

## **Treatment Foster Care Case Management Questions from 2007 Training**

### **1. How do you handle not getting information from the locality?**

The provider is responsible to acquire any information necessary to meet Medicaid requirements. This issue may be something you address with the locality in your contract to provide services.

### **1. Why does KePRO need the name of the locality?**

KePRO will take the locality code submitted by the provider and send it to the DMAS fiscal agent, First Health Services. The locality designated by the provider is considered fiscally responsible for the child. If the incorrect locality code is provided to KePRO, it must be corrected, since this will have some financial impact on the designated locality.

### **2. If a child has been in placement for 45 days or more, is it an Initial Review or a Continued Stay Review?**

If a child has been with the TFC-CM agency for 45 days or more, an Initial Review is required. Information on the FAPT assessment, as well as information on the Comprehensive Treatment and Service Plan and face-to-face visits must be addressed on the request for authorization.

### **3. Do you have to send the FAPT info in to KePRO for a child who has been in placement for 45 days or longer?**

No, the FAPT is no longer required to be submitted to KePRO. The date of the FAPT assessment completion should be indicated on the KePRO fax form.

### **4. When is the FAPT assessment considered complete?**

The FAPT assessment is required to be signed by at least 3 members of the team. The date of the last signer of the assessment is the date the assessment is effective. Each signer should date their signature.

### **5. Who makes up the three FAPT members?**

The locality determines who composes the FAPT.

### **6. Can the IFSP be attached to the FAPT assessment as an update to an older FAPT?**

Yes, as long as the IFSP is current and signed and dated by the required 3 FAPT members and contains the required elements.

### **7. Which signature in file is most important (POC or CM notes) and must it always be dated?**

All medical record documentation requires a dated signature by the provider of the service on the date of completion.

### **8. If you have several CAFAS' in file but one does not meet the moderate/severe impairment criteria, do you bill for the entire period of time all the CAFAS' cover, even if one shows improvement?**

For the initial review, at least one moderate impairment score on the CAFAS in other than the school subscale is necessary. For continued stay reviews the CAFAS score is not the determining factor. The child must have a need for the case management services, and benefit from the service, and this must be documented in the medical record and in the communications with KePRO.

### **9. Does the provider need an updated CAFAS or PECFAS?**

A current CAFAS or PECFAS is required for authorization of Initial and Continued Stay Reviews.

**10. How do you handle the instance where the CAFAS only covers part of the month? How do you bill?**

DMAS now reimburses on a monthly basis, so a provider would not bill until the month is complete. The CAFAS is expected to be completed every 90 days. The provider should ensure the CAFAS is updated timely when seeking Medicaid reimbursement.

**11. Please explain the billing of services if the child's CAFAS scores go down?**

If the child continues to need case management services to support the improvement and this is supported in the medical record, the services may continue. If there are few, if any, services being provided which the case manager facilitates, the billing for the service should be ended.

**12. Is the Reimbursement Rate Certificate required to be kept on file?**

For dates of service March 1, 2007 forward, the Certificate is no longer required. As of March 1, the payment rate is a set monthly rate, currently \$326.50. The Certificate is required for all dates of service prior to March 1, 2007.

**13. What is the number of required contacts per month?**

At least 2 face-to-face contacts with the child must occur each month. One of these must include the child and at least one treatment foster parent.

**14. The two visits face-to-face, is it per week or per month?**

Per month.

**15. How should two different providers handle billing for services, when there is a discharge? Does it deal with who had the patient the longest or which provider meets all the criteria to bill?**

The first provider who has authorization for the month is eligible to submit payment, as long as they have met DMAS criteria for the service. If the child is discharged during the month and admitted to another provider, and the first provider has an authorization, or if the provider has billed, the new provider is not eligible to be authorized, or to be reimbursed for the rest of the month.

**16. Does KePRO consider TFC-CM and Intensive In-Home to be on the same level?**

They both have case management as a component of the service, so would be considered a duplication of services if both provided, without consideration of the payment source.

**17. Can providers do TFC-CM and school based CM and bill for both at same time? Can you have two different case managers in this instance?**

No, it is not acceptable to bill a duplication of services. There should be only one case manager who is facilitating services. When audited, retractions will be made for duplication of services.

**18. What if the treatment plan clearly states treatment is home-based psychotherapy. Can this be provided along with TFC-CM?**

Medicaid reimbursement of psychotherapy in the treatment foster home is possible if the outpatient psychiatric service prior authorization request stipulates the services would be provided in the home. This should be documented as medically justified and should be the exception, not the norm.

If the locality chooses to reimburse for therapy in the home, and Medicaid is reimbursing for the case management, this is appropriate as long as there is no case management component to the therapy reimbursed by the locality.

**19. If a child is transitioning back to a family or prior custodian, can they receive Intensive In-Home Services?**

No they cannot. The Intensive In-Home provider could do the assessment prior to transition back to the home, but not provide services. The TFC agency is providing case management, and Intensive In-Home services, which includes a case management component, would be a duplication of CM services, which Medicaid does not allow.

**20. Who has the authority to restrict which one bills TFC-CM or Intensive In-Home Services? Can the locality dictate who provides the service?**

Yes, it would be the legal guardian of the child who determines which service is to be provided.

**21. Where can you find the locality codes?**

**22.** The locality codes are listed at the back of the TFC-CM fax form and in Chapter I of all of the Medicaid manuals under Exhibits.

**23. Does Medicaid cover mentoring?**

No.

**24. Does Medicaid cover transportation?**

Yes, Medicaid covers transportation for medical appointments for the recipient. It does not cover transport for the case manager.

The recipient (or their representative) would call the transportation contractor, Logisticare, at 866-386-8331 to arrange transport.

**25. If a child is discharged from one provider and moved to another provider, does the request for authorization within 10 days of admission still apply?**

Yes.

**26. How does an agency find out if another agency has an authorization to bill?**

Call the DMAS Provider Helpline at 800-552-8627 or locally at 786-6273.

**27. Is there a minimum amount of time for a provider to close a case for a transfer of a child leaving TFC-CM or to go to another level of care?**

DMAS recommends notice of discharge is sent to KePRO within one week of discharge.

**28. If the agency reduces the services to a child who is improving, can TFC-CM continue?**

If the child continues to need case management services to support the improvement and this is supported in the medical record, the services may continue. If there are few, if any, services being provided which the case manager facilitates, the billing for the service should be ended.

**29. What is the purpose of continued stay reviews?**

Authorization for the service is required, and justification for continued payment is necessary.

**30. Can the same vendor providing TFC-CM also provide Substance Abuse Services?**

Yes, as long as the vendor is enrolled as a Medicaid substance abuse services provider.

**31. Has Clifton Gunderson started TFC-CM audits?**

They are contracted to complete audits in 2008.

**32. What will providers expect and receive with an audit?**

Audits may be done on-site or they may be done as desk audits, with records to be sent in to the auditor. They may be unannounced. The auditors will provide a list of the records they plan to review. The auditors will apply DMAS criteria when reviewing documentation, to ensure services were provided as required. The auditors will compile the information they review and send the provider a summary of their findings, along with a list of any retractions that are recommended to be made. The provider will have

the right to request reconsideration of the findings and if retractions are not overturned, the right to appeal.

**33. IF TFC-CM started in 2000, can it be audited?**

Audits may entail a look back at previous years. DMAS requires medical records to be kept no less than 5 years after the date of discharge.

**34. How far do audits go back in time and do they tell you in advance what period of time will be reviewed?**

There is no set period of time. An audit may be made on only specific records, or a sample of records, or all records, and the time period will be determined by the auditor. Providers are responsible to keep medical records no less than five years after the date of discharge.

**35. Will the audit be done on a sample and include extrapolation?**

The audit can be done on only a sample of records, and at this time extrapolation is not used.

**36. If there is an audit resulting in a retraction, can the provider then bill the locality?**

No, they should not. The Psychiatric Services Manual, chapter II, page 7, states “A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state”.

**37. What impact will the lack of foster homes play in utilization review audits because there is no other home for placement?**

None. Medicaid is reimbursing for the case management service only. If the child is ready for transfer to a lesser level of care, but there are no foster homes available, this does not justify continued billing Medicaid for case management.

**38. If Medicaid denies TFC-CM PA can services be billed to CSA?**

If the reason for the denial is the child does not meet medical necessity criteria for the service, this would be appropriate. If the reason for the denial is due to an untimely submission, this would not be appropriate. If the reason for the denial is due to the locality not providing required documents to the provider for PA, this would be appropriate. Also see question 36.

*For questions about DMAS psychiatric residential treatment program criteria, contact Shelley Jones at [shelley.jones@dmass.virginia.gov](mailto:shelley.jones@dmass.virginia.gov)*

*For questions about the prior authorization process, contact KePRO at 1-888-627-2864 or by e-mail at [ProviderIssues@kepro.org](mailto:ProviderIssues@kepro.org)*

*For on-going provider issues, contact DMAS at [PAUR06@DMAS.virginia.gov](mailto:PAUR06@DMAS.virginia.gov)*