Manual

For

Early and Periodic Screening, Diagnosis

and Treatment

Medically Fragile Case Management

and Expanded EPSDT Services

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MEDICALLY FRAGILE CASE MANAGEMENT
FOR EPSDT INDIVIDUALS

I. GENERAL INFORMATION

A. What is Medicaid?

1. State/Federal funded program to provide medical care/services/items to Medicaid recipients:

   Fee-for-service: Aged, Blind and Disabled (ABD)

   Managed Care: QUEST Health Plans

   Includes mandatory and optional benefits

2. Role of Med-QUEST Division (MQD), Department of Human Services (DHS)

   Authorizes and reimburses for Medicaid services.

   Does not provide direct-care services.

B. What is EPSDT?

Medicaid's child health services for Medicaid individuals under 21 years of age.

Specifics about the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program:

1. Informing of families

2. OBRA 1989 Requirements:

   Services obtained through an EPSDT screen

   No limitations on frequency and/or amount if the service is medically necessary

No limitations on services IF the service is allowable under Medicaid's EPSDT rules & regulations

3. The following optional services are also available to EPSDT individuals, (but not to Medicaid recipients age 21 and older):

   a. Case Management

   b. Skilled Nursing

   c. Personal Care

   d. Chiropractic services

C. What is the definition of Case Management as used by the Medicaid Program

Sections 1905(a)(19) and 1915(g)(2) of the Social Security Act (the Act) define case management as services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services. Activities commonly understood to be allowable include: (1) assessment of the eligible individual to determine service needs, (2) development of a specific care plan, (3) referral and related activities to help the individual obtain needed services, and (4) monitoring and follow-up.

Assessment: This component includes activities that focus on need identification. Activities include assessment of an eligible individual to determine the need for any medical, educational, social, and other services. Specific assessment activities include taking client history, identifying the needs of the individual, and completing related documentation. It also includes gathering information from other sources such as family members, medical providers, and education, if necessary, to form a complete assessment of the Medicaid-eligible individual.

Care Planning: This component builds on the information collected through the assessment phase, and, includes activities such as ensuring the active participation of the Medicaid-eligible individual, and working with the individual and others to develop goals and identify a course of action to respond to the assessed needs of the Medicaid-eligible individual. The goals and actions in the care plan should address medical, social, educational, and other services needed by the Medical-eligible individual.

Referral and Linkage: This component includes activities that help link Medicaid-eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services. For

example, making referrals to providers for needed services and scheduling appointments may be considered case management.

Monitoring and Follow-up: This component includes activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the Medicaid-eligible individual. The activities and contacts may be with the Medicaid-eligible individual, family members, providers, or other entities. These may be as frequent as necessary to help determine such things as (i) whether services are being furnished in accordance with a Medicaid-eligible individual's care plan, (ii) the adequacy of the services in the care plan, and (iii) changes in the needs or status of the Medicaid-eligible individual. This function includes making necessary adjustments in the care plan and service arrangements with providers.

D. Who Qualifies for Medically Fragile (MF) Case Management Services?

Medically Fragile Case Management is covered when an individual meets the following conditions:

a. Eligible for medical assistance from the Department and under 21 years of age;

b. Determined medically fragile and has a medical need for case management due to the medical condition of the individual, and the need for coordination of multiple medical services/items;

c. Able to safely reside in a home or foster home and does not need to be cared for in a facility for medical reasons;

d. Unable to and cannot reside safely in a home without receiving specialized medical services/items in the home; and

e. The provisions of such services will improve the care the family and service providers furnish to the individual, and enable the individual to remain in the home safely.

E. Qualifications of the Medically Fragile Case Management Provider

1. The MF case manager IS THE PRIMARY CASE MANAGER OF THE EPSDT INDIVIDUAL and must be a Medicaid provider.

2. The MF case management provider must be an entity that employs licensed professional nurses, and/or licensed physicians. The nurse must work with a physician. The physician may by an employer, a consultant to the nursing staff, an employee, or the recipient's physician.

3. In all cases, the primary case manager must be a licensed professional nurse or a licensed physician.

4. Although case management services may be provided by the staff of the entity, the licensed professional nurse and/or physician must supervise, consult, and/or advise the staff providing the activities.

5. The assessment of the patient's medical condition must be performed by a licensed professional nurse or licensed physician.

F. Responsibilities of the Medically Fragile Case Manager

1. Assessment:

Medically fragile children in the community and their families have specialized needs that may change over time as the child grows and develops, and the family's circumstance changes. Therefore:

a. For new referrals of ventilator dependent and tracheostomized children from acute care facilities, the MF Case Manager must participate in the assessment of the patient and the family to ensure that the child can be safely cared for in the community. The assessment will involve the participation in the discharge planning with the hospital staff and physicians, all working together in assessing the family's ability to perform the nursing care needed by the child, the suitability of the family residence, and ensuring that the services and supplies (needed by the child) can be provided.

b. The MF case manager is responsible to the MQD. He/she must have a clear understanding of the Medicaid Program, its requirements, and covered benefits. For those children who have been authorized to receive medically fragile case management services, and are living in the community, the MF Case Manager must work with the child's physician and other agencies in ensuring that the services and supplies provided to the child meets his/her current needs, and promote the child's safety in his/her home and community setting.

2. Development and Implementation of the Plan of Care

a. The MF Case Manager works closely with the attending physician, discharging facility, family, community physician, and other health care providers (i.e., home health service providers, providers of durable medical equipment and supplies) in the development and implementation of the plan of care.

b. The plan of care should detail the specific services and items involved in the care of the child.

c. The MF Case Manager organizes and plays a leadership role in meetings with the family and key health care providers in which the plan of care is reviewed, revised, and evaluated.

3. Advocacy

The MF Case Manager also serves as an advocate for the child and family. Advocacy should be directed at improving the child's quality of life and the quality of care he/she receives and assisting the family in understanding the child's needs and increasing the family's ability to advocate for their child.

4. Liaison

a. The MF Case Manager works closely with the MQD's EPSDT coordinator and medical consultants to ensure that the child receives (in a timely and appropriate manner) administrative approval for the services and supplies he/she needs to safely reside in his/her home.

b. The MF Case Manager works closely with the child's primary care physician (PCP), hospitals and hospital based physicians, and other medical specialists to ensure that parents and other caregivers clearly understand the child's plan of care and that the child receives the services he/she needs while in the home.

c. The MF Case Manager works closely with the MQD's fiscal agent to ensure that the authorization of services and supplies needed by the child, are given in a timely and appropriate manner.

d. The MF Case Manager works closely with physicians, nurses, agencies, and suppliers to link them with the MQD and ACS-Medicaid personnel who are able to help the providers settle problems relating to authorizations/claims for services.

e. The MF Case Manager is knowledgeable about the health care, social, and educational services available in the community and helps the child and family access educational services and other community resources which are appropriate for and available to the child and family.

5. Coordination of Care

The MF Case Manager works in collaboration with public health nurses, physicians, and other community providers in coordinating the care the child will need when he/she is in the home. The services/supplies to be coordinated include but are not limited to:

a. Physician services.

b. Services of ancillary health care professionals—speech therapy, physical therapy, occupational therapy

c. Services and supplies provided by vendors of durable medical equipment and medical supplies such as ventilator, ventilator supplies, oximeters, apnea monitors, suction machines, custom wheelchairs and seating arrangements, gastrostomy related supplies, dressings, incontinence supplies, etc.

d. Skilled nursing services and personal care services.

e. Transportation to and from medical care.

f. Non-health care services such as educational services, and recreational services.

g. Support services provided by other agencies.

6. Quality

a. The MF Case Manager works with the child's physician to ensure that the services provided in the home are of good quality.

b. Specifically, the MF Case Manager evaluates and monitors the quality of nursing services being provided to the child in the home

and in other community settings. Also, the MF Case Manager assesses the competency of the persons providing services and ensures that the services do not compromise the safety of the child. Concerns should be reported to the child's physician.

c. The MF Case Manager teaches the family to recognize and report problems affecting the quality of services. Also, the MF Case Manager helps the family assess the child's current needs for services in the home.

d. The MF Case Manager teaches the family to understand when the physician should be contacted and how to obtain medical care for the child on weekends, holidays, and after hours.

e. The MF Case Manager teaches the family to recognize and report problems with equipment and medical supplies used by the child and to contact appropriate suppliers for maintenance, repairs, replacement, and delivery.

G. Expectations

1. Records

The MF Case Manager must keep written documentation of his/her case management activities (assessment/reassessment, plan of care development, implementation, changes, advocacy, liaison, coordination of care, and quality).

a. Records must be dated and signed.

b. All State and Federal privacy and confidentiality requirements must be met.

2. Visits/Contacts (by phone/fax/e-mail)

The number of visits/contacts are dependent on the child's and family's needs. The expectations listed below are specific to the level of MF case management authorized.

II. FIVE LEVELS OF MEDICALLY FRAGILE CASE MANAGEMENT

A. Medically Fragile Case Management for Anticipated Tracheostomy and/or Ventilator individuals WHILE STILL IN ACUTE CARE HOSPITAL:

1. Only for initial discharge from acute care facility to a home/community based non- institutional setting:

a. At least one visit to the family and home prior to discharge must be made. Included in the evaluation of the home is the adequacy of the power (electrical) outlets, safety for oxygen use, working telephone, need for special setting, bed/crib, whether the home is large enough to accommodate the equipment the child needs, etc. Also, an evaluation of the family and its capability to care for the child identifying resources such as relatives, church group, involvement with other community service groups, etc.

b. Visits to the child and family while in the hospital to understand and learn the child's care plan. Evaluation of the family's ability to implement the care plan. No maximum number of visits.

c. All transportation, meals & lodging expenses for MF case management providers who come from neighbor islands are the responsibility of that provider.

2. Preparation for initial discharge from hospital

a. The MF case manager must work with the hospital discharge planner for discharge, including the arrangements for transportation of the patient and any hospital-based professional staff who will accompany the patient.

b. The MF case manager must ensure that the equipment/supplies are in the home and functioning prior to the child's arrival at home and be present when the child arrives from the hospital.

B. Medically Fragile Case management for ventilator-dependent or tracheostomized individuals after initial discharge from hospital

1. For the initial discharge from the hospital, the MF case manager must be present in the home upon arrival of the patient.

2. The nurse case manager must make at least three(3) home visits, and contact the family by telephone, FAX or e-mail at least four (4) times, in the first two (2) weeks following initial discharge from hospital; following subsequent hospitalizations which result in substantial changes in the patient's care plan or home care requirements; or whenever the child has an acute inter-current illness requiring intervention by the child's treating physician.

3. Otherwise, the nurse case manager must visit the patient in the home at least weekly, and contact the family by telephone or FAX at least twice per week, once the child is stable, and the caregivers in the home have demonstrated their ability to provide good care.

C. Medically Fragile Case Management for Medically Fragile individuals who are not ventilator dependent or tracheostomized.

1. This type of case management is of lesser intensity than the previous. It begins upon notification that a Medicaid child, who has been hospitalized, is being prepared for discharge to the home and is in need of case management.

2. It can also begin when a Medicaid child needing case management is identified in the community.

3. Upon authorization of MF Case Management for this client, the following are expected:

Visits and Contacts

a. Initial assessment by the nurse case manager within two days of initial discharge from the hospital.

b. Initial assessment by a nurse case manager within 1 week of acceptance of a child already in the community.

c. Weekly visits by the nurse case manager for the 2 weeks; Contact with the family at least 2 times a week by phone or fax for the first 2 weeks.

d. After the first 2 weeks, if the patient is stable and doing well: One nurse case manager visit every two (2) weeks, once a week contact with family by phone, fax or e-mail.

D. Case management for those Medically Fragile individuals who have been stable (either vent/trach or other) and have not required frequent

assessments, care plan modifications, and whose families need only intermittent assistance to access services

Visits and Contacts

One nurse case manager visit a month: twice a month contact with child and family by phone, fax or e-mail.

E. Additional case management hours provided with W9882 and W9883 to address changing medical needs.

III. CODING REQUIREMENTS FOR MF CASE MANAGEMENT SERVICES

Medically Fragile Case Management services for EPSDT individuals are identified by specific codes that are only valid for providers certified as Medically Fragile Case Management providers.

Five levels of MFCM acuity have been established for reimbursement purposes. A Medically Fragile Case Management Scoring Tool (Attachment 2) has been developed to document MFCM clinical eligibility and determine the appropriate level of acuity and procedure code. A supplemental report must be attached to the Form 1144 for Code W9884 (Attachment 1).

CODE	Description
W9880	Anticipated tracheostomy and/or ventilator dependence following discharge; no acuity-based requirements or modifiers
W9881	Tracheostomy and/or ventilator dependence, and total acuity score (TAS) of 90 or more, including at least 60 from "Medical Problems"
W9882	Non-ventilator/non-tracheostomy dependent patients with a TAS of 60 or more, including at least 30 from "Medical Problems"
W9883	Non-ventilator/non-tracheostomy dependent patient with a TAS of 40-59, including at least 20 from "Medical Problems"
W9884	Additional case management hours provided with W9882 and W9883 to address changing medical needs)

IV. AUTHORIZATION PROCESS FOR MF CASE MANAGEMENT SERVICES

The client's physician must make a prior authorization request for MF case management service. The request for approval by the Department's medical consultant(s) must include the following completed and signed documentation:

1. Form 1144, Request for Medical Authorization, signed and dated by the referring physician indicating the physician's selection of MFCM provider;

2. Medically Fragile Case Management Scoring Tool (Attachment 2);

3. Supplemental Report for Medically Fragile Case management Code W9884 when indicated (Attachment 1);

4. Medical history and discharge summary;

5. Social summary; and

6. Attach photocopy of current Prior Authorization.

V. CLAIM FILING LIMITATIONS FOR MF CASE MANAGEMENT SERVICES

Clarification of specific claims filing issues:

A. If the child requires acute care hospitalization, MF case manager services previously authorized on the form 1144 (codes W9881 and W9882) can be billed for a maximum of 1 month regardless of the length of stay at the acute care hospital. (Example: if a child is hospitalized for less than 1 month, authorized MF case manager services can be billed for one month; if a child is hospitalized for 3 months, only 1 month can be billed).

B. MF case management services for ventilator-dependent tracheostomized children (W9881) can be authorized for one month after the closure of a tracheostomy.

C. Billing for MF case management should be submitted on the Form 1500 using units. Enter 1 in Field 24G.

D. Procedure Code W9880 is allowed once per the lifetime of an individual.

E. Billing for Procedure Codes W9881, W9882 and W9883 should be monthly units on the Form 1500. Enter 1 in Field 24G.

F. No more than 10 points are allowed for Procedure Code W9884 when billed with Procedure Code W9882.

G. No more than 5 points are allowed for Procedure Code W9884 when billed with Procedure Code W9883.

VI. EXPANDED EPSDT SKILLED NURSING AND PERSONAL CARE SERVICES

A. Authorization Process

Anticipated Discharge from Acute Facility

The client's physician must make prior authorization request for Skilled Nursing (SN) or personal care (PC) service. The request for approval must include the following completed and signed documentation:

1. Form 1144 Request for Medical Authorization, signed and dated by the referring physician indicating the physician's selection of SN or PC provider,

2. Home Skilled Nursing Scoring Tool (See Attachment 3);

3. Medical History and Discharge summary; and

4. Social summary.

B. Service Hour(s) Authorization

1. The service hours may vary depending on the medical needs of the client, and generally, does not exceed 40 hrs. Per week. Generally, personal care is not authorized with skilled nursing services.

2. Ventilator dependent individuals maybe authorized for a maximum of 70 hrs. per week.

3. Tracheostomized individuals without ventilators maybe authorized for a maximum of 56 hours per week.

4. For other individuals, the number of hours varies; and generally does not exceed 40 hours per week.

C. Medically Fragile Individuals Residing In the Community

1. Documentation required for Initial Referral and Continuing Services

   a. Completed Form 1144 signed by the physician with designated SN or PC provider who will be providing the service, including medical justification for the services. Complete one line for each month of service requested and each procedure code, not to exceed a total of five months per Form 1144. Amount completed in quantity section should be total quantity for one month.

   b. Home Skilled Nursing Scoring Tool (See Attachment 3);

   c. Medical History/Summary;

   d. Social Summary; and

   e. Photocopy of current Prior Authorization.

D. Assessment for Services

1. MF case manager must assess the family/caretaker's need for the number of hours requested. Factors such as school attendance, improvement in condition, increased number of trained family/caregivers, the changing needs of the family unit, etc., must be considered in the assessment.

2. MF case manager must also assess the bonding of the family/caregiver and the child. Services requested and authorized must not undermine the parent/caregiver and child relationship.

3. Most ventilator dependent children may require 70 hours of skilled nursing hours for the first year after the initial discharge from the hospital. However, as the child becomes more stable, the case manager must prepare the family/caregiver that a reduction in the skilled nursing hours provided by Medicaid may occur.

VII. CLAIM FILING LIMITATIONS FOR EXPANDED EPSDT SERVICES

A. Using From 1500, bill each claim on a monthly basis, using the last date of the month for each service line. Itemization of service dates is not required on the claim since the billing is monthly. However, the medical records must accurately document the exact dates and time of the services.

B. Enter the authorization number in block 23-Prior Authorization Number.

C. Bill using the appropriate procedure code in block 24D.

D. The number of service units must be a whole number. Fractions are not accepted. If the number of hours rendered includes a fraction, round up to the next whole number if it is greater than or equal to .5 and round down if the fraction is less than 5.

E. Enter "E" in block 24H to designate that the service is in treatment for a condition discovered during an EPSDT examination.

F. If tax is charged, use procedure code Z9020. This must be the last line item on the claim.

G. Bill using the Medicaid provider number for expanded EPSDT service appropriate to the location. The provider number on the claim must match the provider number on the Form 1144.

ATTACHMENT 1

Department of Human Services
Med-QUEST Division
Medical Standards Branch

State of Hawaii

P.O. Box 700190
Kapolei, HI 96709-0190

Medically Fragile Case Management Acuity Levels

Code	Description
W9880	Anticipated tracheostomy and/or ventilator dependence following discharge; no acuity-based requirements or modifiers
W9881	Tracheostomy and/or ventilator dependence, and total acuity score (TAS) or 90 or more, including at least 60 from "Medical Problems"
W9882	Non-Ventilator/non-tracheostomy dependent patients with a TAS or 60 or more, including at least 30 from "Medical Problems"
W9883	Non-ventilator/non-tracheostomy dependent patient with a TAS of 40-59, including at least 20 from "Medical Problems"
W9884	Additional case management hours provided with W9882 and W9883 to address changing medical needs

Physician's signature: _____ Date: _____

Supplemental Report for
Medically Fragile Case Management W9884

Patient's Name (Last, First, M.I.)	Medicaiid ID Number	Reporting Period

Case Management Service	Points	Comments/Clarification
New Problem(s)		
Worsening of existing problem(s)		
Increase in care coordination needs due to medical or social reasons		
Increase in assistance with accessing physician/other medical professional services		

Case Management Service	Points	Comments/Clarification
Increase in assistance with accessing supplies/DME		
Increase in assistance with accessing educational/social services		
TOTAL POINTS		

POINTS A point is a measure of the extra work done by the Case Management Agency in managing care and assisting the patient/family for a given month. A point is given for each issue/problem/condition addressed. More than 1 point can be given if the issue/problem/condition is complex and justified by the Comments/Clarification you provide.

For **W9882,** no more than **10** points are allowed; For **W9883**, no more than **5** points are allowed.

Additional information/comments (optional). Please use the back of the form for additional comments/clarification.

Case Manager's signature:_____ Date _____

ATTACHMENT 2

Department of Human Services
Med-QUEST Division
Medical Standards Branch

State of Hawaii

P.O. Box 700190
Kapolei, HI 96709-0190

Medically Fragile Case Management Scoring Tool

NAME: Last	First	M.I.	Birthdate	I.D. Number

	Medical Condition	**Frequency/Complexity**	**Points**	
1	Ventilator	Continuous	50	
		Intermittent	30	
2	Tracheostomy (with or without ventilator)		40	
3	Oxygen therapy	Continuous	20	
		Intermittent	10	
4	Oropharyngeal/nasopharyngeal suctioning*	More than TID	5	
		TID or less	3	
5	Nebulization therapy	More than TID	5	
		TID or less	3	
6	Vascular access catheter	Central	25	
		Peripheral	15	
7	Parenteral nutrition	Continuous	15	
		Intermittent	10	
8	Gastrostomy/jejunostomy/nasogastric tube		10	
9	Continuous pump feeding		10	
10	Specialized oral feeding system		5	
11	Orthopedic appliance	Splint/cast	5	
		Complex	10	
12	Urinary bladder catheterization	Intermittent or continuous	5	
13	Ileostomy/colostomy		5	
14	Isolation/reverse isolation		10	
15	Oral medications	Less than 12 doses/day	2	
		12 or more doses/day	5	
16	IM/SQ medications	Less than 4 doses/day	2	
		4 or more doses/day	5	
17	Intravascular medications	Less than 4 doses/day	5	
		4 or more doses/day	8	
18	Monitors	Cardiorespiratory	10	
		Apnea	5	
		Pulse oximeter	5	
19	Restorative therapy (PT, OT, Speech)		5	
		Subtotal		

Modifiers

Circumstance		**Points**	
1	Non-English speaking	10	
2	Poor communication skills (less than 5th grade level)	10	
3	Single parent/caregiver	10	
4	Remote location (outer island, or >10 miles from primary care site)	10	
5	No automobile	5	
6	Family turmoil/dysfunction	15	
7	Following initial discharge from hospital	50**	
8	Re-admission illness requiring physician intervention	50**	
9	Intercurrent illness requiring physician intervention	20***	
10	Stable (no intercurrent illness or change in care plan for >3 months	-50	
	Subtotal		
	Total Points (Medical Condition + Modifiers)		

*In non-trach patients **For 2 weeks following discharge ***Minimum 2 weeks, until patient back to baseline health

Additional information/comments:_____

_____

Provider: _____ _Date: _____

ATTACHMENT 3

Department of Human Services
Med-QUEST Division
Medical Standards Branch

State of Hawaii

P.O. Box 700190
Kapolei, HI 96709-0190

Home Skilled Nursing Scoring Tool

NAME: Last	First	M.I.	Birthdate	I.D. Number

	Nursing Intervention	**Frequency/Complexity**	**Points**	
1	Ventilator	Continuous	50	
		Intermittent	30	
2	Tracheostomy		30	
3	Oxygen therapy		20	
4	Nebulized Medications	TID or less	10	
		>TID	20	
5	Vascular access catheter		40	
6	Parenteral nutrition	Continuous	40	
		Intermittent	30	
7	Gastrostomy/jejunostomy/nasogastric tube	Gravity feedings	20	
		Pump feedings	30	
8.	Ileostomy/colostomy		10	
9	Urinary bladder catheterization	Intermittent or continuous	10	
10	Orthopedic appliance	Splint/cast (each)	05	
		Complex (describe)	10	
11	Isolation/reverse isolation		30	
12	Enteral Medications	8 doses/day or less	05	
		>8 doses/day	10	
13	IM/SQ medications	4 doses/day or less	10	
		>4 doses/day	15	
14	IV medications	4 doses/day or less	15	
		>4 doses/day	20	
15	Monitor (Apnea, Pulse Oximeter, C-R)		20	
16.	Special Skin Care (Burn, decubiti)	Localized	05	
		Extensive (describe)	10	
17.	Wound Care (describe)		10	
18.	Less than 6 months since initial discharge (discharge date:_____)		40	
19	Less than 3 months since subsequent discharge (discharge date:_____)		30	
20	Other Specialized nursing interventions: _____ _____			
	A. Total Points			

School Attendance Information:

1. Does the child attend school? ☐Yes ☐No
2. If "Yes", number of hours per day:____ Days per week:____
3. Months per year, including Winter and Spring vacation:____
4. ***Is the child's transportation to/from school provided by the Department of Education? ☐Yes ☐No***

Comments and explanations:

_____

_____

_____

Provider: _____ ***Date:*** _____