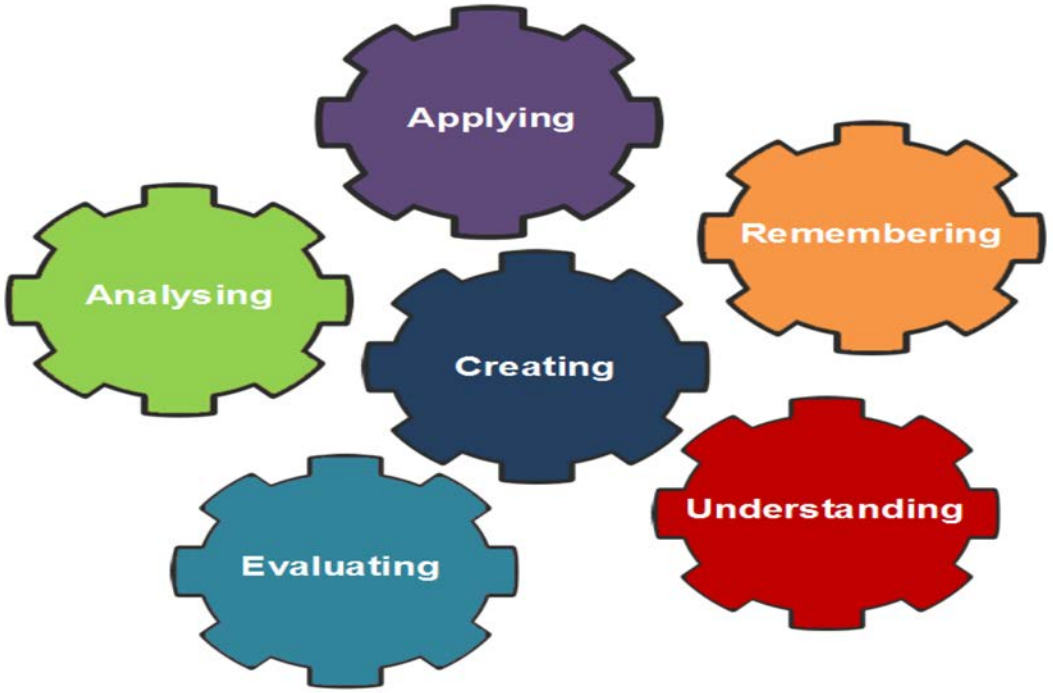
Targeted Case Management

Providing Needed Resource Information for ARChoices Waiver Beneficiaries

Targeted Case Management (TCM)
Understanding the How's and Why's of Your Role in ARChoices



Through the assessment process the LTSS RN identifies the ARChoices client(s) need for the specialized services of a Targeted Case Management provider.

The *beneficiary* then chooses the agency(s) they wish to use from the freedom of choice provider list.

To be a provider:
Provider of **Targeted Case Management** *must be certified by DHS and be qualified to meet the needs of ARChoices 1915(c) waiver clients….*

Requirements that must be met:

Targeted Case Management:

is a Medicaid billable service when identified by the DHS RN "as a needed" referral on the client's ARChoices Person- Centered Service Plan (PCSP) (AAS-9503). However; reimbursement for TCM services is based on accurate; concise documentation that may be subject to review by state and/or federal authorities at any time.

Covered

- Needs assessment
- Development of ‘case management’ care plan
- Obtaining referrals

TCM

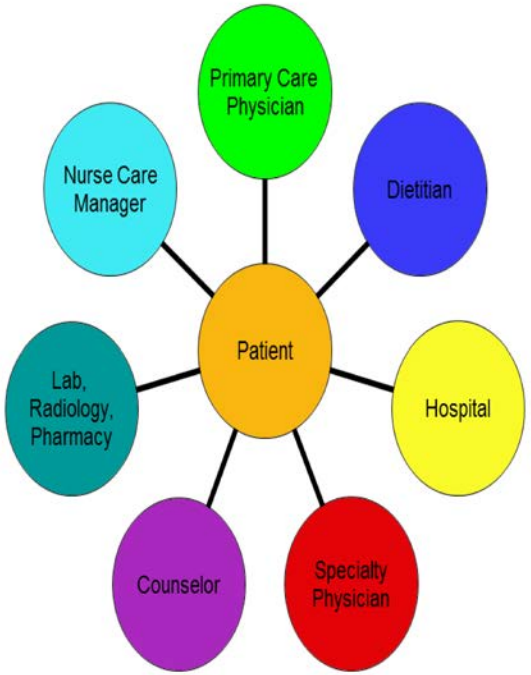
- Scheduling appointments
- Monitoring and follow-up
- *Face to face or telephone* contact with client

Services

- *Sending* emails or faxes to gather supportive client information
- Assisting with application processes
- Conferencing with others in order to meet outlying needs:

Verify and make sure there are no duplication of services

Are the services you're providing being rendered by another agency [whether private, community based or supported through another CMS program].



You have enough to do!!!!

Know your boundaries: provide your expertise in case management.

Remember to keep accurate, concise, and supportive documentation.

Do not take on the responsibility of over-sight for other providers and/or services even within your agency. Keep services separate.

Individual providers in all areas of healthcare must ensure that services rendered meet regulatory requirements and result in client satisfaction.

Let's Talk Documentation:

1. *Sufficient written documentation is required to support each service billed.*

2. *A copy of all documentation must be kept in the client's case file.*

3. *Hard copies of emails and faxes pertaining to the clients care must also be placed into the case file.*

So much information ***has to be maintained on every client:****
every service provided; ***dates with times in-times out*****;**
place of service; units billed; hard copy of faxes and emails;
documentation of an established tickler system;
progress notes that contain updates; ***signatures of case manager providing services*******

Be organized-have a system that works for you !!!

Where to start in the over-all delivery of TCM services.

Assessment and Service Plan Development:

a. ***Collect information****
b. ***Identify Needs*****
c. ***Plan how to meet these needs-set goals [service plan]; evaluate progress and adjust (actions) as needed.***

Think Comprehensive; Think Complete; Think Continue

- ***Comprehensive***: Not just casual data collection; ask in-depth questions. ***Complete***: Think about the individual from the top of their head to the bottom of their feet and everything in between. Physical, mental, emotional, social and educational. ***Continue:*** How can your assistance promote their quality of life while they continue to live at 'home'.

Targeted Case Management Contact Monitoring Form

Initial ☐
Scheduled Visit ☐
Significant Change ☐

Participant Name _____ **Program**_____

Waiver Eligibility Dates _____ **Last Four Digits of SSN** XXX-XX-_____

Agencies/Services Provided in Home (based on Person Centered Service Plan-PCSP):

Date of Contact _____ **Type of Visit:** **Home** ☐ **Telephone** ☐

Start Time _____ **Stop Time** _____

Name of Person Contacted _____ **Relationship to Client**_____

DMS-690 (1-1-16)

Service plan development builds on the information collected through the assessment phase.

The goals and actions in the service care plan must address the Medicaid-eligible beneficiary's medical, social, education, and other needs. **Remember**: *Include that individual-do not talk over or around that person…compliance becomes an issue when a person feels "left out" of the decisions discussed and/or made.*

Keep up with time….

15 minutes = 1 unit

**Assessment and service plan development cannot exceed 12 units/3 hours (whether done at the same time or on different days)*

**Reassessments (except annual)-cannot exceed 8 units: in addition each reassessment (unless annual) has to be highly detailed in order to justify reimbursement.*

**Monitoring visits cannot exceed 6 units per visit-can be conducted by phone, face to face, email and/or fax. These visits do not necessarily have to involve the client personally but must be targeted toward the client's ongoing needs/goals.*

**However, a face to face monitoring visit has to be conducted every three months in order for the TCM to remain in compliance. This quarterly monitoring contact requires the completion of a monitoring form which must be placed in the client's permanent case record.*

Benefit Limits in a ***Nut Shell***

- ***State fiscal year (SFY)***
- ***200 units/50 hours***

***Document reasonable utilizatio**

If you believe your client has no been allocated enough hours for you to successfully provide TCM services; notify the DAAS RN and ask for a review. Providing additional TCM services beyond authorized units (time)on the PCSP is not reimbursable by Medicaid.

Reimbursement

Contingent on beneficiary and provider eligibility at time of service (provider is responsible to verify the client is eligible for Medicaid prior to providing service)

Submit billing on a per unit basis; reflected in a daily total per each service. Documentation should reflect actual times the service was provided within a given 24 hour period; however, the claim should reflect total units per service within a given 24 hour period.

National Code: T1017 with Local Code Descriptions(LCD)
LCD: Modifier (UA)-Assessment/Service Plan Development
LCD: Modifier (UB)-Service Management/Referral and Linkage
LCD: Modifier (UC)-Service Monitoring/Service Plan Updating

National Place of Service (POS) Codes
Patient's Home (12) Physician's Office (11) Other (99)

On 02/14/17 at **9:30 a.m.,** I began Ms. ABC's initial assessment in her home. I followed our standard agency assessment form and started my assessment reviewing her medical and social history. **At 9:58 a.m.,** Ms. ABC's neighbor arrived and reminded the client that she had a hair appointment. Ms. ABC apologized and asked if we could continue later in the day.

At **2:00 p.m**. I returned to the client's home and completed the assessment form including a review of available resources to assist her in maintaining her independence at home…… **At 3:12 p.m.** I exited the client's home.

From **3:48 p.m.-3:56 p.m**. I spoke with xyz agency and made arrangements for the client's _____ needs. At **3:58-4:01** I faxed copies of required information to agency xyz.

From **4:02 p.m.-4:10 p.m**. I spoke with xxx agency and made a referral for the client's _____needs.

Total time for (UA) was 100 minutes-6 complete 15 minute units with 10 minute overage (5-15 min.=1u)

Total time for (UB) was 19 minutes-1 complete unit with 4 minute overage (4 minutes does not =a unit)

Dates of Services From- MM/DD/YY To MM/DD/YY	Place of Service (POS)	Procedures, Services, Supplies CPT/HCPCS	Modifier	Days or Units
02/14/17- 02/14/17	12	Assessment/Service Plan	UA	7u
02/14/17-02/14/17	99	Service Management/Referral	UB	1u

YOU are the ***PIECE*** of the healthcare puzzle that ties service and support together.

Thank-You