Specialized Maintenance Therapy Report to the Legislature

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is approximately $3,500.

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Specialized Maintenance Therapy Report to the Legislature

Introduction

The 2011 laws of Minnesota, Chapter 9, Article 6, sec. 91 directs the commissioner of human services to evaluate whether providing medical assistance coverage for specialized maintenance therapy for enrollees with serious and persistent mental illness who are at risk of hospitalization will improve the quality of care and lower medical assistance spending by reducing rates of hospitalization.

> Sec. 91 SPECIALIZED MAINTENANCE THERAPY.
>
> The commissioner of human services shall evaluate whether providing medical assistance coverage for specialized maintenance therapy for enrollees with serious and persistent mental illness who are at risk of hospitalization will improve the quality of care and lower medical assistance spending by reducing rates of hospitalization. The commissioner shall present findings and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by December 15, 2011.

Executive Summary

The report provides the history and background of coverage of specialized maintenance therapy (SMT) under the Minnesota Health Care Programs (MHCP). The report also includes an analysis of fee-for-service (FFS) paid claims data for enrollees statewide of SMT whose diagnosis meets the definition of serious and persistent mental illness (SPMI) in order to determine whether SMT services may lower hospitalization rates for enrollees with SPMI diagnoses.

Preliminary evaluation of utilization of SMT services indicates that Occupational Therapy SMT (OT-SMT) services account for the vast majority of SMT services provided to MHCP enrollees. Mental health conditions are also the most frequent diagnoses reported by providers that bill OT-SMT services and comprise the SMT services that are received by enrollees with a SPMI. As a result, this analysis was focused on examination of OT-SMT services to determine whether such services lower hospitalization rates for enrollees with a SPMI that receive them.

Such an analysis cannot be done with a high level of scientific rigor since there is a group of enrollees with a SPMI receiving OT-SMT but there is no comparison group with which to compare their outcomes. Using the entire SPMI population for an analysis also presents challenges, as this population is extremely diverse, both in their diagnosis and severity. Additionally, diagnosis data is not specific enough to assess severity within different groups of the SPMI population.

An examination was performed to determine whether enrollees with a SPMI in regions that have greater access and higher utilization of OT-SMT also tend to have fewer hospitalizations than those in regions with low utilization of OT-SMT. A single provider of OT-SMT services in the Twin Cities metropolitan area billed over 90% of all services, indicating utilization of OT-SMT services is greater in the metropolitan area. For enrollees with a SPMI, the regions with higher utilization of OT-SMT were also the regions with higher utilization of hospital services. Lower utilization of hospital services was seen in greater Minnesota where OT-SMT is less available and less utilized.

Hospitalization data was also examined to determine whether enrollees with a SPMI receiving OT-SMT had lower hospitalization rates. Enrollees with a SPMI who received OT-SMT were less likely to be hospitalized than those not receiving OT-SMT (7.6% vs. 11.4%). However, without establishing which group is more likely to need hospitalization, it cannot be concluded that the OT-SMT service itself was responsible for reducing hospitalizations. Indeed, almost 99% of enrollees with a SPMI that were not hospitalized did not receive any OT-SMT services.

Finally, an investigation into other mental health service utilization found that enrollees with a SPMI receiving OT-SMT had 48% more mental health treatment days per year and 41% more units of mental health provided to them than enrollees with a SPMI who did not receive OT-SMT. It is therefore not clear which of the services, if any, or the intensity of the services is responsible for a lower hospitalization rate.

The review of evidence cannot conclude that OT-SMT reduces hospitalization rates in the population of MHCP enrollees with serious and persistent mental illness.

History of Specialized Maintenance Therapy

Specialized maintenance therapy had been included as a covered service by MHCP since the late 1980s and was a service unique to MHCP. An internet search confirms there are no other states that include coverage of SMT in their Medicaid programs and, Medicare has no provision for coverage of SMT. The MN legislature ended coverage for SMT for adults covered by MHCP on January 1, 2012.

Prior to 1999, the definition of SMT in Rule lacked clarity. SMT was limited to occupational therapy (OT) and physical therapy (PT). Speech-language pathology (SLP) was not included as a therapy discipline that could provide SMT. Coverage for SMT was limited to residents in long-term care settings. The legislature, during the 1999 regular session, directed the department to develop recommendations for SMT, working in conjunction with:

- Professionals representing the therapy associations including the
    - Minnesota Occupational Therapy Association (MOTA),
    - Minnesota Chapter of the American Physical Therapy Association (MNAPTA),
    - Minnesota Speech-language and Hearing Association (MSHA),
- Rehabilitation service providers, and
- Patient advocates.[1]

The department convened meetings throughout 1999 of the Rehabilitation Services Workgroup, consisting of over 30 representatives from the following organizations representing providers, peer reviewer, the professional associations, and advocacy groups:

- Professional Rehab Consultants
- RehabWorks
- Phoenix Alternative, Inc.
- Phoenix Service Corporation
- Courage Center
- Disability Law Center
- Capitol Hill Associates
- Care Delivery Management Incorporated
- MNAPTA
- MSHA
- MOTA
- Peer Review with MNAPTA, MOTA, and MSHA

The Rehabilitative Services Workgroup and the department have a long history of collaboration on numerous rehabilitative service issues dating back to the late 1980s and continuing even today with regularly scheduled meetings.

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[1] Minnesota Sessions Laws, 1999 Regular Session, Chapter 245, Article 4, Section 117

Following the meetings of the Rehabilitative Service Workgroup in 1999, the department prepared and submitted a report to the 2000 Minnesota Legislature[2], detailing the recommendation of the group to amend MN Rule 9505.0390 further defining specialized maintenance therapy, broadening the scope of SMT for enrollees regardless of the living arrangement, and incorporating the concepts that specialized maintenance therapy, as a skilled service, is appropriate for persons with chronic or progressive disease conditions to:

- Prevent deterioration and maintain function
- Provide interventions that enable the enrollee to live at the enrollee's highest level of independence, or
- Provide treatment interventions for enrollees who are progressing but not a rate comparable to the expectations of restorative therapy

The proposed rule changes were published in the State Register, Volume 25, number 27, pages 1238 – 1240, January 2, 2001[3], with the final rule promulgated October 1, 2001[4]. See Appendix B: 9505.0390 Rehabilitative and Therapeutic Services, subd. 5, Covered service; specialized maintenance therapy.

Specialized Maintenance Therapy Utilization Review

The charge of this legislative report is to "evaluate whether providing medical assistance coverage for specialized maintenance therapy for enrollees with a serious and persistent mental illness, who are at risk of hospitalization, will improve the quality of care and lower medical assistance spending by reducing rates of hospitalization." There is no accepted method to determine whether a person is "at risk for hospitalization". Nor is there any person-level, objective, evidence-based method to accurately or reliably identify those SPMI individuals who are at risk for hospitalization. Recognizing this difficulty and the difficulty in quantifying "quality of care," the analysis for this report focused on hospitalizations for enrollees receiving service due to a SPMI and enrollees with a SPMI who also received OT-SMT, as occupational therapy was the vast majority of SMT provided for this population; see Table 1.

Enrollees with a SPMI were identified as those enrollees who had at least one Mental Health-Targeted Case Management (MH-TCM) service paid in the Medicaid Management Information System (MMIS). This method was used because it is a standard generally used by DHS to identify enrollees with a SPMI. Although there is no definitive method to identify all enrollees with a SPMI diagnosis, identifying those that received at least one MH-TCM service is a reasonable method because adults must have a diagnosis of SPMI in order to be eligible for targeted case management services. Enrollees who meet the narrow definition of SPMI may also be eligible for and receiving many other services to treat and manage their mental illness, including:

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[2] **Recommendations for the Definition of Specialized maintenance Therapy,** A Report to the 2000 Minnesota Legislature as required by Laws of Minnesota 1999, Chapter 245, article 4, section 117

[3] 25 SR 1238

[4] 26 SR 487

Table 3: Mental Health (MH) hospitalization detail for enrollees with a SPMI

Enrollee County of Residence	Hennepin/Ramsey	Outer Ring	Greater MN	All MN
Number of enrollees with a SPMI w/ at least one MH hospitalization	699	305	948	1,952
Percentage of enrollees with a SPMI with at least one MH hospitalization	13.7%	14.3%	9.5%	11.4%
Total # of MH hospitalizations of enrollees with a SPMI	1,224	492	1,592	3,308
Average number of MH hospitalizations per hospitalized enrollee with a SPMI	1.76	1.62	1.68	1.70
MH hospital days	20,956	6,961	20,547	48,464
Average length of stay (days)	17.1	14.1	12.9	14.7

Overall, enrollees with a SPMI in Hennepin/Ramsey counties and the outer ring counties had greater hospital utilization for treatment of a mental health condition than those in greater Minnesota. The percentage of enrollees with a SPMI who experienced at least one MH hospitalization was highest in the outer ring area (14.3%) and Hennepin/Ramsey counties (13.7%). This rate was lower in greater Minnesota (9.5%). Some of the enrollees were hospitalized more than once during the year. The data indicate that the average number of annual MH hospitalizations per hospitalized enrollee with a SPMI (1.76 per year) is slightly higher in Hennepin/Ramsey counties than the average for the outer ring (1.62 per year) and greater Minnesota (1.68 per year). The average length of a MH hospital stay for enrollees with a SPMI in Hennepin/Ramsey counties is 17.1 days which is 3 days greater than the 14.1 days for enrollees with a SPMI in the outer ring and nearly 4 days greater than the 12.9 days average length of MH hospitalizations for enrollees with a SPMI in greater Minnesota.

The vast majority of enrollees with a SPMI do not receive OT-SMT services. Statewide only 195 (1.1%) of the total 17,170 enrollees with a SPMI received OT-SMT services during the calendar year. This means that 98.9% or 16,975 enrollees with a SPMI did not receive OT-SMT during the year.

Table 4: Enrollees with SPMI who were hospitalized in CY 2010

Receipt of OT-SMT	Total enrollees	Enrollees with a SPMI with MH hospitalization	% of enrollees with a SPMI with a MH hospitalization
Enrollees with a SPMI that received OT-SMT	195	15	7.6%
Enrollees with a SPMI that did not receive OT-SMT	16,975	1937	11.4%

This data indicates that a smaller percentage of enrollees with a SPMI that received OT-SMT were hospitalized than the enrollees that did not. This could suggest that when enrollees with a SPMI receive OT-SMT, they are hospitalized less. As with the differences in hospitalizations between enrollees with a SPMI in the metropolitan area and greater Minnesota, the cause for the difference noted here cannot be established. The difference cannot necessarily be attributed to the OT-SMT services, as it cannot be established whether the enrollees with a SPMI receiving OT-SMT were less likely to be hospitalized than those who were not receiving OT-SMT and therefore would have had fewer hospitalizations anyway. Additionally, these individuals also receive a large amount of mental health services and programs that would also have the potential to impact the outcomes for these individuals, including whether or not they would become hospitalized.

In order to examine whether there was potential impact of the additional services, claims data for mental health services received by enrollees with a SPMI were examined. The

Table 5: Mental health services provided to enrollees with a SPMI during CY 2010

Receipt of OT-SMT	Total enrollees	Average # of MH service days per enrollee	Average # of MH service units paid per enrollee	Average amount paid for MH services per enrollee
Enrollees with a SPMI that received OT-SMT	195	46	562	$4,307
Enrollees with a SPMI that did not receive OT-SMT	16,975	31	400	$3,737

The 195 enrollees with a SPMI that received OT-SMT also received more mental health services during that same time than enrollees with a SPMI not receiving OT-SMT. The enrollees with a SPMI that received OT-SMT had an average of 48% more days of mental health treatment, representing an average of 41% more units of mental health services paid and an average of $570 more paid per enrollee for mental health services than the 16,975 enrollees with a SPMI that did not receive OT-SMT. One or more of the mental health services may be

responsible for the lower rates of hospitalization for the enrollees with a SPMI that received OT-SMT, but it cannot be determined which service, if any, is responsible. This analysis is also limited to those services that fall under the category of "mental health service", and would not include other medical services, long term care, home and community based services or pharmacy services.

Expressed as a percentage of the total SPMI population, 15,038 (87.6%) of the total 17,170 enrollees with a SPMI were never hospitalized and never received OT-SMT services during calendar year 2010. One could argue that this data indicates the "best" outcome (hospitalization avoided) for the SPMI population is likely to be achieved without OT-SMT intervention. However, the same limitations apply to this conclusion, as it is not possible to determine whether these 15,038 individuals would have been less likely to be hospitalized anyway or if the mental health services provided to those who were not hospitalized were more effective than the services provided to the OT-SMT enrollees. This data, when combined with the near absence of OT-SMT and lower hospitalization rates for enrollees with a SPMI in greater Minnesota, does not support a conclusion that OT-SMT leads to lower hospitalization rates for enrollees with a SPMI.

Conclusions

The history of SMT suggests that its intent was to provide skilled PT, OT or SLP services for specified enrollees whose progress was not commensurate with the typical restorative therapy standards. The rules governing SMT have a number of references to physical impairments, such as joint contractures, muscle spasticity, loss of range of motion, and positioning. This suggests that physical disabilities were a significant driver of the creation of SMT. However, claims data indicates that the majority of SMT services provided from 2008 through 2010 were provided to enrollees with mental health conditions and the vast majority of services were provided by one provider of occupational therapy services. When a single provider represents a large majority of billing for any type of service, it is typically cause for some concern. This indicates that the service is not widely utilized outside of that one provider and is not likely representative of the community standard of care for adults with a SPMI diagnosis who are being treated throughout the state.

While supporters of OT-SMT services suggest that these services keep enrollees with a SPMI from ending up in the hospital, the data related to enrollees with a SPMI, their mental health services and their hospitalizations fails to support this assertion. Lower rates of hospitalization could not be attributed to the presence of OT-SMT. In fact, the large majority of enrollees with a SPMI were never hospitalized and did not receive OT-SMT. It can be concluded that services other than OT-SMT keeps the vast majority of enrollees with a SPMI out of the hospital as enrollees with a SPMI are also eligible for and receiving a large amount of mental health services, even some in very specialized programs. It is likely these services are doing as much or even more to reduce hospitalizations for enrollees with a SPMI. The influence of the other mental health services cannot be controlled for in a retrospective claims data analysis.

Finally, there are no existing studies of sufficient quality and method that support a causal relationship between OT-SMT interventions and incidence of hospitalizations. Without an adequate comparison group, it is very difficult to establish such a relationship, as there are too many factors and other interventions associated with the SPMI population that can influence whether or not they will be hospitalized.

Based on this analysis, it cannot be concluded that OT-SMT improves the quality of care or reduces costs by reducing hospitalization rates in the population of MHCP enrollees with serious and persistent mental illness.

Appendix A

1999 Regular Session: Chapter 245, Article 4, Section 117 (signed May 25, 1999)

Sec. 117. [RECOMMENDATIONS FOR DEFINITION OF SPECIALIZEDMAINTENANCE THERAPY.]

The commissioner of human services shall develop recommendations for definitions of specialized maintenance therapy for each type of covered therapy, in consultation with representatives of professional therapy associations, providers who work with patients who need long-term specialized maintenance therapy, and patient advocates. The commissioner shall provide the recommended definitions to the chairs of the house health and human services finance committee and the senate health and family security budget division, by November 15, 1999.

Appendix B

9505.0390 REHABILITATIVE AND THERAPEUTIC SERVICES

Subp. 5. Covered service; specialized maintenance therapy.

To be eligible for medical assistance payment, specialized maintenance therapy must:

A. be provided by a physical therapist, physical therapy assistant, occupational therapist, occupational therapy assistant, or speech-language pathologist;

B. be specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 60 days unless the service is a Medicare covered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare;

C. be provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's physical, cognitive, or psychological deficits result in:

(1) spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient's previous level of function; (2) a chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, cardiovascular function, integumentary status, or positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient's current environmental demands; or (3) health and safety risks for the recipient;

D. have expected outcomes that are functional, realistic, relevant, and transferable to the recipient's current or anticipated environment, such as home, school, community, and work, and be consistent with community standards; and

E. meet at least one of the criteria in sub items (1) to (3):

(1) prevent deterioration and sustain function; (2) provide interventions, in the case of a chronic or progressive disability, that enable the recipient to live at the recipient's highest level of independence; or (3) provide treatment interventions for recipients who are progressing but not at a rate comparable to the expectations of restorative care.

Appendix C

Mental Health-Targeted Case Management

Eligible MH-TCM Recipients

An individual, or the child's family, is generally interested in, or referred to, case management services because the adult is looking for help in coping with the mental illness or emotional disturbance, and finding services and resources to support the individual in living independently and accomplishing goals. Typically, the adult's mental illness, or the child's emotional disturbance, has caused significant disruptive periods in the individual's life and functional impairment. The symptoms of the mental illness and the resulting problems with coping may have resulted in psychiatric hospitalizations, residential treatment, crisis situations. Adults receiving AMH-TCM typically have diagnosis of major depression, bipolar disorder, or schizophrenia. More specifically, MH-TCM services are targeted for adults with a "serious and persistent mental illness." Serious and persistent mental illness is defined in Minnesota Statute (M.S.) 245.462 Subdivision 20, and children with "severe emotional disturbance". Severe emotional disturbance is defined in Minnesota Statute 245.4871 Subdivision 6. Children's MH-TCM is a service for children up to age 18 (with possible extension to age 21). Adult MH-TCM is for adults age 18 and older. There is no upper age limit. MH-TCM is a covered service for eligible enrollees in fee-for-service and prepaid (managed care) Minnesota Health Care Programs, such as MinnesotaCare and Medical Assistance. If an individual's private health insurance does not cover AMH-TCM services or if the individual is uninsured, the eligible individual can obtain MH-TCM services through their county human services department.

How to Access Services

Individuals, or their family or friends or service providers, who think that the individual might benefit from MH-TCM services, can obtain more information by contacting the social/human services department of the county of residence, or tribal government of the tribe that the individual is a member of, or the MCO that the individual is a member of. Eligibility for and the appropriateness of MH-TCM services will need to be determined. This includes an interview with the adult or child and family. A diagnostic assessment will need to be completed (or if there is a current diagnostic assessment completed within 180 days, it will need to obtained and reviewed). The county, tribal government or MCO must assist the individual in obtaining a diagnostic assessment, if needed. In the "fee-for-service" model, the county, as the Local Mental Health Authority, determines eligibility for MH-TCM for county residents. The tribal government can determine eligibility for MH-TCM for tribal members to be provided MH-TCM by the tribal authority enrolled in the MHCP as a recognized provider or a provider agency contracted by the tribe. In the "fee-for-service" model, as the Local Mental Health Authority, a county is responsible for the provision of adult MH-TCM to eligible residents, including individuals without insurance coverage or insurance coverage that does not cover MH-TCM, of the county. In the "pre-paid managed care" model, the managed care organization (MCO) (health plan or county-based purchasing organization), or an entity designated by the MCO, determines eligibility for MH-TM for the MCO's members.

A new diagnostic assessment must be completed at least every three years as part of the determination of continuing eligibility for adult MH-TCM. A new diagnostic assessment must

be completed at least every year as part of the determination of continuing eligibility for children's MH-TCM.

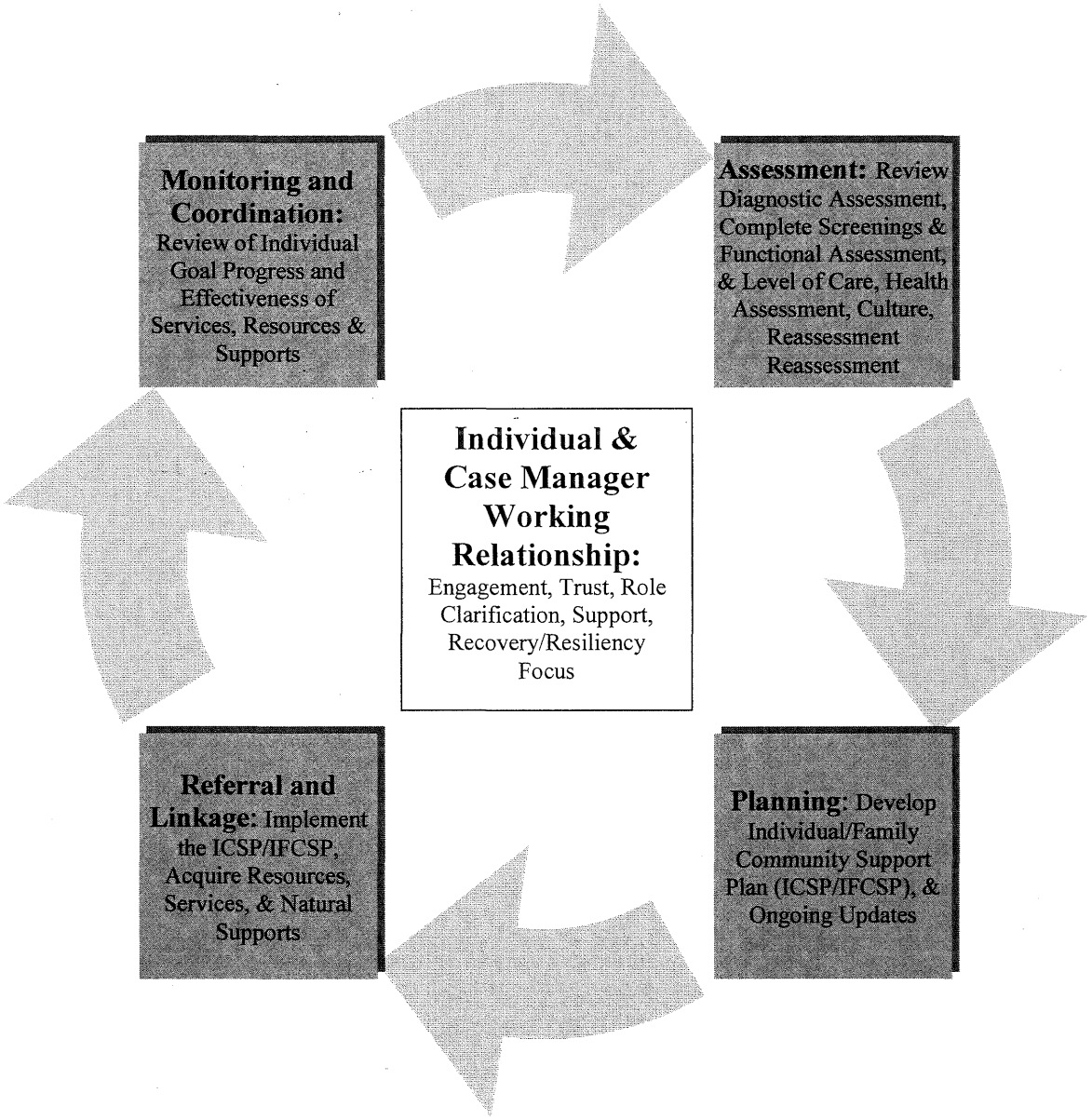
Brief definition of MH-TCM services
A case manager assists an individual, and the child's family, in identifying the individual's goals, strengths and needs; plans with the individual what services and community resources might help the individual to accomplish the individual's goals; helps refer (and often accompany) the individual to obtain services and resources; and then monitors and coordinates with those services and resources to assure that the individual is getting the help needed to accomplish the individual's goal and to address the individual needs, recovery, and resiliency.

These are the four service components to MH-TCM services that case managers provide to their clients:

1. Assessment
2. Planning
3. Referral and linkage
4. Monitoring and coordination.

Mental Health Targeted Case Management: Core Service Components and Process

"Gaining access to needed medical, social, educational, vocational, and other necessary services"



The case manager is helping the client (and child's family) to access any needed service or community resource (not just mental health services). Common services and resources include: health care coverage, affordable housing, medical/dental/vision services, financial benefits, support groups, social clubs and organization, education/schools, vocational training programs. Services and resources that will help the individual to accomplish the individual's goals and recovery/resiliency, address needs, and support the individual's self-sufficiency and participation in community life.

Case management services are usually provided in the client's home and community and the site of services and resources that the client is being referred to. The case manager usually meets with the individual once or twice a month. With releases of information from the client, the case manager does lots of telephone coordination and meetings with service providers and community resources that the client is interested in and/or using.

Minnesota statute defines Mental Health Targeted Case Management services (MH-TCM) as activities that are designed to help the individual in gaining access to needed medical, social, educational, vocational, and other necessary services as they relate to the client's mental health needs. Case management services include developing a functional assessment, and individual/family community support plan, referring and assisting the person to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

Mental Health Targeted Case Management is not:

☐ therapy or rehabilitation services;
☐ teaching basic living skills;
☐ legal services;
☐ performing a diagnostic assessment;
☐ administration, management or monitoring of a client's medications; or
☐ transportation services.

MH-TCM Billing

MH-TCM Billing Procedures

Bill MH-TCM services online using MN–ITS 837P
Counties and county-contracted vendors: Bill one claim per month.
Tribes and FQHCs: Bill one claim per encounter. Enter the date of service.
Do not enter a treating provider NPI number on each line item.

In fee-for-services, MH-TCM (non-tribe run provider agency) reimbursement is a monthly rate paid if at least one qualifying case management core service component is provided consistent with the ICSP/IFCSP goals in at least one face-to-face contact with the client during that month: OR, for adult recipients, at least a telephone contact within which at least one case management core service component is provided consistent with the ICSP goals with the client, plus at least one qualifying face-to-face contact with the client has occurred within the preceding two months.

MH-TCM claims will deny when a face-to-face contact occurs within the preceding two months prior to a change in eligibility status and the first contact under the new eligibility status (if client changes provider agency, county, MCO) is a telephone contact. For reimbursement during the month, there needs to be a face-to-face contact in the month when there is a change in eligibility state. Providers must resubmit the claim with case notes documenting the face-to-face contact using the AUC cover sheet.

Mental Health Targeted Case Management Services

Procedure Code	Modifier	Service Name	Provider	Unit	Rate
T1017	HE HA	Face-to-face encounter – client age 17 and under with a SED	Indian Health Service – 638 or FQHC Case Manager; Case Manager Associate	Face-to-face encounter where qualifying MH-TCM service provided to tribe member	Federal encounter rate
T1017	HE	Face-to-face encounter – client age 18 or over with a SPMI	Indian Health Service – 638 or FQHC Case Manager; Case Manager Associate	Face-to-face encounter where qualifying MH-TCM service provided to tribe member	Federal encounter rate
T2023	HE HA	Face-to-face contact – client age 17 and under with a SED	County or county-contracted or tribe-contracted entity; case manager; case manager associate	1 unit per month**	County monthly rate determined by annual DHS MH-TCM time study. County-contracted or tribe-contracted monthly rate negotiated by county or tribe with provider, and approved by DHS.
T2023	HE	Face-to-face contact – client age 18 or over with SPMI	County or county-contracted or tribe-contracted entity; case manager; case manager associate	1 unit per month*	County monthly rate determined by annual DHS MH-TCM time study. County-contracted or tribe-contracted monthly rate negotiated by county or tribe with provider, and approved by DHS.
T2023	HE U4	Telephone contact – client age 18 or over with SPMI	County or county-contracted or tribe-contracted entity; case manager; case	1 unit per month*	County monthly rate determined by annual time study. County-contracted or tribe-contracted monthly rate negotiated by

			manager associate		county or tribe, and approved by DHS.

* A face-to-face contact is required in at least one month out of a quarter. MH-TCM claims will deny when a face-to-face contact occurs within the preceding two months prior to a change in eligibility status and the first contact under the new eligibility status is a telephone contact. Providers must resubmit the claim with case notes documenting the face-to-face contact using the AUC cover sheet.

** The adult rate for MH-TCM is paid for MH-TCM services (children or adult) to recipients over the age of 17.whether provided by an adult or children's MH-TCM provider agency.

Note: In "pre-paid managed care" model, the MCO-contracted provider of MH-TCM is reimbursed a monthly rate negotiated between the provider agency and the MCO. The monthly rate is paid if at least one case management core service component is provided consistent with the recipient's ICSP in at least one face-to-face contact with the recipient during the month. MCOs have the option to reimburse with "tiered" monthly rates based on the MH-TCM service intensity or recipient level of care need. The MCO determines if telephone contact with the recipient will be a reimbursed service.

The provider agency bills and is reimbursed by the MCO; not DHS. DHS pays the MCO a capitation to manage health care services, including MH-TCM, for the enrollees of the MCO.

Other MH-TCM billing considerations:

Financial responsibility: A MH-TCM provider must be sure that it has a contract or authorization from the entity that is financially responsible to pay for MH-TCM to the individual adult. Some individuals eligible for MH-TCM might be temporarily residing in a county to obtain treatment or other services in that county. However, that county may not be the county of financial responsibility.

Telemedicine Delivery of Mental Health Services: Effective October 1, 2006, MHCP covers delivery of mental health services through telemedicine

Use of telemedicine can qualify as a planned "telephone contact &2023 HE U4" for purpose of billing adult MH-TCM services. Videoconferencing does not qualify as the required "face-to-face" contact for purposes of billing MH-TCM services.

Use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Team MH-TCM: From 256B.0625 Subd.20 Payment for mental health case management provided by vendors who contract with a county shall be based on a monthly rate negotiated by the host county, and approved by DHS. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.