COMMONWEALTH OF PENNSYLVANIA

OCT 25 2010

Dear County Administrators and Behavioral Health Managed Care Organizations:

In 2009, The Department of Health and Human Services Office of Inspector General (OIG) conducted a review of Pennsylvania's Medicaid Targeted Case Management (TCM) program for calendar years 2003 through 2005. The purpose was to determine whether the Pennsylvania Department of Public Welfare (DPW) claims process for TCM services complied with federal and state requirements.

During the audit, the OIG found that the providers of TCM did not always comply with federal and state requirements. Based upon a review of claims, a portion of the claims were deemed unallowable because the services were unsupported by case records or insufficiently documented. The unallowable claims included: billing for services when a person was not at home; not providing specific documentation of the necessity, circumstances and recipient of services; not documenting the nature and extent of the service as compensable under Pennsylvania state plan; illegible case notes and the absence of case records all together. This resulted in a return of funds to the federal government.

The OIG recommended that DPW ensure that future TCM services claimed under the Medicaid program are properly documented in accordance with federal and state requirements. To that end, OMHSAS is re-issuing existing guidance to providers as it pertains to billing and payment for TCM (includes Intensive Case Management, Resource Coordination, and Blended Case Management) services. The guidance provided is derived from various regulations, bulletins, and policy clarifications identified in the ensuing paragraphs of this letter.

Documentation/Recordkeeping

The providers of TCM must ensure that the following documentation requirements are adhered to:

- Verification of eligibility to receive TCM, such as past treatment records, behavioral health assessments, psychiatric or psychological evaluation, letter summarizing treatment history, Individual Education Plan (IEP), and the like.
- The record shall contain a preliminary working diagnosis as well as a final diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- Treatments/services provided to the individual as well as the treatment/service plan shall be entered in the record.

- The record shall indicate the progress at each visit, change in diagnosis, change in treatment and response to treatment.
- The disposition of the case shall be entered in the record. The record shall contain documentation of the medical necessity of a rendered, ordered or prescribed service.
- Case notes shall:

    - Be legible.
    - Verify the necessity for the contact and reflect the goals and objectives of the targeted case management service plan.
    - Include the date, time and circumstance of contacts, regardless of whether or not a billable service was provided.
    - Identify the consumer by name or case number on both sides of each page on which there is writing on both sides. The consumer's name and case number should appear together earlier in the file.
    - Be dated and signed by the individual providing the service.

- Records shall be retained for 7 years. Note: Although ICM regulation indicates that records need to be retained only for 4 years, the federal standards stipulate 7 years of record retention. In order to meet the federal requirement, OMHSAS is asking that all records be maintained for 7 years. Please also note that the requirement in the Blended Case Management bulletin OMHSAS-10-03 is already consistent with the federal standards for record retention (7 years).
- Providers shall make those records readily available for review and copying by state and federal officials or their authorized agents. Readily available means that the records shall be made available at the provider's place of business or, upon written request, shall be forwarded, without charge, to the Department.

Billable/Non-Billable Services

- Provider staff meetings, trainings, recordkeeping activities and other non-direct services are not Medicaid reimbursable. The costs for these activities are already built into the overall rate structure.
- The unit of service for billing purposes shall be 1/4 hour of service (15 minutes) in which the targeted case manager or targeted case manager supervisor is in face-to-face or telephone contact with the consumer, the consumer's family or friends, service providers or other essential persons for the purpose of assisting the consumer in meeting his needs. Multiple contacts can not be combined to claim as a unit of service (example: three distinct contacts, each lasting 5 minutes can not be combined to bill as one unit of service). Additionally, time spent on activities that do not constitute actual contacts are not Medicaid reimbursable (example: leaving a voice mail message or just waiting for consumer).

- During a 1/4 hour period, if one or more targeted case management staff (who are providing services together) makes service contact with a consumer (or a consumer's family member if the consumer is a child), then the maximum number of units that may be billed shall equal the number of staff persons involved or the number individuals being served, whichever is smaller.
- The Department will participate in 100% of the approved expenditures for the following components of targeted case management:

    - Assessment and understanding of the consumer's history and present life situation; service planning, based on the consumer's strengths and desires, to include activities necessary to enable the consumer to function as an integral part of the community.
    - Informal support network building.
    - Use of community resources, to include assistance to consumers or the consumers' parents, if the consumer is a child, in identifying, accessing and learning to use community resources.
    - Linking with resources.
    - Monitoring of service delivery.
    - Aggressive and creative attempts to help the consumer gain access to resources and required services identified in the treatment plan.
    - Life support and problem resolution, to include direct, active efforts to assist the consumer in gaining access to needed services and entitlements.

- TCM services provided to individuals in inpatient settings are reimbursable only under certain conditions as outlined in the Policy Clarifications ICM-04 RC-01 FBMHS-09, and TCM-01 (please contact your OMHSAS Field Office if you do not have copies of these policy clarifications)

The items listed above represent the minimum standard. The following links have been provided for additional clarification;

* **ICM Regulation:** http://www.pacode.com/secure/data/055/chapter5221/chap5221toc.html
* **Resource Coordination Bulletin:** http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003673169.aspx?BulletinId=1006
* **Blended Case Management Bulletin:** http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003673169.aspx?BulletinDetailId=4566

Counties, BH-MCOs and TCM providers must ensure that TCM staff are trained and supervised to ensure compliance with appropriate recordkeeping and documentation procedures; therefore we ask that you share this information with your TCM staff, if applicable, and with your contracted provider(s) to ensure compliance with the federal and state requirements. In addition, I encourage your periodic review of services and documentation.

Additionally, OMHSAS has partnered with Western Psychiatric Institute and Clinic (WPIC), Drexel and Behavioral Health Training and Education Network (BH-TEN) to develop a more comprehensive training curriculum to ensure that future TCM staff have a thorough grounding on Medicaid documentation, recordkeeping/retention and billing requirements.

I trust you can appreciate the importance of this request. Thank you for your support and cooperation. If you have any questions or concerns, please contact Amanda Pearson at apearson@state.pa.us.

Sincererly

Sherry H. Snyder
Acting Deputy Secretary