

MEMORANDUM

TEXAS DEPARTMENT OF HUMAN SERVICES

SUBJECT: Community Care Policy Clarification CBA/HCSS 99012, CCAD 99009

TO:
Regional Directors
Aged & Disabled Services

FROM:
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Long Term Care Services
State Office W-511

DATE: March 16, 1999

The following questions request clarification on coordination of Medicaid Home Health services from the Texas Department of Health (TDH) and Community Based Alternatives (CBA) services.

Policy Question 1:

Is there a difference between what Medicaid Home Health will cover if a CBA participant has Medicare and Medicaid, or Medicaid Qualified Medicare Beneficiary (MQMB), or Medicaid only? (If there is a difference in items covered, CBA case managers need additional information regarding these differences).

Policy Clarification 1:

Yes, a CBA participant's coverage makes a difference in what is covered.

- For Medicare/Medicaid recipients, Medicare must be utilized as the primary resource for payment of home health benefits.
- For recipients with MQMB coverage, Medicaid pays the deductible and coinsurance on claims that cross over from Medicare, whether or not the service is a benefit of Medicaid.
- For recipients who have Medicare and Medicaid (but not MQMB), Medicaid pays the deductible. In addition, Medicaid pays the coinsurance if the service is a benefit of Medicaid (according to Medicaid benefits and limitations).

It is the responsibility of Home and Community Support Services (HCSS) agency nurses to know when to access Medicare and Medicaid.

Policy Question 2:

What is the CBA case manager's responsibility in assuring that Medicaid Home Health is being utilized? Many of the HCSS agencies are not using the new Form 3676 noting homebound status nor including forms 2067s with the pre-enrollment packets or changes. Items potentially eligible through Medicaid Home Health are still being requested on the ISP attachment. Are case managers expected to contact the HCSS agency and request a reason for not utilizing Medicaid Home Health?

Policy Clarification 2:

The case manager's responsibility is to determine if the HCSS agency has assessed the applicant/participant for being homebound as a beginning qualifier for Medicaid Home Health. The case manager must submit to the HCSS agency the revised Form 3676, CBA Pre-Enrollment Home Health Assessment Authorization, as authorization for an assessment. If the agency assesses that the applicant does not meet the homebound requirement and enters "No" in item 6, and if the case manager considers the client to be homebound, a referral is made to the regional nurse for follow up. The rationale for not being homebound should be entered on Form 3676 in the Comments section by the HCSS agency registered nurse (RN) at the pre-enrollment home health assessment. For service plan changes and at the annual reassessment, the rationale for not being homebound is entered on a Form 2067 by the HCSS agency RN. All rationales for not billing Medicaid Home Health are subject to review by DHS nurses upon request from the case manager as stated in Information Letter 98-04, dated June 1, 1998.

Policy Question 3:

If an HCSS agency requests an item that appears to be covered under Medicaid Home Health but does not submit any documentation indicating Medicaid Home Health was accessed, should the case manager send the request back to the HCSS agency and ask them to access Medicaid Home Health if they have not, or provide documentation of the denial of Medicaid Home Health if they did? How long should the case manager wait to hear from the HCSS agency before authorizing the item on the individual service plan (ISP) (especially if it is a one time type item?) What is the case manager's responsibility regarding a Form 2065 to the participant for these type requests not associated with the initial or reassessment ISP?

Policy Clarification 3:

If CBA procedures are followed by the HCSS agencies, the case managers will have supporting documentation of Medicaid being accessed.

If the case manager identifies an item or item(s) requested on the CBA ISP that may be covered under Medicaid, he can request review from the regional nurse as stated in Information Letter 98-04, dated June 1, 1998, page 4. The regional nurse should follow up with the HCSS agency and send the request back to the HCSS agency if determined appropriate for a Medicaid referral.

The procedure that HCSS agencies are to follow when requesting items covered under Medicaid is explained in Information Letter 98-04, dated June 1, 1998, Attachment I.

National heritage Insurance Company (NHIC) has a 24 hr. turnaround for prior authorization requests. If the prior authorization is requested by fax, an approval response will go out in the mail to the HCSS agency within 24 hrs. of receipt of the prior authorization by Medicaid Home Health. If the prior authorization is requested by telephone, an approval may be given immediately or within 24 hrs. NHIC sends written denial notices to clients only.

Considering the above, the case manager should hear from the HCSS agency within 2-5 DHS work days as to the requested items being approved or denied.

The case manager's responsibility regarding a Form 2065 has not changed. Whenever an item is denied through CBA, the case manager must give the client proper denial notice on a Form 2065 with his right to appeal.

Policy Question 4:

Can a durable medical equipment (DME) company refuse to supply items to call CBA participant because Medicaid Home Health will not pay the full cost of the item? Can CBA provide the item if the DME refuses, or can the DME provide the items and the HCSS agency request the difference be paid by CBA funds? Are the suppliers bound by Medicaid/Medicare assignment?

Policy Clarification 4:

No, Medicaid providers cannot refuse to supply items if Medicaid does not pay the full cost of the item. Medicaid providers agree to accept Medicaid payment as payment in full.

Yes, Medicare/Medicaid suppliers are bound by Medicare/Medicaid assignment.

Policy Question 5:

Should a referral be made to TDH if a DME provider refuses to supply Medicaid items to a Medicaid recipient? If yes, to whom should the referral be made?

Policy Clarification 5:

Yes. If the client is the one reporting the problem, they can call the Medicaid hotline at 1-800-252-8263. If it is a matter of educating the provider and if the reporting person is from DHS, they can call TDH at (512) 338-6520 or (512) 338-6504 and request that the HCSS NHIC provider representative educate the provider regarding his assignment to provide Medicaid. If it is apparent to a DHS staff person that the DME provider is knowledgeable of his assignment with Medicaid but is still refusing to supply Medicaid products to Medicaid recipients, the DHS staff person should call Health and Human Services, Medicaid Program Integrity, at (512) 490-0421 or (512) 490-0402 and make a referral for follow up.

Policy Question 6:

In most instances, does Medicaid pay what Medicare doesn't pay on a claim?

Policy Clarification 6:

The determination for payment is made on a case to case basis by NHIC staff based on the criteria for payment found in the Texas Medicaid Provider Procedures Manual which represents policy of the Texas Medicaid program.

If you should have any questions, contact your CBA contact person.

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Becky Beechinor

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