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) – to create a single identity for all members receiving services through Medicaid health plan partners. The overarching brand and program alignment also includes fee-for-service Medicaid members, ensuring smoother transitions for individuals whose health care needs evolve over time.

“Mayo Portland Adaptability Inventory (MPAI-4)” means an evaluation tool that measures functional outcomes for post-acute brain injury programs, based upon 29 functional measures in three clinical areas- Ability, Adjustment, and Participation indexes.

"Medically necessary" means an item or service provided for the diagnosis or treatment of an individual's condition consistent with community standards of medical practices determined by DMAS and needed to maintain an individual in the community instead of placement in an institution.

"Member" means an individual who is enrolled with the Virginia Medicaid program.

"Physician or Primary care provider" means a practitioner who provides preventive and primary medical care and certifies service authorizations and referrals for all medically necessary specialty services. Primary care providers may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, and specialists who perform primary care functions such as surgeons, clinics including, but not limited to

health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

“Qualified Brain Injury Support Provider (QBISP)” means a certificate in a training program through the ©Neurobehavioral Training Institute that promotes practical education for direct care staff that is supported by daily supervision to enhance care for persons with behavioral challenges. Training information can be found here: https://qbisp.training/.

“Registered Nurse (R.N.)” means a person who is licensed or holds a multi-state licensure privilege to practice professional nursing as defined in the Nurse Practice Act.

“Service Authorization” means the process of determining whether or not the service request meets all criterion for that service and gives authority to providers to allow reimbursement for services.

“State Plan for Medical Assistance” means the set of Medicaid benefits approved by the Commonwealth of Virginia and the Centers for Medicare and Medicaid Services (CMS).

“Telehealth” as defined in the Telehealth Services Supplement means use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth encompasses telemedicine as well as a broader umbrella of services that includes the use of such technologies as telephones, interactive and secure medical tablets, remote patient monitoring devices, and store-and-forward devices.

PROVIDER REQUIREMENTS

Case Management Agency Requirements

The provider agency shall hold a CARF accreditation for:

- Employment and Community Services/Support Coordination

The provider agency also must:

- Have a current, signed agreement with DMAS or its contractor to provide Brain Injury Services Case Management. If the individual is enrolled with an MCO, BIS CM providers for MCO members must be contracted with the member’s assigned MCO.
- Guarantee that individuals have access to emergency assistance either directly or on-call 24 hours per day, seven days per week and holidays. This may be done via telephone and face-to face contact and/or coordination with other providers and DBHDS administered crisis services.

- Demonstrate the ability to serve individuals in need of comprehensive services regardless of an individual's ability to pay or eligibility for Medicaid reimbursement. (i.e., lapse in coverage, transitional care, etc.).
- Have the administrative and financial management capacity to meet state and federal requirements; and,
- Document and maintain individual case records in accordance with state and federal requirements.

In addition, the provider agency:

- Shall participate in activities designed to safeguard individual's health and safety in accordance with CARF Accreditation standards.
- Shall participate in reporting activities defined by DMAS that are designed to assure ongoing program compliance.
- Pursuant to 42 CFR 441.301(c)(1)(vi), "providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person-centered plan of care, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered plans of care in a geographic area also provides HCBS."
- In order to meet this requirement an individual that provides case management services must not be employed (directly, or as a contractor) by an entity that provides other HCBS services.
- Furthermore, an individual or entity that provides case management/support coordination services must not have an interest (as defined in 42 CFR 411.354) in a provider of other HCBS services.

Brain Injury Services Case Manager Staff Qualifications

Providers may bill for Brain Injury Services (BIS) case management only when the services are provided by qualified case managers. Providers must verify that qualified case managers possess the qualifications/credentials, knowledge, skills, and abilities specified in this section.

Qualifications/Credentials:

BIS case managers must either hold a bachelor's degree OR be licensed by the Commonwealth as a registered nurse.

BIS case managers must also be certified as a Qualified Brain Injury Services Provider (QBISP) or a Certified Brian Injury Specialist (CBIS) prior to independently delivering billable BIS case management services.

BIS case managers must have knowledge of:

- BI conditions, its causes, and best practices in supporting individuals who have BI.
- Treatment modalities and intervention techniques, such as positive behavior supports, person-centered practices, independent living skills training, community inclusion/employment skills, supportive guidance, family education, crisis intervention, discharge planning, and support coordination.
- Different types of assessments and their uses in service planning.
- Individuals' civil and human rights.
- Local community resources and service delivery systems, including support services or programs, eligibility criteria and intake process, termination criteria and procedures, and generic community resources.
- Types of BI related programs and services.
- Effective oral, written, and interpersonal communication principles and techniques.
- General skills of documentation.
- The service planning process and the major components of an ISP.
- Cultural diversity and competency.
- An understanding of working on a multi-disciplinary care team and principles of care coordination; and,
- Awareness of and commitment to ethical care practices and professional conduct.

Case managers must have skills in***:***

- Interviewing individuals with a brain injury and their responsible parties/caregivers.
- Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to conduct a complete needs assessment of the eligible individual.
- Negotiating with individuals and service providers.
- Observing, recording, reporting, and documenting an individual's behaviors.
- Identifying and documenting an individual's needs for resources, services, and other assistance, including public benefits such as WIC, SNAP, Employment, Auxiliary Grants.
- Identifying services within the established service system to meet the individual's person-centered needs and preferences.
- Coordinating the provision of services for the individual by diverse public and private providers, generic and natural supports.
- Using information from assessments, evaluations, observations, and interviews to develop and revise support plans as needed.
- Formulating, writing, and implementing individualized plans of care to promote goal attainment and community integration for individuals with BI.

- Monitoring and follow-up activities to include making necessary adjustments to the care plan and service arrangements with providers as necessary and ensuring the services are implemented per the ISP.
- Using information from assessment tools, evaluations, observations, and interviews to develop and revise as needed individual support plans (for example to ensure the ISP is implemented appropriately, identify change in status or to determine risk of crisis/hospitalization).
- Identifying community resources and organizations and coordinating resources and activities.
- Advocating for continuity of services, system flexibility and community integration, proper utilization of facilities and resources, accessibility, and individual rights.
- Assessing or being aware of risks and accessing appropriate emergency services as needed; and,
- Identifying safety barriers and potential disruptions in care and implementing steps to resolve.

Case managers also must have abilities in:

- Demonstrating a positive regard for individuals and their families (e.g., treating people as individuals, allowing risk taking, avoiding stereotypes of people with a brain injury, respecting individual and family privacy, and believing individuals can grow and contribute to their communities).
- Being persistent and remaining objective.
- Working as a team member maintaining effective inter-interagency and intra-agency working relationships.
- Working independently, performing position duties under general supervision.
- Communicating effectively both verbally and in writing.
- Establishing and maintaining ongoing supportive relationships with individuals and their families; and,
- Conducting face-to-face contacts with the individual (and family members, as appropriate).

Providers of case management must ensure that enrolled individuals have free choice of the available providers of support coordination/case management services and free choice of the providers of other medical care under the State Plan for Medical Assistance.

BIS CASE MANAGEMENT ELIGIBILITY DETERMINATION

Required Activities

The following services and activities must be provided:

Assessment and Service Initiation Process

Upon receipt of a referral, and prior to the delivery of BIS case management, the case manager must make an evaluation visit to where the individual resides to conduct an assessment for service planning and begin the MPAI-4 assessment of severity of the brain injury and the person-centered planning process.

The MPAI-4 may be completed in collaboration with individuals with BI, their significant other(s), medical or rehabilitation professionals, and other designated observers who know the individual well. Comparisons among independent ratings are critical for effective rehabilitation planning, and for revealing more subtle problem areas. Scoring and interpretation of the MPAI-4 require professional training and experience.

The BIS Case Manager will use the collected clinical information to: determine whether the individual meets medical necessity criteria; assess the individual's immediate service, health, and safety needs; determine services to meet the individual's identified needs and preferences to the maximum extent possible; explore the use of local community resources available to the general public to meet those needs; and, determine whether the case management provider agency has the capability and staffing to provide ongoing support coordination if the individual meets criteria.

As part of the intake process, the case manager must collect existing medical documentation that demonstrates the member's diagnosis of a traumatic brain injury. If there is no documented diagnosis, then the case manager and/or the member's managed care organization care coordinator shall assist the member in accessing a physician who can document whether the member has a diagnosis that is eligible for receipt of the brain injury case management service.

Additionally, the case manager must complete the Mayo-Portland Adaptive Index-4 screening to determine whether the member meets the required severity threshold for BIS case management service.

Members who do not meet the DMAS definition of TBI criteria nor have physician documented TBI will not need to be assessed using the MPAI-4 and shall be referred to their MCO to receive coordination of care.

Medical Necessity Criteria

To be eligible to receive brain injury case management services, the individual must reside in the community or be planning for discharge from a facility within 180 days.

Individuals shall have a physician documented diagnosis of traumatic brain injury (TBI) with associated functional impairments resulting from the injury that meet the severity threshold.

- A TBI is defined as brain damage due to a blunt blow to the head; a penetrating head injury; injury resulting in compression to the brain; severe whiplash causing internal damage to the brain; or head injury secondary to an explosion.
  Exclusions: Brain damage secondary to other neurological insults (e.g., infection of the brain, stroke, anoxia, brain tumor, Alzheimer's disease and other conditions causing dementia, and other neurodegenerative diseases) is not considered to be a TBI.
- The TBI is severe as indicated by a T-score of 50 or above on the MPAI-4, and has caused chronic, residual deficits and disability, including significant impairment of behavioral, cognitive and/or physical functioning, resulting in difficulty managing everyday life activities, and an ongoing need for assistance with accessing needed medical, social, educational, behavioral health, and other services.

- If an individual has a MPAI T-score of 50 through 59 the individual must meet **at least one** of the following indicated functional deficits on the assessment:

Ability Index:

Physical Abilities:

A score of 4 on Item 1. Mobility: Problems walking or moving about including balance problems; *and a* score of 4 on Item 2. Use of Hands: Impaired strength or coordination in one or both hands.

OR

A score of 4 on Item 3. Vision and a score of 4 on Item 4. Audition.

OR

Cognition:

A score of 4 on Item 8. Attention/Concentration

OR

A score of 4 on Item 9. Memory, and a score of 4 on Item 10. Fund of Information

OR

A score of 4 on Item 9. Memory, and a score of 4 on Novel Problem-solving

OR

A score of 4 on Item 10. Fund of Information, and a score of 4 on Novel Problem-solving

OR

Adjustment Index:

A score of 4 on Item 14. Depression.

OR

A score of 4 on Item 15. Irritability, anger, aggression.

OR
A score of 4 on Item 20. Impaired self-awareness.

OR

Participation Index:
A score of 4 on Item 25: Self-care.
OR
A score of 4 on Psychotic symptoms.

COVERED SERVICES

BIS Case management services are activities designed to assist an individual in accessing and maintaining needed medical, behavioral health, social, educational, employment, residential, and other supports essential for living in the community and in developing his or her desired lifestyle.

Services shall include:

- Comprehensive assessment to include but not limited to the MPAI-4.
- Development and periodic revision of an ISP that is based on the information collected through the assessment.
- Linking individuals to needed services such as through a waiver, other State Plan services, as well as medical, social, educational, and other direct service activities; and coordinating and monitoring those services.
- Identifying a course of action to respond to the assessed needs of the eligible individual. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that link the person with medical, social, educational providers, or other programs and services that are capable of addressing identified needs and achieving goals specified in the ISP.
- At least one face-to-face contact with the individual every 90 days, which may vary based on intensity of case. Other contacts are required as warranted by an individual's needs and conditions.
- Case management may be provided for up to 6 months prior to discharge from facility-based services.

Service Requirements

Case management services shall:

- Gather materials to document that the member meets the medical necessity criteria for the service and submit the documentation for review and authorization of reimbursement.

- Link to and assist the individual with services and supports specified in the ISP. These may include medical, social, educational, housing, transportation, vocational or other resources that help address identified needs and risk factors to achieve person-centered goals.
- Assist the individual with locating, identifying, obtaining, or scheduling needed services and resources. Aid the individual in accessing appointments and community resources, such as enabling their access to care and receipt of services. This may include finding and locating provider and service resources, including the use of MCO supports; help with completing appointments; and coordination with other service providers to ensure appropriate supports are in place.
- Coordinate services and service planning with other agencies and providers involved with the individual. This shall include:
    - Providing the member's MCO, Care Coordinator with useful feedback, and alerting MCO Care Coordinators of concerns regarding potential issues that could lead to a member's disenrollment. or disruption in services
    - Notifying the MCO Care Coordinator of concerns about the status of the health and welfare of member that require attention.
    - Ensuring access to care and successful facilitation of service delivery.
    - Alerting other providers of observed concerns as needed and related to other areas of specialty when an individual's health, safety and welfare are compromised.
    - Participating in an individual's Interdisciplinary care team meeting as invited and needed.
- Enhance community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills and to use vocational, civic, and recreational services.
- Assist the individual to participate in appointments and community resources to ensure access to care and successful facilitation of service delivery.
- Make collateral contacts with the individual's significant others to promote implementation of the ISP and community integration.
- Monitor service delivery and utilization to ensure ongoing progress and delivery of services. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home when applicable), and all services. Monitoring may also include review of service provider documentation.
- Monitor and track designated outcomes as required by the program.
- Provide education and counseling that guides the individual and develops a supportive relationship that promotes the ISP.
- Follow-up and make necessary reporting related to the individual regarding the submission of critical incidents.

The activities listed above will not automatically qualify a provider for reimbursement if they are determined to be unrelated to the needs and goals on the ISP.

Service Limitations:
Payment for BIS case management services under the State Plan for Medical Assistance shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

The case manager maximum caseload is not to exceed 35 individuals at any time.

Case managers are responsible for identifying when an individual is residing in a provider owned or controlled service setting that does not meet the Home and Community Based Services settings requirements.

Individuals below 18 years old would be served through the DD or ID Case Management process or other state plan case management services that the individual is eligible to receive.

Individuals may choose case management agencies and case management service types including periods of time when a specific service need is based on the primary diagnostic and treatment needs. However, it is preferable for the Brain Injury Services Case Manager to coordinate all services on behalf of the individuals without any impact on choice of treatment or waiver service needs.

Billing can be submitted for an active individual only for months in which direct or individual related contacts, activity, or communications occur, consistent with the ISP.

The provider shall be reimbursed for no more than one BIS Assessment, per member, every six months.

Person Centered Planning

Individual Service Plan Development

This activity includes discovering the individual's strengths, needs, goals, and preferences. The case manager will appropriately facilitate the assessment process through utilization of person-centered discovery tools and practices to engage the individual and his circle of support, and will coordinate referrals and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including medical, social, educational, or other programs and services. The ISP must align with other care plans from other rendering providers to avoid duplication of services and contraindications.

Development and implementation of a person-centered ISP, including action and/or service plans, begins with an assessment and is a process to determine the resources needed to meet the individual's functional and social needs. The ISP is developed with the active participation of the individual, (or the individual's authorized health care

decision maker) and others and shall be based on the information collected through the assessment. The ISP must specify the goals and actions that will address the medical, social, educational, and other services identified through the assessment.

To determine the need for any medical, educational, social or other services, these assessment activities include:

- taking client history;
- identifying the individual's needs, strengths and wants and completing related documentation; and
- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual, and assuring completion of the annual reassessment of eligibility and level of care.

Person Centered Planning Requirements

Case managers are responsible for monitoring and evaluating progress for all services displayed in the action and/or ISP.

The case manager will provide and coordinate high quality services to the individual, while promoting seamless, integrated, coordinated care. Monitoring the person-centered ISP will be completed by the case manager in a face-to-face contact every 90 days from the date of the initial ISP. After the initial ISP is activated, the case manager will either call or visit the individual within 30 days and no more than 40 days from initial ISP activation to ensure implementation of services.

The case manager should routinely engage in assessment and person centered planning activities to review eligibility for case management and other services needed by the individual by referencing existing medical necessity criteria and the needs of the individual. At a minimum, the case manager shall perform annual person-centered assessments to review eligibility and service planning. The case manager is responsible for coordinating changes in the ISP to:

- Ensure Medicaid coverage is maintained to promote continuity of care and avoid disruptions in receiving services.
- Assist the member with completing enrollment applications for benefits and annual redeterminations.

Ensure eligibility for needed services is consistent and based on the member's needs.

- Notify all providers about a change and when they are to begin or end services. Notify all providers when a care plan is in a terminated or re-start status. The case manager will be responsible for evaluating the effectiveness of all services. Evaluation is demonstrated through: monitoring the progress from identifying need to meeting goals/preferences identified by the individual; direct collaboration and coordination with providers to ensure services are within the individual's

preferences; and adjusting action and plans of care appropriately to identify changing needs that meet the individual's needs.
- At a minimum, the BIS case manager must review the ISP every 90 days to determine whether service goals and objectives are being met, and whether any modifications to the ISP are necessary.
- The case manager will follow the DMAS provider manual and MCO rules for BIS CM termination procedures when an individual is no longer eligible or willing to receive services. This includes providing a thirty (30) day notice to individuals.

Service Monitoring

Monitoring consists of ongoing contact with the individual and his or her family to ensure services are implemented per the ISP. Monitoring is intended to ensure that individuals and his or her family are getting the support they need, when they need them, in order to see measurable improvements in their lives.

- Monitor ISP implementation through monitoring visits with the individual, at the minimum frequency outlined in this document or increased monitoring frequency based on the need of the individual;
- Visit with the individual and his or her family, and providers of service for monitoring of health and welfare and ISP implementation;
- Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health and welfare of individuals;
- Review individual progress on outcomes and initiate ISP team discussions or meetings when services are not achieving desired outcomes;
- Monitor individual and his or her family satisfaction with services;
- Arrange for modifications in services and service delivery, as necessary to address the needs of the individual, and modify the ISP accordingly;
- Ensure that services are identified in the ISP;
- Work with the authorizing entity regarding the authorization of services on an ongoing basis and when issues are identified regarding requested services;
- Communicate the authorization status to ISP team members, as appropriate;
- Validate that service objectives and outcomes are consistent with the individual's needs and desired outcomes;
- Advocate for continuity of services, system flexibility and community integration, proper utilization of facilities and resources, accessibility, and individual rights;
- Monitoring outcomes as selected by the member and addressing goals not being actively pursued at the choice of the support team/member.

APPEALS and RIGHTS

Please see Chapters II and III of the CCC+ Waiver, Developmental Disabilities Waiver, Addiction & Recovery Treatment Services, Mental Health Services, Rehabilitation, Hospital, Practitioner, or the Nursing Facilities Manual for information regarding appeals.

See Chapter II of the CCC+ Waiver, Developmental Disabilities Waiver, Addiction & Recovery Treatment Services, Mental Health Services, Rehabilitation, Hospital, Practitioner, or the Nursing Facilities Manual for information regarding Section 504 of the Rehabilitation Act and the Civil Rights Act of 1964.

Members enrolled in managed care, should contact their MCO for additional information on the grievance process, complaints process, and redress for rights complaints. Members may also contact their MCO to request support for any serious incident involving the member or a service provider.

SERVICE AUTHORIZATION

All BIS Case Management services must be service authorized by DMAS or its contractor. Reimbursement for BIS case management services requires a service authorization. The provider agency that submits the service authorization must also complete the intake assessment.

Service authorization requests may require supplemental documentation from the member's record to include:

- A letter or other signed documentation from a physician that documents the traumatic brain injury; AND
- The Mayo Portland Adaptability Index-4 documentation, including the T-score and;
- Any specific functional scoring required to document the functional limitations of the member.

Member Benefit Program	**Service Authorization Entity**
FFS*	KEPRO
Managed Care	Contact the MCO for service authorization information.*

*In order to be reimbursed for BIS TCM provided to an individual enrolled in managed care, providers must contract with and follow their respective MCO contract(s). Additional information and requirements are included in the "Doing Business Spreadsheet" on the DMAS website (https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/brain-injury-services/). Contracted MCO's must follow DMAS program rules when authorizing Brain Injury Services.

The following codes must be used to submit service authorization requests and to submit claims:

SERVICE NAME	REIMBURSEMENT CODE
BIS Case Management	S0281
BIS Case Management Assessment	S0280

A provider's service authorizations request for BIS TCM (S0281) shall be no greater than 6 months.

Upon the initiation of services, a provider will submit a service authorization request for both the assessment code (S0280) and for BIS TCM (S0281). The provider will request authorization for the case management for the month in which the intake and MPAI-4 were completed along with the physician's diagnosis confirmation. The provider's request for BIS TCM can span the subsequent months.

> For example: on July 20, 2023, a provider submits a request for both the intake (which was completed between June 25th and July 19, 2023) with an additional request for ongoing BIS TCM. The intake will be authorized for 6/25/23-7/20/2023, additionally the initial BIS TCM service will be authorized from August 1, 2023, through January 31, 2024.

Following the initial service authorization request, ongoing requests for BIS TCM (S0281) will be authorized for up to a six-month duration.

Documentation Requirements

1. The assessment, subsequent re-assessments, and the annual reassessment by a qualified BIS case manager must be reflected with appropriate documentation and maintained in the individual's record. The physician documented TBI diagnosis and the relevant MPAI-4 documents (including treatment provider records) shall also be maintained in the individual's record.

2. The Individual's ISP must include the dated signature of the individual or the individual's authorized health care representative and other relevant family members or friends involved in the development of the ISP. All ISP (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer.

3. There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when

appropriate) sign a document verifying freedom of choice of providers was offered and this provider was chosen.

4. A release form must be completed and signed by the individual for the release of any information.

5. There must be an ISP from each provider rendering services to the individual. The ISP is developed by the individual service provider related solely to the specific tasks required of that service provider and the desired outcomes. Plans of care help to determine the overall goals for the individual. The plans must state long-term service goals and specified short-term objectives in measurable terms. For case management services, specific objectives for monitoring, linking, and coordinating must be included.

6. Case management records must include the individual's name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual declined services, and a timeline for reevaluation of the plan. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

7. The case manager shall document review of the ISP every 90 days to determine whether service goals and objectives are being met, satisfaction with the program, and whether any modifications are necessary. Other providers must coordinate reviews of the POC with the case manager every three months.

8. Documentation must demonstrate that the case manager provides active case management monthly and a face-to-face contact with the individual occurs at least once every 90 calendar days.

9. The case manager must revise the ISP whenever the amount, type, or frequency of services rendered by the individual service provider's change. When such a change occurs, the case manager must involve the individual or the individual's authorized health care representative in the discussion of the need for the change.

BIS CASE MANAGEMENT BILLING REQUIREMENTS

The unit of service for Case Management Assessment is one unit which equals one calendar month. A claim for the BIS TCM procedure code, S0281, cannot be submitted in the same month as the TCM Assessment code, S0280.

The unit of service for BIS Case Management is one unit which equals one calendar month. Payment for BIS TCM is available only for allowable activities that are pre-authorized and provided by a qualified provider in accordance with an approved POC that

meets Brain Injury Case Management program criteria. BIS Case Management services are limited to the number of months authorized by DMAS or its designee.

- Case Management services for the same individual must be billed by only one type of Case Management provider. See Chapter V for billing instructions.

Billing can be submitted for case management only for months in which direct or client-related contacts, activity, or communications occur. These activities must be documented in the clinical record and be identified in the ISP. The provider should bill for the specific date of the face-to-face visit, or the date the monthly summary note has been documented, or a specific date service was provided. Providers are NOT to span the month for Case Management services.

Reimbursement shall be provided only for "active" case management clients, as defined in the “service requirement” section. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

Federal regulation 42 CFR § 441.18 prohibits providers from using case management services to restrict access to other services. An individual cannot be compelled to receive case management or condition receipt of case management on the receipt of other Medicaid services, nor can an individual be required to receive another service if they are receiving case management. For example, a provider cannot require that an individual receive case management if the individual also receives medication management services.

In accordance with 42 CFR § 441.18(a)(8)(vii), reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in institutions of mental diseases (IMDs) and individuals of any age who are inmates of public institutions. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.

Services rendered during the same month as the admission to the IMD is reimbursable for individuals ages 22 – 64, if the service was rendered prior to the date of the admission.

Two conditions must be met to bill for Case Management services for individuals that are in acute care psychiatric units or who are in institutions and who do not meet the exclusions noted above. The services may not duplicate the services of the facility discharge planner or other services provided by the institution, and the community case management services provided to the individual are limited to six months of service, 180 calendar days prior to discharge from the facility.