Department of Medical Assistance Services
600 East Broad Street
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https://dmas.virginia.gov

MEDICAID MEMO

Federal Targeted Case Management Regulations – Effective May 6, 2009

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The purpose of this memorandum is to delineate the federal regulations that are in effect related to the provision of case management services rendered through Medicaid and FAMIS. Please see the Medicaid Memo dated August 15, 2006 for previous information regarding case management.

On December 4, 2007, the Centers for Medicare & Medicaid Services (CMS) issued an Interim Final Rule with comment period in the Federal Register that implemented provisions of the 2006 Deficit Reduction Act. It also included changes to reimbursement for targeted case management services (72 FR 680901). The rule was to be effective March 3, 2008, but the regulations were placed under a moratorium until July 1, 2009. On May 6, 2009, CMS published their proposal to rescind certain provisions of the Interim Final Rule and on June 30, 2009, CMS published the rescission of parts of the case management regulations.

The following is a summary of the regulatory changes that affect providers of targeted case management services. For the entire notice with all provisions, please refer to the Federal Register (Vol. 74, No. 124 FR 31183) at http://edocket.access.gpo.gov/2009/pdf/E9-15345.pdf. The regulations are effective as of May 6, 2009.

CMS rescinded the following:

1. Sections 440.169(c) and 441.18(a)(8)(viii), which limited the number of days prior to discharge from an institutional stay that case management can be billed. The interim final rule had limited case management to the final 60 days of a stay that lasted at least 180 days and to the final 14 days of a stay that lasted less than 180 days.
2. Section 441.18(a)(5), which limited case management services to only one case manager. This allows a different case manager for the purposes of coverage when the regular case

manager is not available and for case managers within an agency to work together. This provision does not allow more than one type of case management to be billed.

3. Section 441.18(7)(vi), which required that the case manager document the need for coordination with other case managers.
4. Section 441.18(a)(8)(vi), which required that case management be billed in increments of 15 minutes.

CMS retained the following provisions, which went into effect on July 1, 2009:

1. Case Management is defined as a "service to assist individuals, eligible under the State Plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services."
2. Allowed case management activities include completing a comprehensive assessment, developing a specific care plan, referrals to needed services, monitoring, and follow up.
3. Case management may not include the provision of direct services; the only allowed services are assessment, planning care, referring, monitoring, and follow-up. Counseling and education to better enable a person to access or benefit from services such as medical, housing, medication management, or symptom management is permitted. Provision of direct services, such as psychotherapy or Mental Health Support Services is not allowed as part of case management.
4. Clients must have free choice of providers.
5. Case management may not be used to restrict access to other services. An individual cannot be compelled to receive case management if he or she is receiving another service, nor can an individual be required to receive another service if he or she is receiving case management. For example, a provider cannot require that an individual receive case management if the individual also receives medication management services.
6. Case management cannot duplicate payments for other Medicaid or other program authorities. Payments for case management services cannot be made to more than one provider. Medicaid case management cannot pay

for functions or services that are required by other programs, such as foster care. Case management services can be reimbursed, but functions that are required by foster care, such as home assessments, are not reimbursable by Medicaid.

7. Case management records must, at a minimum, 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. Please refer to the Community Mental Health Rehabilitative Services Manual for complete requirements.

Compliance

The Department of Medical Assistance Services (DMAS) or its designated contractor(s) conducts periodic utilization reviews on all programs. Providers will be held to these and all other regulations that are in effect when they are reviewed. Participating providers are responsible for ensuring that requirements for services rendered are met and documented prior to receiving payment from DMAS. Payment will be retracted when the provider has failed to comply with established federal and state regulations or policy guidelines.

REQUESTS FOR DUPLICATE REMITTANCE ADVICES

In an effort to reduce operating expenditures, requests for duplicate provider remittance advices will no longer be printed and mailed free of charge. Duplicate remittance advices will be processed and sent via secure email. A processing fee for generating duplicate paper remittance advices will be applied to paper requests, effective July 1, 2009.

ALTERNATE METHODS TO LOOK UP INFORMATION

Effective August 1, 2009, DMAS authorized users now have the additional capability to look up service limits by entering a procedure code with or without a modifier. Any procedure code entered must be part of a current service limit edit to obtain any results. The service limit information returned will pertain to all procedure codes used in that edit and will not be limited to the one

procedure code that is entered. This is designed to enhance the current ability to request service limits by Service Type, e.g., substance abuse, home health, etc. Please refer to the appropriate Provider Manual for the specific service limit policies.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real- time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. For more information on the services that are offered, contact the vendors. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the “DMAS Content Menu” column on the left-hand side of the DMAS web page

for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a

manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr-enewsletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.