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MEMORANDUM FOR HOME AND COMMUNITY BASED SERVICES STAFF AND STAKEHOLDERS

FROM: Verena Cox, Bureau Chief
Bureau of Long-Term Services and Supports

SUBJECT: Guidance for Case Management and Financial Management Services - ILW

This memorandum is to provide guidance to Home and Community Based Services (HCBS) staff and stakeholders as it relates to the authorization of Case Management (CM) and Financial Management Services (FMS) for participants enrolled in the Independent Living Waiver (ILW) (Policy 3.55).

CM Guidance:

- CM shall be authorized for **all** participants enrolled in the ILW.
- CM assists ILW participants in monitoring the provision of services in the care plan, reviewing the care plan and the participant's needs, identification of abuse, neglect and/or exploitation, and assisting the participant gaining access to needed services regardless of the funding source. For more information, see ILW Policy 3.55.
- One unit of CM shall be authorized the first full month following the authorization of the initial ILW enrollment. CM shall be reauthorized every twelve months for participants that remain enrolled in the ILW. During a reassessment, CM shall be authorized for the first full month following (re)authorization of services.
- If a participant enrolled in the ILW has not had CM authorized in the past twelve months, one unit of CM shall be authorized with the effective date being the first full month following the discovery.
- If there is a provider change within twelve months of a CM authorization, the new provider shall be authorized one unit of CM effective the first full month following the provider change.
- HCBS providers shall use procedure code T2024 U6 when billing for CM. HCBS providers shall use the same National Provider Identifier (NPI) for CM as is used for Consumer Directed Services (CDS).

FMS Guidance:

- One unit of FMS equals one month of FMS (Policy 3.00, Appendix 1).

- FMS assists ILW participants to facilitate the employment of personal care attendants and provide administrative assistance on behalf of the ILW participant in regards to payroll functions and other supportive services. For more information, see ILW Policy 3.55.
- The ILW participant must be authorized for *Consumer Directed Personal Care, Independent Living Waiver* (as shown in the HCBS Web Tool) in order to be authorized for FMS, as the FMS authorization automatically populates when *Consumer Directed Personal Care, Independent Living Waiver* is added to the care plan. Therefore, the FMS authorization cannot be added or removed independent of the *Consumer Directed Personal Care, Independent Living Waiver* authorization.
- HCBS providers shall use procedure code T2040 U6 when billing for FMS. HCBS providers shall use the same NPI for FMS as is used for CDS.

Increasing Compliance:

- Division of Senior and Disability Services (DSDS) staff shall notify HBCS providers when CM and/or FMS is added to a care plan to allow the provider to make staffing arrangements to deliver the service.
- DSDS staff shall notify the HCBS provider when CM is removed, or if a participant is no longer enrolled in the ILW.
- When notifying HCBS providers of the authorization of the ILW service, DSDS staff are encouraged to inform and emphasize that it is the responsibility of the provider to deliver CM and FMS, and bill accordingly.
- HCBS providers shall refer to the ILW Policy 3.55 for detailed examples of CM and FMS activities.
- HCBS providers are responsible for billing for CM and FMS.

Information for HCBS Providers:

CDS providers must be enrolled as an Independent Living Waiver provider to bill for CM and FMS. To be considered for the Independent Living Waiver, currently-enrolled CDS providers must complete the FMS addendum and fax to Missouri Medicaid Audit and Compliance (MMAC) Provider Enrollment at 573-634-3105.

- The Financial Management Services (FMS) Addendum is located at MMAC's Provider Enrollment Applications and Forms webpage https://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/provider-contracts-forms/

Questions from Providers:

- Questions regarding provider enrollment shall be emailed to MMAC Provider Contracts Unit at MMAC.IHSCONTRACTS@dss.mo.gov.
- MO HealthNet-enrolled providers may address questions regarding claim filing, claims resolution and disposition, and participant verification by calling MMAC Provider Communications at (ph) 573-751-2896.

Additional program information can be found at:

- MO HealthNet webpage: https://dss.mo.gov/mhd/
- MO HealthNet Fee-For-Service Providers webpage: https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm
- MMAC Provider Information webpage: https://mmac.mo.gov/

Questions regarding this memorandum should be directed to the Bureau of Long Term Services and Supports (BLTSS) via e-mail at LTSS@health.mo.gov.

VC/sb