PerformCARE	Policy and Procedure
Name of Policy:	Mental Health/Substance Abuse Targeted Case Management Reimbursable and Non-Reimbursable Services
Policy Number:	CM-037
Contracts:	☒ All counties ☐ Bedford / Somerset ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Clinical Care Management Department
Related Stakeholder(s):	All Departments
Applies to:	Associates
Original Effective Date:	11/07/05
Current Effective Date:	08/15/08
Last Revision Date:	08/15/08
Last Review Date:	07/01/14
Next Review Date:	07/01/15

Policy: TCM providers will bill for only those services which are considered to be reimbursable. PerformCare TCM providers are expected to follow PerformCare guidelines as well as DPW and state guidelines regarding the request and provision of TCM services, including but not limited to, Title 55 Department of Public Welfare Chapter 5221 Regulations, "Intensive Case Management Services" and MH Bulletin OMH-93-09, "Resource Coordination", and PA Code Chapter 1153. Blended Case Management - DPW/OMHSAS Chapter 5221 Waiver Approval.

Effective 8/15/08, PerformCare has determined that for ICM and Blended Case Management, a unit of service for billing purposes is ¼ hour of service or the better part thereof in which the ICM or BCM or 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 as identified in the treatment plan.

Purpose: To list and define targeted case management services which may and may not be billed to PerformCare.

Definitions: **TCM:** Targeted Case Management which includes Intensive Case Management, Resource Coordination and

Blended Case Management
ICM: Intensive Case Management
RC: Resource Coordination
BCM: Blended Case Management
MH: Mental Health
SA: Substance Abuse
BH-MCO: Behavioral Health Managed Care Organization

Procedure:

1. TCM Reimbursable Services
   - 1.1. Transportation of a Member that results in case management service is a billable service.
   - 1.2. Direct and collateral contacts, including phone contacts, with or pertaining to the Member.
   - 1.3. Transition Periods - If a Member moves out of the zone or out of the current provider's service region, PerformCare will authorize up to 30 days of TCM services to assure that the Member is connected with services in their new community as long as the Member is still active with PerformCare. PerformCare expects that the TCM is aware of the move and as part of the current authorization is connecting the Member to needed services in their new community. This does not include movement to a Residential Treatment Facility (RTF) or a Community Residential Rehabilitation Service (CRR-HH).
   - 1.4. If a face-to-face contact is attempted and a TCM travels to the meeting destination and the Member is not present for the visit, the TCM may bill for travel time.
   - 1.5. To be billable, accompaniment to court must be reflected in the service plan and further the Member's attainment of their treatment goals.
   - 1.6. TCM services may be billed while a Member receives inpatient services with no additional requests needed from IP services; the claims must be submitted utilizing the IP-specific codes for TCM.
   - 1.7. Messaging to deaf/hard of hearing Members.
2. TCM Non-Reimbursable Services
   - 2.1. Non-direct services such as staff meetings; including discussions regarding a Member during staff meetings, paperwork completion (paperwork done without the Member present; PerformCare Request Form completion), unanswered telephone

calls, and supervision are not billable services.

2.2. Participation in Member complaint and grievance meetings will be considered a billable, reimbursable service. Per OMHSAS Regulations Chapter 5221 Mental Health Intensive Case Management, the service is intended to help to consumer gain access to resources and required services identified in the treatment plan. Life support and problem resolution is to include direct, active efforts to assist the consumer in gaining access to needed services and entitlements. As long as all other Payment requirements are met by the provider, ICM, Blended, and RC providers are allowed to bill. This is limited to assisting Members and families with HealthChoices Member Complaints and Grievances, and does not include participation in any other authorization activity, administrative action, or provider dispute with PerformCare.

2.3. Time spent in travel solely for the purpose of transporting a Member to and from a location (appointments, shopping, etc.) is not reimbursable.

2.4. Retrieving voicemail messages is not billable.

2.5. Time spent checking and responding (i.e. emailing back) to email is not billable unless email is documented to be the interpretive method of communication with a Member with hearing problems.

3. SA ICM roles permit payment for additional items such as time spent transporting Members.

4. Portion of Billable Units for RC and ICM

4.1. RC -- For RC billing and payment, OMHSAS Bulletin OMH-93-09 outlines that "Payment for a quarter-hour, *or major portion thereof*, unit of service will be made at a county negotiated, Departmentally approved, cost-based fee-for-service rate" (italics added). Appendix BB of the HealthChoices Program Standards and Requirements waives the Payment section of the bulletin as not applicable to HealthChoices and allows the BH-MCO to set policy in this area. PerformCare defines a unit of service to be the better part of a 15 minute interval which would be 7.5 minutes or more 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. In this regard, the Payment provisions of OMH-93-09 are to be followed by RC providers.

4.2. ICM – For ICM billing and payment, OMHSAS Regulations Chapter 5221.42 (f) outlines that "The unit of services for billing purposes shall be ¼ hour of service *or portion thereof* in which the intensive case manager or intensive 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" (italics added). Appendix BB of the HealthChoices Program Standards and Requirements waives this and other Payment sections of the regulations as not applicable to HealthChoices and allows the BH-MCO to set policy in this area. PerformCare therefore defines a unit of service to be the better part of a 15 minute interval which would be 7.5 minutes or more 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.

4.3. For both RC and ICM, to facilitate proper billing and payment controls, it is expected that providers will record actual clock time spent on the billable activity on each progress note, or other appropriate notation in the record.

4.4. As outlined in general provisions found in PA Code, Chapter 1101.51(e) medical records must fully disclose the nature and extent of the services rendered. Therefore, start and stop clock times for the billable activity can be recorded in either am/pm or military time formats, but must be clear and consistent in use.

Furthermore, PA Code, Chapter 5221.42 (f)(2) states when one or more TCM's acting together make service contacts with or for one or more consumers or family members, if the consumer is a child, during the ¼ hour period the maximum number of units that may be billed shall be equal to the number of staff persons involved or the number of cases being served, whichever is smaller. If a portion of a 15-minute unit has been billed for one Member or billable

activity, the remaining portion cannot also be billed as an additional 15-minute unit. Each clock-time 15-minute billable unit can only be submitted for reimbursement once, even if only a portion of the time is used. For example, if 3 brief collateral contacts (e.g., phone calls) occurred within the same 15-minute clock time span, only 1 unit should be billed, even if independently each contact would be considered billable activities.

Related Policies:
CM-013 Denial Notice Procedure
CM-036 Mental Health/Substance Abuse Targeted Case Management Initial and Reauthorization Requests and Discharges
CM-039 Targeted Case Management Contact Expectations
CM-040 Targeted Case Management Role Expectations

Related Reports:
OMHSAS Bulletin OMH-93-09 Resource Coordination: Implementation

Source Documents and References:
OMHSAS Regulations Chapter 5221 Mental Health Intensive Case Management

Superseded Policies and/or Procedures:
None

Attachments:
None

Approved by:

Primary Stakeholder