

# DECLARATION OF EMERGENCY

## Department of Health and Hospitals Office of the Undersecretary Bureau of Health Services Financing

### Case Management Reimbursement



The Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, has adopted the following rule in the Medicaid Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This emergency rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and shall be in effect for the maximum period allowed under the Administrative Procedure Act or adoption of the rule, whichever occurs first.

The Bureau of Health Services Financing reimburses optional targeted case management services for the following specific population groups: 1) mentally retarded or developmentally disabled individuals; 2) developmentally disabled infants and toddlers; 3) high-risk pregnant women (limited to the metropolitan New Orleans area); 4) HIV infected individuals; 5) seriously mentally ill individuals. In addition, reimbursement is provided under the Home and Community-Based Services Waiver Program for case management services provided to participants in the Home Care for the Elderly Waiver.

The department adopted emergency rules which enhanced program requirements by setting uniform standards for case management services delivered to the above referenced populations and specified the reimbursement methodology based on the provision of a 15-minute unit of service for the on-going services component of case management services. These rules were adopted effective July 22, 1994 and August 13, 1994 (*Louisiana Register*, Volume 20, Numbers 6 and 7). Subsequent emergency rulemaking continued this initiative in force as published in the *Louisiana Register*, (November 20, 1994, Volume 20, Number 11; April 20, 1995, Volume 21, Number 4; August 20, 1995, Volume 21, Number 8 and November 20, 1995, Volume 21, Number 11). Subsequently the department determined that it was necessary to discontinue the unit of service reimbursement methodology and instituted a revised methodology through emergency rulemaking (*Louisiana Register*, Volume 21, Number 10). This revised methodology included a monthly reimbursement rate for both components of case management services, the initial assessment/service plan development and the ongoing services. This methodology also provided for the following two exceptions: 1) both payment methods, assessment fee and the monthly rate for on-going services, were retained for the high-risk pregnant women group; and 2) assessments prior authorized for the MR/DD and the seriously mentally ill populations through September 30, 1995 and completed by October 31, 1995 were to be reimbursed in accordance with the prior payment methodology. Monthly reimbursement rates were assigned for each population group based upon minimum standards for service delivery for each of these groups.

The following emergency rule continues the above initiative force. This action is necessary to avoid a budget deficit in the medical assistance programs and to comply with the line item appropriation limit for case management services for state fiscal year 1996. Program reports through January 31, 1996 indicate that program expenditures total \$8,503,797 or 38 percent of the \$22,138,498 appropriated for the state fiscal year 1996 with one-half of the year remaining. Therefore the department has determined that it is essential to maintain the flat monthly reimbursement methodology in order to ensure compliance with the legislative appropriation for case management services.

#### **Emergency Rule**

The Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, adopts the following minimum program standards and reimbursement methodology to govern the reimbursement for optional targeted and waiver case management services under the Medicaid program.

#### **I. General Provisions**

A. All reimbursement for optional targeted and waiver case management services shall be made in accordance with all applicable federal and state regulations.

B. The reimbursement rate for optional targeted and waiver case management services is a monthly rate for the provision of mandated monthly minimum services. It is not a capitated rate. Service hours provided in different months that are less than the minimum standard shall not be rolled up in order to meet the minimum standards for service delivery required for reimbursement. Providers shall not bill for failed attempts to make contact with either consumers or collaterals.

C. Billed case management services shall be monitored through the use of provider record review, consumer survey for verification of services provision and quality of service, and verification with collaterals of contacts made on behalf of the recipient. Any situation involving fraud and/or abuse in the provision of case management services will be referred to the bureau's SURS Unit for investigation. A subsequent referral will be made to the state attorney general's Medicaid Fraud Control Unit by the SURS Unit if a criminal investigation is warranted.

D. The following Minimum Program Standards are required for the reimbursement of case management services.

1. Seriously Mentally Ill Individuals

a. A minimum of four hours of documented case management services in each month in which services are billed. The four hours must include one face-to-face contact with the consumer in addition to case management activities such as assessment, service plan development/update, linkage to services and follow-up/monitoring.

b. Services shall be authorized for a maximum six-month time period. All services must be documented on the CAMIS service log and be entered into CAMIS. Weekly submission of CAMIS data is required.

c. The procedure code applicable to case management services for this population is Z0090 and the monthly payment rate is \$223.

2. Mentally Retarded/Developmentally Disabled Individuals

a. A minimum of three hours of documented case management services is required in each month in which services are billed. The three hours must include one face-to-face contact with the recipient in addition to case management activities such as assessment, service plan development/update, linkage to services and follow-up/monitoring. Two home visits are required in a six-month period. Service provider records MR/DD waiver participants must be monitored by the case management agency on a quarterly basis.

b. Services shall be authorized for a maximum six-month time period. All services must be documented on the MRCAMIS service log and be entered into MRCAMIS. Weekly submission of MRCAMIS data is required.

c. The procedure codes applicable to case management services for the MR/DD population is Z0092 for waiver participants and Z0091 for nonwaiver participants. The monthly payment rate is \$147 for both groups of the MR/DD population.

3. Developmentally Disabled Infants and Toddlers

a. A minimum of two hours of documented case management services in each month in which services are billed. The two hours must include one face-to-face contact with the recipient in addition to case management activities such as assessment/service plan development/update, linkage to services and follow-up/monitoring. Two home visits are required in a six-month period. Service provider records for MR/DD waiver participants must be monitored by the case management agency on a quarterly basis.

b. Services shall be authorized for a maximum six-month time period. All services must be documented on the MRCAMIS service log and be entered into MRCAMIS. Weekly submissions of MRCAMIS data are required.

c. The procedure codes applicable to case management services for the infants and toddler population is Z0094 for MR/DD waiver participants and Z0093 for nonwaiver participants. The monthly payment rate is \$133 for both groups of children.

4. Persons infected with HIV

a. A minimum of two hours of documented case management services in each month in which services are billed. The two hours must include one face-to-face contact with the recipient in addition to case management activities such as assessment, service plan development/update, linkage to services and follow-up/monitoring. A home assessment is a required component of the initial assessment for HIV case management services.

b. The procedure code applicable to case management services for this population is Z0095 and the monthly payment rate is \$99.

5. High Risk Pregnant Women of the Metropolitan New Orleans Area

a. A minimum of one hour of documented case management services in each month in which services are billed. This must include one face-to-face contact with the recipient in addition to case management activities such as assessment, service plan development/update, linkage to services and follow-up monitoring. A home assessment is a required component of the initial assessment for high risk pregnant women case management services.

b. In addition, the following contacts are required: 1) a minimum of monthly verbal contact with the recipient's obstetrician or his staff, 2) weekly verbal contact with the recipient beginning with her thirty-seventh week of pregnancy until the delivery, 3) quarterly home visits with the recipient, 4) weekly contact with other service providers and/or informal supports, and 5) a postpartal home visit to be made within 10 to 14 calendar days after delivery focusing on postpartal concerns and infant care.

c. The procedure codes continue to be X0057 for assessment and X0058 for ongoing services and the monthly payment rates are \$130 for the assessment and \$57 for on-going services.

d. Only one assessment service shall be reimbursed for each pregnancy.

6. Case Management Services for participants of the Home Care for the Elderly Waiver Program

a. A minimum of two hours of documented case management services in each month in which services are billed. The two hours must include one face-to-face contact with the consumer in addition to case

management activities such as assessment, service plan development/update, linkage to services and follow-up/monitoring.

- b. Service provider records must be monitored by the case management agency on a quarterly basis.
- c. The procedure code continues to be Z0088 for this population and the monthly payment rate is \$99.

D. Assessments prior authorized for the MR/DD populations and the seriously mentally ill population through September 30, 1995 and completed by October 31, 1995 are reimbursable under the prior reimbursement methodology.

Interested persons may submit written comments to Thomas D. Collins, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule.

Bobby P. Jindal  
Secretary

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