STATE OF MISSOURI

TARGETED CASE MANAGEMENT FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES MANUAL

I. INTRODUCTION

Targeted Case Management (TCM) for persons with developmental disabilities has been a MO HealthNet (Medicaid) service program in Missouri since January, 1991. The term 'targeted' means that the case management services under this program are not available to all MO HealthNet eligible people—only to those who are eligible for the services of the Missouri Division of DD (Division of DD) (42 CFR 440.169 (b)). The principal service under this TCM program is referred to as support coordination or case management and the staff who provide this service are support coordinators or case managers.

TCM may only be billable/reimbursable for an eligible individual. An "eligible individual" is a person who is both eligible for MO HealthNet and for Division of DD services **at the time** the services are furnished.

TCM services are broadly defined in 42 CFR 440.169 as services furnished to assist individuals in gaining access to needed medical, social, educational, and other services. In order to receive case management services, the individual must be MO HealthNet eligible under the State plan and must either reside in a community setting or be in the process of transitioning to a community setting, in accordance with 42 CFR 441.18. In the MO HealthNet service program, case management is referred to as Targeted Case Management, or TCM. The term "Targeted Case Management" is used interchangeably in this document to refer to Division of DD support coordination.

As indicated in Social Security Act §1915 (g)(1) the State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

Missouri State Plan for DD Case Management indicates the State assures access to services:

Case management services will be provided in a manner consistent with the best interest of individuals and will not be used to restrict an individual's access to other services under the plan.

The receipt of case management services shall not be required in order to receive other Medicaid services. The receipt of other Medicaid services shall not be required to receive case management services.

Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan; and

For persons transitioning from a qualified medical institution to the community the State assures Federal Financial Participation (FFP) is only available to community providers

and will not be claimed until the individual is discharged from the medial institution and enrolled in community services.

Only staff of the Division of DD's Regional Offices and certain other entities specified by the Division's Director are eligible to provide the services. This is to assure that eligible individuals receive help from case managers who have appropriate education and specialized experience.

Support coordination activities may take place with or without the eligible individual present. It may include contacts with others, assessments, planning and documenting on behalf of the eligible individual.

Support coordinators may assist guardians and others in enabling an individual to gain access to needed services, but they may not be utilized to replace or fund the function of guardian, public administrator or conservator.

II. PARTICIPANT ELIGIBILITY

Missouri State Plan for DD Case Management indicates the target group as:
All Medicaid eligible persons with a developmental disability as defined in 9 CSR 45-2.010. A developmental disability is a disability which-
Is attributable to:

- Intellectual Disability, cerebral palsy, epilepsy, head injury or Autism, or a learning disability related to a brain dysfunction; or
- Any other mental or physical impairment or combination of mental or physical impairments; and
- Is manifested before the person attains age twenty-two; and
- Is likely to continue indefinitely, and
- Results in substantial limitations as defined in 9 CSR 45-2.010(2)(F)(4) in major life activities, and
- Reflects a person's need for a combination and sequence of special, interdisciplinary, or generic care, habilitation or other services which may be of lifelong or extended duration and are individually planned and coordinated.

The target group of persons served through Division of DD TCM services does not include individuals who are served in Institutions for Mental Disease (IMD) who are between the ages of 22 and 64, nor to individuals who are inmates of public institutions.

To be eligible for TCM services provided by support coordinators of the Division of DD, of a Regional Office, an approved County Board or other not-for-profit agencies, an individual must be determined to:

- Have a developmental disability as defined in 630.005 RSMo (and 9 CSR 45-2.010) and determined by a Division of DD Regional Office;
- Be eligible for MO HealthNet in order for the TCM Provider to submit claims to MO HealthNet for reimbursement;
- Not reside in ICF/ID or other MO HealthNet-funded nursing facilities unless the person has a transition plan to move into the community.

The Missouri Department of Social Services, Family Support Division (FSD) is responsible for determining if individuals are eligible for MO HealthNet. Only MO HealthNet eligible individuals who are enrolled for services through the Division of DD are eligible for TCM that is billable to MO HealthNet. The individual must be enrolled with a Regional Office with an eligible program code on the day of service, in order to be eligible for the TCM program.

If the individual is eligible for Division of DD services and MO HealthNet, a support coordinator will explain that all support coordination time spent on behalf of the person will be logged and billed to MO HealthNet, including time spent in meetings or on phone calls, making contacts, and completing documentation. Communication must assure the person or their family or guardian that billing MO HealthNet for TCM in no way limits

the person's eligibility for other MO HealthNet services or the amount of those MO HealthNet services he or she may receive.

To see who's eligible for the TCM service, please refer to MO HealthNet Benefits Table https://dss.mo.gov/mhd/providers/education/docs/tcmi-idd.pdf.

III. PROVIDER PARTICIPATION

To participate in the MO HealthNet Program, the TCM provider must satisfy the following requirements:
The Department of Mental Health (DMH), through an inter-agency agreement with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance Unit (MMAC), reviews all requests for participation in TCM and provides validation of the applicant's certification status to MMAC. MMAC, based upon review of the application and designation by DMH, approves or denies the application request.

Division of DD Regional Offices, County SB-40 Boards, designated by the Division of DD, or other not-for-profit agencies designated by the Division of DD may provide TCM services for persons with developmental disabilities. Qualified County SB-40 Boards, or other not-for-profit agencies designated by the Division of DD to provide TCM services shall maintain an active case management contract with the Division of DD. A not-for-profit agency is only an eligible case management provider within a county or counties where it has an active case management contract with the County SB-40 Board in that county or has a case management contract with the Division of DD. The not-for-profit agency shall be registered with the Secretary of State.

Division of DD Regional Offices or approved County SB-40 Boards that meet the requirements set forth in 42 CFR 447.10 may serve as an Organized Health Care Delivery System (OHCDS). Otherwise, qualified providers shall not be required to provide services through an OHCDS agreement. An entity that contracts with an OHCDS to provide case management services must meet the same requirements and qualifications as apply to providers enrolled directly with the Medicaid Agency. All contracts executed by an OHCDS for case management services shall meet the applicable requirements of 42 CFR 434.6 and 45 CFR Part 74, Appendix G.

Following are conditions of eligibility for Regional Office support coordination, and for County Boards and other not-for-profit agencies enrolling in the TCM Program for persons with Developmental Disabilities.

Case Managers will be employed by:
Regional Offices of the Missouri Division of Developmental Disabilities (Division of DD);
County Senate Bill 40 Boards designated by the Division of DD; designated by the Division of DD; or
Not for profit agency registered with the Missouri Secretary of State, designated by the Division of DD. In addition, a designated not for profit shall have a case management agreement with a County Senate Bill 40 Board, or have a case management agreement/contract with the Division of DD.

Qualifications of TCM Support Coordinators
Support coordinators shall meet qualifications as per Division Directive 2.040; 42 CFR 483.430; 9 CSR 45-3.010(1) (D); The Medicaid Waiver Manual; and the TCM Contract with Missouri Division of Developmental Disabilities. Background screenings are

identified in 9 CSR 10-5.190; and Support Coordinator training requirements are described in the TCM Contract.

The Medicaid State Plan on file with, and approved by, the Centers for Medicare and Medicaid (CMS) requires case managers, employed by a provider of Targeted Case Management to have the following minimum experience and training:

Effective July 1, 2018, case managers shall have one of the following qualifications:

1. A Registered Nurse license; or
2. A Bachelor's degree from an accredited college or university

Case managers employed by a qualified provider on or before June 30, 2018 shall remain qualified.

Division of DD TCM Monitoring

The Division of DD operates the TCM Program for persons with developmental disabilities under a cooperative agreement with MO Department of Social Services. By the terms of this cooperative agreement, the Division of DD has agreed to monitor sub-state TCM providers for procedural compliance with laws and regulations, and with the conditions of participation. This monitoring will be performed by the Division of DD according to a protocol developed between the Division and the County Board, and other not-for-profit TCM providers.

Division of DD Staff conducts reviews with TCM entities that have been delegated waiver administrative functions in the following areas. One record per TCM employee, who is providing TCM, is reviewed annually to include the following:

1. Participant waiver enrollment:
    a. Qualifications of staff;
    b. Evidence the ISP was prepared according to guidelines;
    c. Evidence due process and appeals processes are followed;
    d. Accuracy of information entered in the Division's Consumer Information Management system;
    e. Evidence records are maintained for each individual receiving support coordination; and
    f. Evidence individual was provided choice of waiver service or ICF/ID service.
2. Participant waiver enrollment managed against approved limits.
3. Level of care evaluation:
    a. Qualifications of staff;
    b. Evidence the ICF/ID Level of Care Form was completed following the procedures;
    c. Evidence the individual was accurately found eligible or ineligible; and
    d. Evidence individuals were re-evaluated annually by qualified staff, who followed the process; and
    e. Evidence determinations were accurate.
4. Review of ISP's.
5. Verify proper signatures are in place for waiver documents as applicable.
6. Utilization management:
    a. ISP supports waiver services that are prior authorized;

b. Support coordinator case notes indicate monitoring was conducted of individuals to prevent occurrences of abuse, neglect, and exploitation using risk assessment and planning;
c. Service authorizations accurately reflect ISP and budget plan;
d. ISP's are updated/reviewed at least annually, or when warranted by changes in the individual's needs;
e. Evidence that provider monthly reviews were done and documented in case notes;
f. Evidence that quarterly reviews were prepared;
g. Evidence services were delivered in accordance with the ISP including the type, scope, amount, duration, and frequency as specified in the plan.

7. Quality assurance and quality improvement activities.

Training

The Division of DD will offer training to all contracted TCM providers when entities initially begin providing targeted case management. Additional training will be provided to all TCM providers when the Division of DD TCM policies and procedures change, and on an as-needed basis. All TCM providers are responsible for ensuring their staff are provided sufficient training on applicable CMS assurances, Federal and State statutes and CSRs.

Rate of Payment

The reimbursement rate for TCM services will be determined in accordance with the methodology described in the State plan for TCM for persons who have developmental disabilities as approved by the Centers for Medicare and Medicaid Services (CMS).

The Provider Enrollment Unit

The Provider Enrollment Unit must be notified in writing of any changes in the TCM provider's status. The notification must include the NPI number and the requested change. Examples of changes are: Address or telephone number change; change from a Social Security number to a Tax Payer I.D. number; change in certification status, etc.

Specific information about MO HealthNet participation requirements for TCM can be obtained from the Provider Enrollment section, Missouri Medicaid Audit and Compliance Unit, P.O. Box 6500, Jefferson City, Missouri 65102, or e-mail mmac.providerenrollment@dss.mo.gov.

IV. BILLABLE SERVICES

The following service activities of TCM are billable components, when provided on behalf of an individual and documented as relating to their individualized support plan.

Missouri State Plan for DD Case Management services
State plan provides the following definition of services: Case management for individuals with developmental disabilities.
Case management activities include:

1. Assessment
    - Assessment of the individual's need for medical, social, educational and other services.
    - Completion of the Health Risk Screening Tool (HRST). The HRST process must be conducted as a component of the annual Individual Support Plan (ISP) process for waiver individuals and may be completed for non-waiver individuals, and may be updated throughout the ISP year when changes in the individual's status are identified. The HRST will assist with the identification of additional supports and services and the development of any applicable Health Risk Support Plans as a component of the ISP.
    - For Non-residential waiver individuals, the rater will be an assigned SC that is providing waiver case management services. The rater will be responsible once the HRST is identified to be in fully rated status for the entry and completion of any identified Health Risk Support Plans (HRSP) as a result of the HRST rating findings.
    - For residential waiver individuals, upon completion of the HRST and HRSP(s) identified, the SC will review the completed HRSP(s), provide their electronic signature, and ensure that the HRSP(s) are attached to the current ISP for inclusion as information for the Healthy Living section of the ISP. The SC will follow-up on any identified area of service coordination based upon the completed HRSP(s) and note in their monthly documentation. This process may include the need for services through state plan or waiver. The SC may assist the individual in accessing appropriate services, if identified as a component of support coordination. The assigned SC will review monthly RN Oversight documentation in the electronic HRST Monthly Oversight Nursing Documentation module and attest to their review in the system. The SC will follow-up on any identified area of service coordination based upon the nursing documentation. Lack of monthly RN Oversight Nursing documentation will be noted in service monitoring notes and followed up per support monitoring protocol.
    - Initially determining and documenting an individual's need for individualized, specialized services for a developmental disability, including case management. Also informing and otherwise assisting the individual's or others responsible for the applicant during the assessment process.
    - Obtaining necessary releases, collecting records, preparing ecological and behavioral assessments, arranging other assessments as needed, and

coordinating the overall assessment process to identify the comprehensive array of services and supports needed.

- Facilitating Individual Support Plan (ISP) development and on-going review as a member of the interdisciplinary team. Interpreting the comprehensive assessment and ISP outcomes to the individual and /or responsible others.
- Re-assessments are completed annually at a minimum, or more frequently as the individual's needs change.

2. Planning for Services
   - From the ISP, developing and writing an individualized support plan (ISP) which will enable the prioritized outcomes of the ISP to be attained.
   - At a minimum, annually reviewing the ISP to ensure it continues to be appropriate to the needs of the individual and effective in achieving the prioritized outcomes in the ISP.
   - When needed, as indicated by the individual's response to the prioritized outcomes, re-designing the ISP to further promote individualized training and growth or to incorporate new outcomes.
   - Development (and periodic revision) of an individual's support plan (ISP), based on the information collected through assessment, also includes such activities as:
     - Specifying the goals and actions to address the medical, social, educational, and other services needed by the eligible individual;
     - Ensuring active participation of the eligible individual, and working with the individual, and/or the individual's authorized health care decision maker, and others associated with his or her support team to develop those goals and actions;
     - Identifying a course of action to respond to the assessed needs of the eligible individual.

3. Case Coordination
   - Locating appropriate service providers and community resources to provide the services specified in the support plan, and coordinating these services with other staff, collateral agencies and providers identified in the ISP.
   - Meeting with the individual and persons chosen by the individual on an on-going basis to plan, promote, assist and assure the implementation of the ISP and to guide and encourage their participation in strategies to address the prioritized outcomes identified in the ISP.
   - Directly assist the person to access the services in the ISP, as well as any other services and resources needed to address habilitation outcomes, including crisis services. Such assistance includes advocating on the individual's behalf and being present with the individual at services and resources when advocacy or other guidance is necessary to assure the individual's access to and utilization of those services and resources.
   - Case coordination does not include transporting the individual for any reason.

4. Support Monitoring

- Monitoring service delivery to assure implementation of the support plan and monitoring progress toward outcomes specified in the ISP.
- Monitoring service delivery to assure individual is afforded both his or her legal and constitutional rights.
- In response to negative monitoring findings, intervening with the planning system and/or service delivery system to address the problem(s).
- Support monitoring is performed at least quarterly. At least one face-to-face contact is required annually.

5. Quarterly reviews
   - Quarterly reviews are required for individuals with purchased services funded by State/Federal/or County board funds. The purpose of the report is to summarize progress or at least maintenance of the individual with the current supports.
   - This will involve review of progress notes written and/or submitted by the provider(s) of the purchased services. It is to be completed every three months from the implementation date of the plan.
   - A quarterly review should include evaluating the documentation of service provision and evaluating whether the services and supports provided are helping the person attain the outcomes in the plan or at least maintaining their current level. The intent is to draw information from the provider's records.

6. Case Documentation
   - Completing necessary documentation on all aspects of case management as it applies to individuals receiving case management, including case openings, assessments, plans, referrals, progress notes, contacts, due process requirements, discharge planning, and case closure.
   - Case management includes contacts with non-eligible individuals who are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual in obtaining services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
   - Time spent in case management activities may consist of in-person or other contacts with the individual and all others involved or concerned with his or her care, compiling and completing necessary planning and other documentation, and travel to and from contacts and activities related specifically to the individual. Case notes will be maintained which identify the individual, the case manager and the activity, as well as the date, units of service (5 minute increments), and place of service.

Transition/Transfer of Case Responsibility

This is an instance where two support coordinators from different Division of DD TCM agencies may be providing a certain amount of TCM services necessary for the individual transferring from one TCM entity to the receiving TCM provider. The need for this capability derives from the requirement that individuals be given informed free

choice of service providers, including support coordinators within the identified TCM entity.

Regional Offices, County Boards, and other not-for-profit TCM agencies are, to varying degrees across the state, sharing support coordination responsibility. For instance, transfers of files may be necessary or making contact with providers to acquaint them with the change.

Another example where there may be a case transfer from one TCM entity to another is when an individual moves to another part of the State.

For TCM activities involving support coordinators from the sending and receiving entities, the following conditions shall apply to billable services:

- During the period of case transfer, there may be billable activities from each TCM entity that are viewed as independent. In these instances, close communication between these support coordinators is essential to ensure TCM activities that will be billed by both entities are independent and not duplicative in any way. This distinction must be documented in each logging case note. For example, the sending TCM support coordinator may engage in activities specific to transferring the case to the receiving TCM entity (closing the case). The receiving TCM support coordinator may be completing activities to become more familiar with the individual and the services the person receives (opening the case).

- When TCM activities of the support coordinator from one agency cannot be distinct or independent from that of the support coordinator from the other agency, only one support coordinator may log billable TCM for the activities. This requires close communication between the two support coordinators as to who will log billable TCM and the other non-billable. For example, if both Division of DD support coordinators from the sending and receiving TCM entities attend the same planning meeting and serve the same function in support of the individual, only one support coordinator can log billable TCM and the other would log using a non-billable TCM code.

- There are two HCPCS codes in the Medicaid Information System (EMMIS) applicable to Division of DD TCM claims: G9012HI (Other Specified Case Management-5 minute unit); and G9012HITS (Other Specified Case Management-Case Transfer Follow-up Services-5 minute unit).

    - <u>Transfers When One TCM Entity Uses CIMOR for Logging and the Other Does Not</u>
      Regional Offices, some County Boards, and other Not-for-Profit TCM agencies use CIMOR for logging. For TCM entities that utilize the CIMOR system for case management logging, the support coordinator should use logging code 000040 when completing applicable billable TCM activities associated with transferring an individual's case to a TCM entity that does not utilize CIMOR for logging. This applies no matter which way the transfer goes; until the transfer is complete. Logging the 000040 code in CIMOR (which maps to G9012HITS for claims to

MO HealthNet) will generate a bill which will keep the other TCM entity's billing from failing as a duplicate service.

- Transfers When Both TCM Entities Use CIMOR for Logging
  If both sending and receiving TCM agencies use CIMOR for logging applicable billable TCM associated with transfer of case responsibility, the support coordinators from both agencies will need to communicate to determine who will log billable case management using the 000040 code in CIMOR, while the other support coordinator would use another billable TCM code in CIMOR, to prevent TCM claims failing as a duplicate service.

- Transfers When Neither TCM Entity Uses CIMOR for Logging
  For case transfer among County Board TCM entities that use a different system other than CIMOR for TCM logging and submitting TCM billing claims to MO HealthNet, the support coordinators from both agencies will need to communicate to determine who will log billable case management using the G9012HITS code, while the other support coordinator would use another billable TCM code, to prevent claims failing as a duplicate service.

- It is expected that the transition/transfer of case responsibility shall be completed within 30 days.

- Transition/Transfer of Case documentation: Enter a case note. Each case note entry must describe/justify the need for the dual support coordinator responsibility. Further, as applicable for both support coordinators submitting billable logging, explain the difference in TCM service provided and that it is not a duplication of service.

Conflict Free TCM Transition

- The TCM entity may provide waiver services, but NOT to an individual for whom the agency provides support coordination. System changes are in transition, and the state will complete the system changes by December 31, 2018, in accordance with the timeline separately submitted to CMS.

- During the annual plan meeting, or as the situation arises during support monitoring, the support coordinator will discuss options with the individual to avoid conflicted arrangements. If a TCM entity is providing both TCM and direct services to the same individual, the individual will have to choose that provider for either TCM services or direct services. The support coordinator will educate and inform the individual on choices of TCM entities and waiver providers to prevent conflicted arrangements.

- One of the Division's integrated quality functions is the targeted case management reviews conducted by the technical assistance coordinator (TCM TAC) reviews, with a sampling which includes 100% sampling of all Support Coordinators:
  a. Verification that the conflict of interest statement is included in the service support plan; and

b. Interaction/contact with consumers and/or their guardians to verify effectiveness of the procedures.

Individual Transition from an Institution
Support coordinators may support an individual who is transitioning to a community living arrangement from a Title XIX (MO HealthNet) certified nursing home or habilitation center. Services may be logged not to exceed the last 180 consecutive days the person was in the Title XIX facility, but must not be billed until after the date of discharge to community services.

Billing an Activity for Someone Not on Your Caseload
Support coordinators, supervisors, and other TCM-qualified staff may all log a TCM service as primary support coordinator if all the following conditions apply for the individual:

- The activity being logged is a legitimate TCM activity provided to or on behalf of a specific individual;
- The individual is eligible for TCM;
- The person performing the activity meets the qualifications to provide TCM; and
- One person is performing the activity at the time.

Case Closure
Case closure involves terminating a person from the service delivery system.
Example: Completing discharge summaries or other forms for recording the individual's removal from the services delivery system. Sometimes this is done as a result of the individual's death. Although case closure services provided after the date of death should be logged, the support coordinator should prevent the service being billed to MO HealthNet by logging with a non-billable code.

Documentation: A case note, plus a discharge summary, etc., in the individual's file.

V. SERVICE LIMITATIONS AND NON-BILLABLE ACTIVITIES

Missouri State Plan for DD Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6502 of the Deficit Reduction Act. The direct delivery of an underlying medical, education, social, or other service to which the eligible individual has been referred;
- Activities integral to the administration of foster care programs;
- Activities for which third parties are liable to pay.

1. TCM shall not be billed while a person is in a nursing facility, or a state operated or private Intermediate Care Facility for persons with ID/DD. However, for individuals who reside in these aforementioned Medicaid qualifying institutions, who are transitioning into the community, support coordination is only billable as TCM during the last 180 consecutive days of their stay while transitioning to the community. Support coordination may not be billed to MO HealthNet as TCM for reimbursement until the individual has been discharged from the institution and has been enrolled in community services.
2. TCM may not be provided to individuals in an Institution for Mental Disease (IMD) who are between the ages of 22 and 64, nor to individuals who are inmates of public institutions.
3. TCM shall not be billed while a person is in a state-operated psychiatric facility.
4. TCM may be billed while a person is in an acute care hospital, including inpatient psychiatric settings. The TCM functions do not duplicate hospital services, including discharge planning.
5. TCM shall not be billed for time spent collecting information and determining if a person is eligible for Division of DD Regional Office services.
6. TCM shall not be billed for time spent helping an individual initially applying for MO HealthNet. Once the person is MO HealthNet eligible, TCM received to assist the person with subsequent reinvestigations for MO HealthNet eligibility may be billable TCM. In order for TCM to be billable, the individual must have current eligibility for Division of Developmental Disabilities and be MO HealthNet-eligible on the dates the billable TCM occurred. Further, the activities must fall within the definitions for billable TCM as per this manual. The TCM documentation shall clearly describe the TCM activities associated with MO HealthNet eligibility reinvestigations.
7. TCM must not be used to restrict an individual's access to other MO HealthNet services.
8. TCM shall not be solely responsible for authorizing or denying access to other MO HealthNet services, such as DD Home and Community-Based Waiver services.
9. A MO HealthNet-eligible individual is not required to receive support coordination that is billable as TCM as a condition of receiving other MO HealthNet state plan services.
10. A MO HealthNet-eligible individual is not required to receive other MO HealthNet services, such as DD Home and Community-Based Waiver services, as a condition of receiving support coordination that is billable as TCM.

11. TCM is only available for the cost of support coordination if there are no other third parties liable to pay for those services, including reimbursement under medical, social, educational, or other programs.
12. As per State Plan, payment for case management or targeted case management services must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. For example, if support coordination is billable under another program or as part of another service, it may not also be billed as TCM.

Crisis Team Activities
SPECIAL INSTRUCTIONS: LOGGING CRISIS TEAM ACTIVITIES for Regional Office Staff ONLY

Crisis team activities can be divided into three categories with relation to MO HealthNet covered services:

1. Support coordination "type" activities,
2. Crisis intervention activities that could be covered under one of the waiver programs, and
3. Other types of activity.

Support coordination "Type" Activities
A special situation exists when the person in crisis is or could be a participant in any of the Division of DD's three MO HealthNet Waiver programs. As explained below, crisis intervention is a service covered under each waiver program, for up to eight weeks per episode, and billable by Regional Offices. All the crisis intervention activities should be billed to the waiver. Exceptions can be made; team leaders must just understand the potential for accidental duplication and assure it does not occur.

Crisis Intervention Activities Coverable Under a Waiver
On many occasions, the crisis team member will be the primary intervener. This is a direct service (crisis intervention) rather than a planning or linking function (support coordination). When the crisis team member personally provides direct care or intervention, or when the activity is strictly clinical, such as recording behaviors or coaching and instructing, the activity is a direct crisis intervention service.

Crisis intervention is a waiver service. All crisis intervention services may be billed to MO HealthNet when the individual is MO HealthNet eligible, enrolled in the DD Comprehensive, Community Support, or Missouri Children's Developmental Disabilities (MOCDD) Waivers, and the service is properly authorized through the DD prior authorization system.

For individuals not enrolled in one of the waivers, the crisis team should log direct crisis intervention services with code 030001. This will provide a record of time spent and the service provided; however, MO HealthNet will not be billed.

Accompanying an Individual
Under certain conditions, the support coordinator is required to accompany a person to explain, to advocate or otherwise intervene in, or to augment a process in which the

person's access to services is being questioned or determined. Likewise, accompanying a person into the community may be necessary for planning or linking to services, or to observe and monitor the effectiveness of the supports being provided. However, thehe Center for Medicare and Medicaid Services (CMS) takes the policy position that transporting an individual is a "direct service" and hence not a billable TCM activity. CMS's position on direct service starts with the definition of TCM in the Social Security Act—"...services which will assist individuals...in gaining access to needed medical, social, educational and other services." According to CMS, TCM is a service that connects a person with another service. Therefore, if the case manager actually provides any support to the individual, particularly involving "counseling, accompanying, or transporting," CMS calls it a direct service, which is not billable. Billable activities are described in the Billable Services section of this manual.

Multiple Agencies

When a person is enrolled in multiple agencies, he is likely to have a "case manager" for each. If those "case managers" are performing the same activity, CMS would only consider one of them to be legitimate for payment by MO HealthNet. On the other hand, if the various "case managers" have clearly different functions, only the time spent doing the same activity would be duplicative.

For instance, individuals served through the Division of DD may have a dual diagnosis of a mental illness and receive case management from an administrative agent for the Division of Behavioral Health Services. When conducting an activity together, the two support coordinators should determine who is primary and who is secondary. When the activities overlap, such as during a planning meeting, the secondary support coordinator must log in such a way as to suppress billing for his time in the meeting by logging a non-billable code.

Another example is the young child who may have a case manager from the Healthy Children and Youth program for assistance with physical health problems and a support coordinator through the Division of DD to assist with supports for mental or behavioral problems. Again, these two "case managers" need to work together, but where they are both attending the same meeting or talking with each other, one needs to be the primary support coordinator and the other the secondary.

Activities Which Shall Not Be Billed as TCM

If a provider wants the logging system to include all of their staffs' activities, including those that are not billable, the provider may consider developing additional codes for staff to use that will be excluded by their Medicaid billing system.

Note: The Division also has a code (111111) for "non-billable case management" which it uses to track support coordination activities that it does not bill to Medicaid. Providers may want to utilize this option.

Following are activities which support coordinators sometimes perform, but which are not billable as targeted case management services.

Knowledge Enrichment

Continuing one's education and professional growth, which includes attending conferences and seminars, is a critical activity. Because it is not specifically for the benefit of one individual, it cannot be billed as targeted case management.

Networking
Networking involves developing community relationships and community support systems which benefit the lives of individuals with developmental disabilities and their families. Networking is distinguished from linking resources in that networking is not related to specific supports for a particular individual or family. Therefore, it cannot be billed as targeted case management.

Direct Support
Support coordinators sometimes provide direct support to a person such as helping him move to a new apartment or transporting him to a store or appointment or helping the person pay a bill. Any service which is "direct support" is not billable as TCM. Additional examples of non-billable services are helping a person shop, helping a person do laundry, balancing a person's checkbook, counseling, training, etc.

Crisis Intervention
Providing support directly to an individual during a crisis situation might include data collection, oversight or instruction. However, since this is direct clinical intervention (direct support), it is not billable as targeted case management. Connecting a person with crisis intervention services, however, could be billed as targeted case management under Linking Resources.

Abuse Neglect Investigations
While resolving situations of abuse or neglect may involve TCM activities such as planning and linking resources, conducting the investigation is not billable.

Certification Survey Function
Attending a certification survey function such as an enhancement planning meeting is not billable unless one of the individuals being discussed is in the support coordinator's caseload. In this case, time spent helping to plan enhancement, which will benefit this person, would be billable.

Utilization Review
The time a support coordinator spends serving on the Utilization Review Committee (URC) is not billable. Time a support coordinator spends advocating to the URC on behalf of an individual may be billable.

Other Activities
Activities that do not fall under billable support coordination must be logged with the appropriate service system code. Do not use MO HealthNet billable targeted case management codes. For example, activities logged solely as, "took Jack to pick-up his clothes", "transported Mary to court appointment", "took Jim to the park", "helped Susan move to her new apartment", "assisted Terry with shopping", etc. are, as stated, neither crisis intervention nor case management; rather, these descriptions indicate a direct service, which is not billable to MO HealthNet.

VI. ADMINISTRATION OF HCBS WAIVERS

All TCM entities may also administer certain functions related to the Home and Community-based Comprehensive, Community Support, the MOCDD Waiver and the Partnership for Hope Waiver. The requirements of the waivers are explained in the MO HealthNet Developmental Disabilities Waivers Manual. However, there are additional requirements related to the administration of these waiver programs, as follows.

Eligibility Determination
Regional Office, County Board, and other Not-for-Profit agency support coordinators may perform assessments and develop required level of care evaluations to assist in establishing eligibility for the waiver programs, but final eligibility must be determined by the Regional Offices.

Individual Support Plan
All waiver services must be included in an approved Individual Support Plan (ISP) prior to service delivery. The ISP process and plan must include all elements required by 42 CFR 441.301 (c)(1)-(3). Furthermore, the type of plan acceptable under the waivers is an ISP developed in accordance with developmental disabilities Individual Support Plan Guide. ISP's may be developed by the TCM entity support coordinators, but they shall be subject to review by the Regional Offices and review by the MO HealthNet Division. ISP's shall also be subject to Division of DD Utilization Review processes. County Boards, and other Not-for-Profit TCM agencies are encouraged to use the Division's process; however, they may use their own process if the standards equal or exceed the Division's. The Regional Office will provide technical assistance as requested.

Re-assessments of individuals' needs to medical, social, educational and other services shall be completed annually at a minimum, or more frequently as the individual's needs change.

Freedom of Choice
The targeted group consists of eligible individuals who have developmental disabilities. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities receive needed services.

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.
2. Eligible individuals may not choose the same entity to provide both case management and waiver services in violation of 42 CFR 441.301(c)(1). The case manager will educate and inform the individual on choices of TCM entities and waiver providers to prevent conflicted arrangements.

Waiver Choice
Individuals and their guardians must be given free choice of all available waiver service providers. ISPs for waivered services must not restrict choice. This requires the support coordinator to give all pertinent information and not to bias individuals' free choice.

All waiver services have to be necessary to the support of the individual in the community, as determined by a planning team and approved by the Regional Office.

The individual (or family or guardian) has to be informed about services available under the waiver.

The individual has to be informed about which waiver services are considered necessary to support him or her successfully and why the decision was made. This decision is reached through an assessment and planning process, with consensus being the goal. Nonetheless, the individual may appeal the decision if he/she is dissatisfied, and the support coordinator will then need to explain both the informal and formal avenues of appeal.

Finally, the individual has the right to reject any or all waiver services. This may result in participation in the waiver not being feasible, but it is a choice. Termination from the waiver, following due process notification is required.

Due Process and Appeals
Appeals related to MO HealthNet eligibility decisions are the responsibility of the Family Support Division (FSD). For additional information contact FSD Information Center. https://dss.mo.gov/dss_map/

Responsibility of the Support Coordinator
When adverse action concerning waiver eligibility, denial or reduction in services may occur, the support coordinator may assist individuals as needed in requesting an appeal and preparing for the hearing.

If the adverse action concerns termination or reduction of services, the individual may request the disputed service(s) be continued until the hearing is held and a decision is made on the appeal. If the result of the agency's decision is upheld, the individual may be required to pay for the continued services. If the agency's decision is overturned, the individual will not be responsible for the cost of services.

Value-Based Payment
Value-based payment (VBP) is an approach that offers a way to transition from a fee-for-service payment where providers are reimbursed based on the quantity of services they provide, to a system that reimburses providers based on the value and quality of the services they provide.

- DD TCM providers are eligible for a VBP when the DD TCM staff serving in the role of the Health Risk Screening Tool (HRST) rater are engaged in completing the initial HRST for waiver participants. The performance period shall be a state fiscal year (SFY) (7/01-6/30) starting state fiscal year 2023. The VBP is a standardized one-time payment rate of $72.20 per waiver participant for completing of the initial HRST for the waiver participants in the electronic system prior to the end of SFY 2023. The VBP will be disbursed within 6 months following the end of SFY2023.

VII. ADEQUATE DOCUMENTATION

As TCM services are provided, the support coordinator is responsible for logging the activity. The Division's information system in CIMOR includes TCM logging screens so that support coordinators can log activities directly into the system as services are provided. The automated system also has an expandable field for entering a narrative explanation, which, in this manual, is called a case note (commonly referred to as a log note).

Each provider is responsible for developing their own logging system, which may be either on paper or a computer system. The provider must ensure that the system collects minimum required information specified below.

In order for TCM services to be billed to MO HealthNet, there must be an identifiable charge related to an identifiable and allowable service that was rendered by a qualified provider on behalf of an eligible person included in the target group.

Required Information
Missouri State plan for DD Case Management for persons with developmental disabilities indicates providers shall maintain case records that document for all individuals receiving case management as follows:

- The name of the individual;
- The dates of the case management services;
- The name of the provider agency (if relevant) and the person providing the case management services;
- The nature, content, units of case management services received and whether the goals specified in the care plan have been achieved;
- Whether the individual has declined services in the care plan;
- The need for, and occurrences of, coordination with other case managers;
- A timeline for obtaining needed services; and
- A timeline for re-evaluation of the plan.

Further information on the aforementioned documentation requirements are described below and in other sections of this manual, where applicable.

Documentation requirements for TCM provided by the Department of Mental Health are found in **13 CSR 70-3.030**
https://www.sos.mo.gov/cmsimages/adrules/csr/current/13csr/13c70-3.pdf.

Logging documentation shall be completed contemporaneously with the date the TCM activity was provided. For purposes of documentation, this CSR defines "contemporaneous" as the time the service was performed or within five (5) business days, of the time the service was provided.

The support coordinator is responsible for including the following information when a case note is made to support a bill to MO HealthNet:

- First name, last name, and either middle initial or date of birth of the MO HealthNet participant;
- Accurate, complete, and legible case note of each service provided; DMH ID of the individual receiving service;
- Name of the support coordinator providing the logged service activity;
- Date the service was provided (month/day/year);
- Amount of time in hours and minutes required to complete each TCM activity. Indicate any time spent in travel associated with the TCM activity (see note below);
- Setting in which service was rendered (Service Location);
- Individual plan with regular updates;
- Progress notes;
- Discharge summaries when applicable;
- Other relevant documents referenced in the case notes such as letters, forms, quarterly reports, and plans of care.

Case note regarding travel time:
The support coordinator should indicate in the case note total amount of travel time to and from activity, or break out travel time to the activity and from the activity. Example: "ISP completed at the individual's home. Travel time to and from the person's home total was 1 hour". Or, this can be worded as "….travel time from office to the person's home was 30 minutes, and from the person's home back to the office was 30 minutes."

If a support coordinator is conducting multiple TCM functions for more than one person in a given day, the support coordinator may split the total travel time. This may involve travel to one or more locations in the course of the travel to provide billable TCM for more than one person. For example, support monitoring for more than one individual at a group home, the travel time can be equally split among the individuals for whom the support monitoring was conducted. If the travel to and from the group home was 45 minutes total to provide support monitoring for three individuals, the travel time would be 15 minutes for each person. The case note should indicate total travel time of 45 minutes was divided out equally for three persons; thus, 15 minutes travel each.

The following documentation shall be maintained and produced in the event of an audit:

- ISP with regular updates;
- Progress notes;
- Discharge summaries when applicable;
- Other relevant documents referenced in the case note such as letters, forms, quarterly reports and plans of care;
- Documents pertaining to case management assessment/reassessments should be maintained in the record and available for review.

Audit Requirements
State and federal auditors may also review claims for all MO HealthNet services billed by the Division or billed by provider agencies in association with a program administered by the Division of DD, such as the MO HealthNet Home and Community-Based Waiver. In audit situations, the Division of DD must be able to clearly substantiate, explain and sometimes defend the activity for which a charge was made to

MO HealthNet. Review periods may go back as far as six years. Often, individuals who were assigned to a case at the time services were delivered are no longer available to explain notes. Routine documentation avoids potential problems with audits.

Provider's failure to furnish documentation

If a provider fails to reveal and retain adequate documentation for services billed to MO HealthNet this can result in the recovery of the payments for those services not adequately documented and can result in sanctions to the provider's participation in the MO HealthNet program. This policy continues to be applicable in the event the provider discontinues as an active participating MO HealthNet enrolled provider as the result of a change of ownership or any other circumstance.

Retention of Records

The contractor will retain all records pertaining to TCM for six (6) years after the close of the contract year unless audit questions have arisen with the six year limitation and have not been resolved. All records shall be retained until all audit questions have been resolved.

VIII. BILLING REQUIREMENTS

Billing Format
Claims and adjustments must be billed electronically using MO HealthNet's website emomed.com, or send the HIPAA 5010 version of the 837P. To send HIPAA 5010 version of the 837P, providers must follow the HIPAA guidelines obtained from WPC-EDI at http://wpc-edi.com/ and payer specific instruction from the Medicaid companion guide at http://www.dss.mo.gov/mhd/providers/index.htm.

To obtain electronic connection specifications, providers must call MO HealthNet's fiscal agent, Wipro InfoCrossing at 573-635-3559. Providers must have their Medicaid Provider number when calling InfoCrossing.

Place of Service
It is required there be a place of service code that indicates where the activity took place.

Unit of Service
A TCM service unit is five minutes.

Time Limit for Original Claim Filing
Claims from participating providers who request Medicaid reimbursement must be filed by the provider and must be received by the state agency within 12 months from the date of service. The counting of the 12 month time limit begins with the date of service and ends with the date of receipt.

Time Limitations for Re-submission of a Claim
Claims must be submitted to MO HealthNet for payment within 12 months of the date of service. If the claim is denied or returned to the provider, the provider has 12 additional months from the date it is denied/returned, not 24 months from the date of service.

Service Codes
There are internal service codes that the Division uses to document the provision of TCM services. These codes are listed below. County Boards may elect to use these codes or develop their own. Regardless of what code a County Board chooses to use, any activity that is logged must be within the scope of the activities listed below and defined in the Billable Services section of this manual.

000020 Planning Supports
000021 Linking Resources
000022 Support Monitoring/Quality Enhancement
000023 Quarterly Review of Progress on ISP's
000030 Documentation
000040* Transition/Transfer of Case
20000T** Transition from Eligible Title XIX Placements (State operated ICF/ID, Private ICF/ID, Nursing Home)
022001 Case Closure

All allowable TCM services are then billed to MO HealthNet under one procedure code G9012HI.
*Transition/Transfer of Case is billed under G9012HITS (Other Specified Case Management).
**See "Title XIX Placements (Eligible Place of Residence)" in this manual for more information on billable TCM process for persons who are transitioning from these facilities into community supports.

Transitioning from an Institution
TCM is generally not billable for persons who reside in a Title XIX certified facility (SNF or ICF nursing home, private ICF/ID, or state operated ICF/ID) even if the service is delivered someplace else. There is an exception for persons who reside in a Title XIX certified facility whose ISP includes a plan for relocating (transitioning) to a community living arrangement. (Transition does not include moving from one institution to another.) Once a person has transitioned into the community, MO HealthNet can be billed for case management services the person receives related to relocating to the community, not to exceed the last 180 days the person resided in the facility. Billing cannot occur until after the date of discharge into the community.

Title XIX Placements (Ineligible Place of Residence)
As mentioned above, some individuals who receive TCM services reside in Title XIX certified facilities, which are ICF's, SNF's or ICF/ID Facilities (both private ICFs DD and state-operated habilitation centers). MO HealthNet will not reimburse TCM services for individuals who reside in these facilities, because the facility is already being paid a per diem.

Note:
- There is an edit in CIMOR that checks to determine if the individual resides in a Title XIX facility on the date of the TCM service. If the individual does reside in a Title XIX facility, CIMOR will mark the service as non-billable.

- If your TCM entity does not use CIMOR for billing, your agency is responsible for ensuring that a support coordinator is not billing for non-billable services.

Title XIX Placements (Eligible Place of Residence)
MO HealthNet will reimburse TCM services for up to 180 days for individuals who reside in institutions when the individual is transitioning from the institution to a community living arrangement such as a living arrangement funded through the waiver. For TCM providers that use CIMOR for billing, in order for a support coordinator to submit billable logging for individuals who are transitioning to the community, the 20000T code must be utilized and Service Location should designate ICF/ID, nursing facility, or skilled nursing facility. This will allow TCM to be billed and paid for persons who are being transitioned from a Title XIX state-operated ICF/ID, private ICF/ID, or nursing home. Transition activities coded with 20000T shall not be billed to MO HealthNet until after the date of discharge into the community. Support coordinators can log applicable transition activities, while the person is residing in an ICF/ID or nursing facility, by using a non-billable code. Once the person has successfully transitioned to the community, the code

can be changed to 20000T and submitted as a billable TCM claim for that date of service.Claims with the 20000T code shall only be billed for service dates up to 180 consecutive days prior to the effective date of successful transition.

This does not include persons who transition from one institution to another, for example, move from a state operated ICF/ID facility to another, or to a nursing home or private ICF/ID.

Note that Residential Care Facilities (RCF's) I & II are not Title XIX certified facilities. TCM services logged for individuals living in these facilities will be billed.

Quantity of Service

The developmental disabilities billing system takes the total time a support coordinator spends on a given activity for a given individual on a given day and converts the time to tenths of an hour. A TCM service unit is five minutes. Providers must design their billing system to also bill services in five minute increments.

IX. ADMINISTRATION

System Edits Prior to Billing
On a semi-monthly basis, staff in DMH Information Technology Services Division (ITSD) process pending Medicaid claims in the DMH CIMOR system and submit claims electronically to MO HealthNet. The program bills service data that has been entered to the MO HealthNet claim since the last billing cycle. Services are not added to a MO HealthNet claim until 30 days after the date of service. Logged data is edited for:

- Billable service code;
- Individual is MO HealthNet eligible;
- Service location;
- Individual is not in a nursing home or ICF/ID level of care.

These internal DD codes will not be billed to MO HealthNet (Regional Office non-billable codes)

111111 Non-Billable Case Management Services
000050 Quality Improvement
000070 SIS Activity
020001 Intake/Screening Admission
395001 Consumer Advocacy
900001 Other Community Indirect Services
960001 Clinical Services Supports
960003 Personal Plan Mentoring
970001 Staff Development
120001 Psychosocial Evaluation

Service Location
MO HealthNet requires each claim to include a “place of service”. In CIMOR, DMH support coordinators must indicate a service location, below lists the available service locations.

- Home
- Intermediate Care Facility/Developmental Disabilities
- Office
- Custodial Care Facility
- Nursing facility
- Skilled Nursing Facility
- Other Place of Service

X. PROHIBITION AGAINST FALSE CLAIMS

The Federal False Claims Act (Section 1902(a) (68) of the Social Security Act) requires an entity that furnishes Medicaid reimbursed items or services totaling at least $5,000,000 annually to establish and disseminate written policies regarding the law, rights of employees to be protected as Whistleblowers, and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. The policies are to be made available to all directors, officers, administrators, managers, staff, employees, contractors, agents, students, physicians or professionals associated with the entity.

References:
Section 6032 of the Deficit Reduction Act of 2005 (Section 1902(a) (68) of the Social Security Act)

Missouri Anti-Fraud Laws Related to Health Care:
- Missouri State Statutes: 191.900-191.910
- Missouri Code of State Regulations 13 CSR 70-3.0.30

Section 1902(a) (68) of the Social Security Act relates to "Employee Education about False Claims Recovery". The False Claims Act provides that any person who knowingly presents or causes to be presented to the U.S. Government (including Medicaid program) a false or fraudulent claim for payment or approval; knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; conspires to defraud the government by getting a false or fraudulent claim paid or approved by the Government; or knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government is liable to the US Government for a civil penalty of not less than $5,000 and not more than $10,000 plus 3 times the amount of damages which the Government sustains because of the act of that person.

"Knowingly" or "knowing" means that a person with respect to information has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

Although the Act imposes liability only when the person acts knowingly, it does not require the person submitting the claim to have actual knowledge that the claim is false. If a person acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, the person may also be found liable.
In summary, the False Claims Act imposes liability on any person who prepares and/or submits a claim to the federal government that he or she knows (or should know) is false. Following are some examples:

1. A support coordinator creates a false case note for an eligible individual or intentionally enters excessive time spent in providing coordination on a case note in order to gain credit for time worked.
2. A billing office staff alters a service code or other components of a billing record in order to get a charge to be paid by MO HealthNet, in disregard for the actual service that was provided.

If an employee becomes aware of actual or suspected fraud and abuse, he or she is required by federal and state law to report the activity. Such an employee is sometimes referred to as a Whistleblower. Federal and state laws have been enacted to protect Whistleblowers to encourage the reporting of misconduct involving false claims. This is referred to as the "qui tam" provision.

Reporting information to the Missouri Medicaid Audit and Compliance Unit
Contact Missouri Medicaid Audit and Compliance (MMAC) for provider enrollment, provider review, provider self-disclosure, sanction, or participant lock-in issues at telephone number 573-751-3399. You may also contact MMAC by using the form at the following website: https://mmac.mo.gov/contact-us/ or by mail at:

Missouri Medicaid Audit and Compliance
P.O. Box 6500
Jefferson City, MO 65105

Provider Self-Disclosures
Providers who want to contact MMAC for self-disclosures can find the form on the following website: https://mmac.mo.gov/providers/self-audits-self-disclosures/. The form may either be emailed to: mmac.financial@dss.mo.gov or mailed to the following address:

Missouri Medicaid Audit and Compliance
Financial Section – SELF DISCLOSURE
P.O. Box 6500
Jefferson City, MO 65102-6500

For additional information about MMAC, please visit the main website at:
https://mmac.mo.gov/

Reporting Medicaid Fraud
Department of Social Services, Division of Legal Services — Investigations Unit
Phone: 573-751-3004

DLS Fraud email: Ask.MHD@dss.mo.gov

To report fraud, please call the number for the area of Missouri where you live:

- Central: 877-770-8055
- Eastern: 877-860-3052
- Southeast: 877-603-4323
- Western: 877-698-0760

- Southwest: 877-839-4316

https://dss.mo.gov/dls/public-assistance-fraud-form.htm

Or contact MMAC
MMAC Participant Telephone Number: 573-751-3285
MMAC Provider Telephone Number: 573-751-3285
MMAC Fraud Email: MMAC.reportfraud@dss.mo.gov

You may also send the complaint in writing to:

Department of Social Services
Division of Legal Services — Investigations Unit
P.O. Box 1527
Jefferson City, MO 65102

Reporting Medicaid Fraud as a Whistleblower:
Section 191.907 of the Revised Statutes of Missouri allows any person who reports MO HealthNet fraud to receive a financial reward.

To report fraud, call the Medicaid Fraud Hotline toll free at **800-286-3932**, email AG@ago.mo.gov, or download a complaint form at: https://www.ago.mo.gov/criminal-division/medicaid-fraud/medicaid-fraud-complaints. Please complete the form and mail to the following address:

Missouri Attorney General's Office
P.O. Box 899
Jefferson City, MO 65102

CMS-1500 Claim Form
For all TCM services, the provider submits all billing information to the DMH, who in turn bills this information to MHD. This includes all adjustments.

Resubmission of Claims
Providers may view their claims in CIMOR or may use the Remittance Advice if services were submitted to CIMOR electronically on a HIPAA 837.
Services that resulted in zero payment on a claim can be resubmitted if the claim denied due to a correctable error. The error that caused the claim to deny should be corrected before resubmitting it to MHD through CIMOR. The provider may use the Replace button on the service in CIMOR to resubmit a claim to MHD.

Inquiries
All inquiries regarding TCM services that the MO HealthNet Agency receives are referred to Division of DD. The Division must explain in writing to the individual and the MO HealthNet Agency what specific activity was performed for each charge made to MO HealthNet during the quarter in question. In order to do this, the County Board and the not-for-profit agency must keep clear documentation that is easily retrievable.