Targeted Case Management - Recuperative Care

Effective September 1, 2024

"Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time."

-Provider Relations

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Background

Targeted Case Management (TCM) - Recuperative Care (RC)

[Michigan Medicaid Policy (MMP) 24-27]

Targeted Case Management (TCM) Recuperative Care (RC) is a short-term transitional program for Medicaid beneficiaries meeting eligibility requirements, experiencing homelessness and are discharging from an inpatient hospital admission.

Beneficiaries too ill or frail to return to their living environment but are not eligible to continue hospital-level care, skilled nursing care, or other inpatient Medicaid services.

- **Eligible population**:
  - Beneficiaries must be over 18 years old.
  - Meet Medicaid eligibility requirements.
  - Experiencing homelessness and Discharging from an inpatient hospital
  - Beneficiaries must be medically stable, independently mobile, and be able to managed and perform their own activities of daily living (ADLs)
  - Beneficiaries must be able to manage medications and DME independently.
  - Require ongoing case management and support.
  - Beneficiaries must be at risk for re-hospitalization or severe complications without the support of RC services.
  - Not eligible for continued hospitalization or another inpatient or higher acuity setting; such as a Nursing Facility.

- **Recuperative Care covered for the eligible population enrolled with:**
  - Fee-For-Service (FFS) Medicaid
  - Healthy Michigan Plan
  - Managed Care

*Emergency Service Only, Plan First, and other limited coverage plans are **excluded** from coverage for recuperative care.

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Provider Requirements

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Recuperative Care Provider Requirements

- CHAMPS > MDHHS Provider Enrollment page.
- Standards for Medical Respite Care Programs - National Institute for Medical Respite Care (nimrc.org)

RC providers seeking Medicaid reimbursement:

- Must be enrolled with MDHHS > Obtain a Type 2 (Organization) National Provider Identifier (NPI) and enroll in CHAMPS.
- Meet the National Institute for Medical Respite Care (NIMRC) standards for medical respite care programs.
- Complete the Michigan Recuperative Care Provider Attestation Form (BPHASA-2428) along with providing any requested documentation.
  - Must complete the attestation every 3 years.
  - Must revalidate every 5 years in CHAMPS.

- An RC provider will provide:
  - Case Management
  - Room and Board
  - Coordination of medical care and Medicaid services.

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RC Provider Responsibilities

Recuperative Care Provider must have:

- Private or semi-private rooms for Medicaid beneficiaries
- Allow 24-hour access to rooms
- Clean linens for each beneficiary upon admission
- At least three meals per day must be provided
- Secure place to store personal belongings
- Secure medication storage accessible by the beneficiary
- Appropriate storage for all durable medical equipment (DME)
- On-site access to laundry and shower facilities
- 24-hour access to staff, and staff on-site who are minimally trained in first aid and basic life support on-site at all times
- Written policies to allow beneficiary visitors to enter the facility/room
- Written policies and procedures for life-threatening emergencies
- A facility that is compliant with local and state fire safety standards.

Prior Authorization

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Prior Authorization

- **Contact PRD Recuperative Care phone numbe**r: 844-732-8764
- **FFS Beneficiaries** – Prior authorization (PA) must be obtained from PRD for care coordination (**G9002**) and room & board (**S9976**).
- **Medicaid Health Plan (MHP) Beneficiaries** – PA must be obtained from PRD for only room & board (**S9976**).

- Recuperative Care services must be authorized by the MDHHS Program Review Division (PRD) prior to the start of services for all beneficiaries.
- Prior to requesting a prior authorization, the RC provider must complete the Recuperative Care Prior Authorization Request Data Form (BPHASA-2427) and maintain it in the beneficiary's record.
- RC services are authorized and billed per day.
- RC coverage will not exceed 90 days per hospital discharge.
- Reference Michigan Medicaid Policy (MMP) 24-27 for additional details on the documents to have available when requesting authorization during the telephonic review.

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Prior Authorization Request Determinations

- If the RC provider does not provide complete information needed during the telephonic request, no determination will be possible, and the provider must contact the PRD RC phone line at a later date when complete information can be provided.

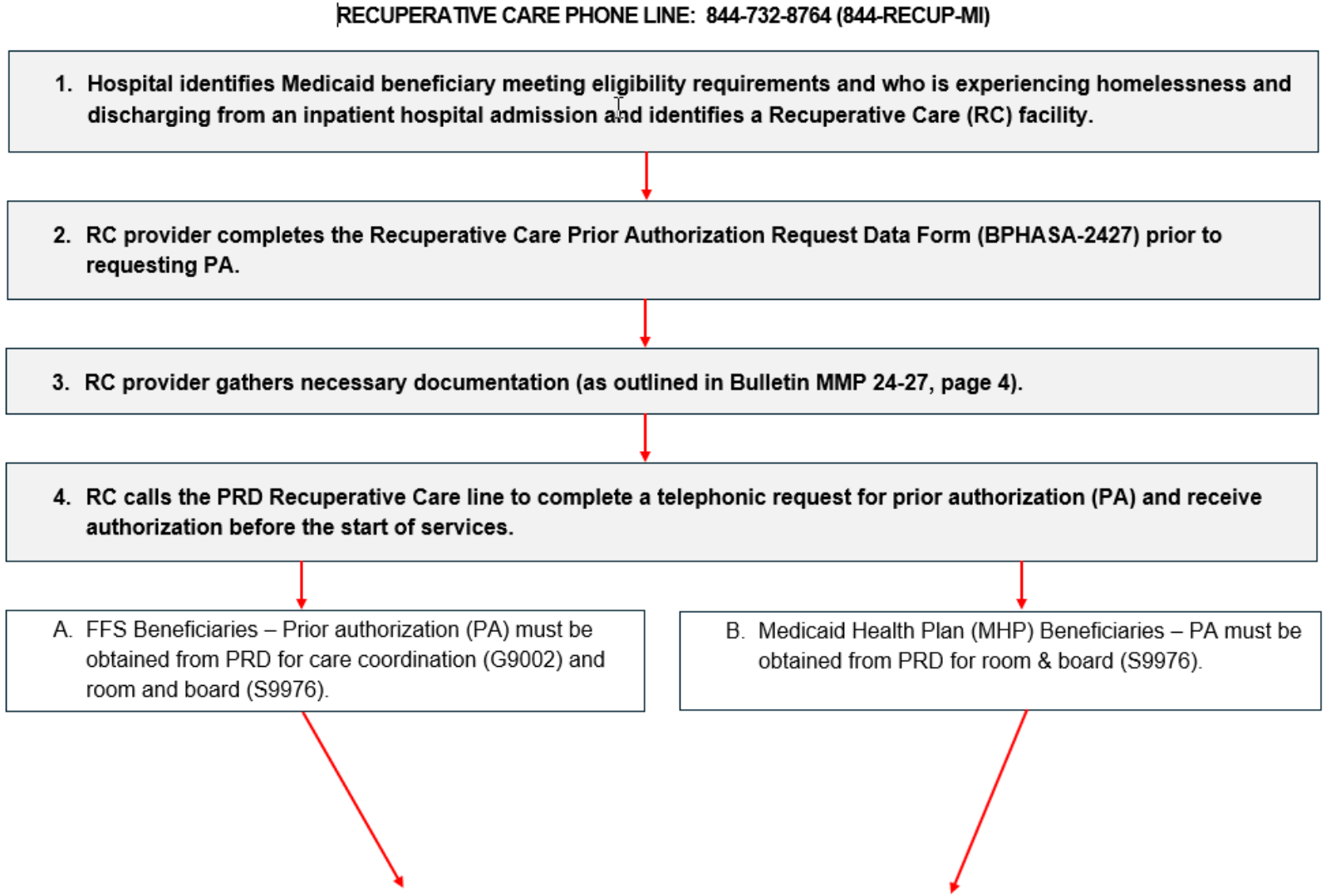
Approval of RC services

- The provider will be issued an authorization number and end date at the conclusion of the telephonic request.
- The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDHHS will not reimburse the provider for services provided and billed.
- To ensure payment, the provider must verify beneficiary eligibility monthly at a minimum.
- If a beneficiary is re-hospitalized during a PA period, upon discharge, RC services may be resumed with the same RC provider without requiring a new PA. Extension of a PA interrupted by a re-hospitalization will be reviewed and considered on an individual basis.
    - Extension of a PA beyond 90 days will be considered on an individual basis.

Denial of RC Services

- If services are denied, the RC provider will be informed of the denial.
- The beneficiary will be sent a letter notifying them of the denial with an explanation of their appeal rights. A copy of the letter will be sent to the RC provider.

Prior Authorization Workflow



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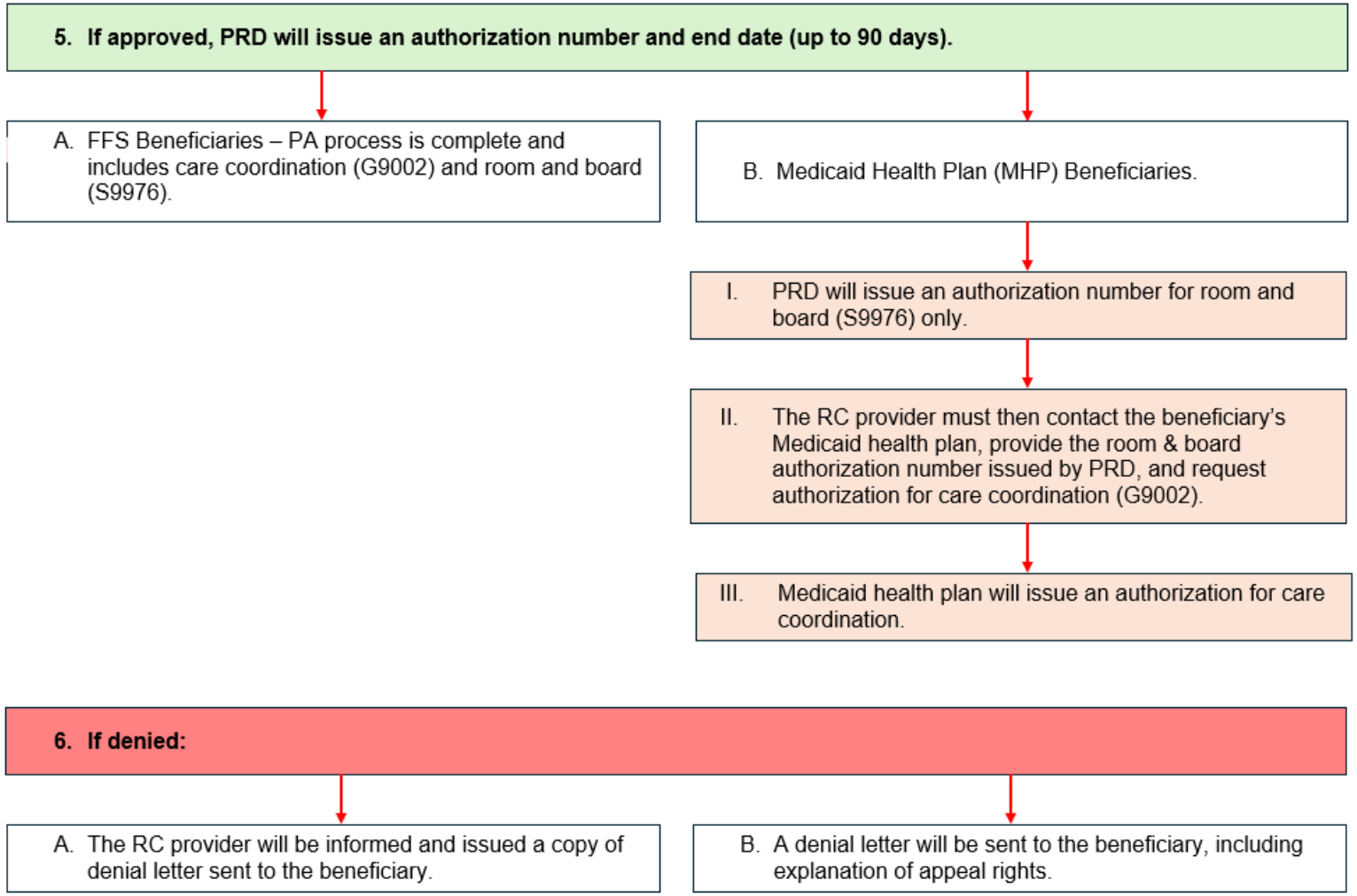
Prior Authorization Workflow



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Covered and Non-Covered Services

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Covered Services

- The purpose of TCM RC services: Provide a comprehensive array of case management services that are appropriate to the conditions of the beneficiary, and to provide room and board.

Covered Services - At a minimum, TCM-RC services must include:	Non-Covered Services
An in-person comprehensive assessment, history, re-assessments, and identification of a course of action to determine the specific needs of the beneficiary and to develop an individual Plan of Care (POC);	Professional services are not covered by RC.
Planning, linking, coordinating, follow-up, and monitoring to assist the beneficiary in gaining access to services;	Durable medical equipment (DME) and medical supplies are not covered by RC.
Assistance in establishing permanent housing;	
Coordination with the beneficiary's primary care provider (PCP), other providers, and MHP, as applicable;	
Room and Board	

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Billing

Billing

- Current covered RC procedure codes will be maintained on the RC fee schedule located on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Special Programs.

- RC claim will be submitted on a professional format - CMS 1500 claim form, by the Medicaid- enrolled RC provider.
- RC services are to be billed as follows:
  - S9976 (lodging per diem) 1 unit/visit per day
  - G9002 (care coordination) 1 unit/visit per day
- The PA number must be reported on the claim
- The day of admission will be reimbursed if the beneficiary is in the facility prior to midnight
- The day of discharge is not reimbursed
- For TCM, services should be billed based upon the beneficiary's enrollment. Example: FFS – billed to FFS, Managed care- billed to managed care.
- For room and board, both MHP and FFS enrolled beneficiary claims should be submitted through CHAMPS for FFS reimbursement.

Discharge from Services

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Discharge from Services

- Managed Long-Term Services and Supports (MLTSS)
- Long-term services and supports (LTSS): Assistance with an individual's everyday activities of living to help them remain as independent as possible.
- When LTSS is provided under a managed care, this is referenced as Managed LTSS.
- Under the MLTSS system, managed care plans, under contract with the State, coordinate the delivery of all approved supports and services for each program participant.

- RC providers must ensure either one of the following before discharging a beneficiary from RC services:
  - The beneficiary's medical condition has improved.
  - The beneficiary is being discharged to another setting that can meet their needs.
- **Note**: The beneficiary may choose to discharge at any time or with no housing option if that is their choice.

Provider Resources

MDHHS website:
www.michigan.gov/medicaidproviders

We continue to update our Provider Resources:

- CHAMPS Resources
- Listserv Instructions
- Provider Alerts
- Medicaid Provider Training Sessions

Provider Support:

ProviderSupport@Michigan.gov
1-800-292-2550

Thank you for participating in the Michigan Medicaid Program