TEXAS
Department of Aging
and Disability Services

COMMISSIONER
Jon Weizenbaum

December 8, 2015

To: Deaf Blind with Multiple Disabilities Providers (DBMD)
Financial Management Services Agencies (FMSAs)

Subject: Information Letter No. 15-75
Reimbursement for Pre-Enrollment Assessment Activities in Deaf Blind with Multiple Disabilities Program

The purpose of this Information Letter (IL) is to inform DBMD providers of the case manager's responsibilities during the pre-enrollment process and the documentation required for reimbursement of pre-enrollment assessment activities. Pre-enrollment assessment activities occur when the DBMD case manager performs the initial face-to-face, in-home visit with an applicant as part of the eligibility determination process to determine if the individual meets the appropriate diagnostic and functional criteria for enrollment into the DBMD Program.

Initial Contact

If initial contact to the individual is made within five business days after the program provider receives the Texas Department of Aging and Disability Services (DADS) notification of being selected as the provider, the case manager may bill for pre-enrollment activities.

Initial Face to Face Visit

During the initial face-to-face, in-home visit as described in Title 40 of the Texas Administrative Code (TAC) §42.212, the case manager must explain to the individual or legally authorized representative (LAR) the DBMD Program services and supports; the application and enrollment process; the individual's rights and responsibilities, including the right to request a Medicaid Fair Hearing; the mandatory participation requirements; the procedures for an individual or LAR to file a complaint regarding a DBMD Program provider, both verbally and in writing; procedures for reporting an allegation of abuse, neglect, and exploitation; the consumer directed services (CDS) option; the voter registration process, if the individual is 18 years of age or older; and how to contact the program provider, the case manager, and the registered nurse.

Additionally, the case manager must assist an individual who has not established Medicaid financial eligibility, or the individual's LAR, with the completion of an application for Medicaid financial eligibility and submission of the completed application to the Health and Human Services Commission (HHSC) within 30 calendar days after the initial visit.

Additional Visits

An appropriate professional must complete an adaptive behavior screening assessment and a registered nurse must complete a nursing assessment. The case manager may complete Form 8578, Intellectual Disability/Related Conditions (ID/RC) Assessment and Form 8662, Related Conditions Eligibility Screening Instrument (RCESI). The case manager must also obtain the signature of the individual or LAR on Form 8601, Verification of Freedom of Choice, designating the individual's choice of DBMD Program services over enrollment in the Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) and obtain the signature of the individual or LAR on the DADS Release of Information Consent form or a similar form developed by the program provider. If the required assessments described in this paragraph are not completed during the initial visit, the case manager must ensure the assessments are completed within 10 business days after the date of the initial visit.

If the individual is Medicaid eligible and receiving services in a nursing facility or an ICF/IID, he/she may benefit by using Transition Assistance Services (TAS) to transition from an institutional setting to a home in the community. The case manager must provide the individual or LAR with a list of TAS provider agencies and complete Form 8604, TAS Assessment and Authorization, with assistance from the individual or LAR. Form 8604, TAS Assessment and Authorization is used to identify the individual's essential needs for TAS, and provide estimated amounts for TAS items and services.

After receiving the signed and dated Form 8578, ID/RC Assessment from the physician, the case manager must convene a service planning team (SPT) meeting within 10 business days after receipt of the approved ID/RC Assessment to develop an enrollment Individual Plan of Care (IPC).

During the SPT meeting, if the individual is requesting residential habilitation, nursing, or specialized nursing to be included on the enrollment IPC, the case manager must ensure the service planning team determines whether the individual requires a service backup plan for those services and ensure the service backup plan is developed if needed. Additionally, the case manager must ensure Form 6504, Prior Authorization for Dental Services is completed and signed by the dentist if the individual/LAR is requesting dental services other than an initial dental exam.

Within ten business days after the service planning team meeting, the case manager must complete an enrollment Individual Program Plan (IPP) and submit a request for enrollment to DADS for review providing the documents listed in 40 TAC §42.212(k)(2)(A) – (K).

Process for Reimbursement of Pre-Enrollment Assessment Activities

The provider must notify DADS using Form 6503, DBMD Summary of Services Delivered, listing the specific pre-enrollment assessment activities that the DBMD case manager performed. The DBMD case manager also must check the box labeled “Pre Assessment” within the “Authorized Services” section of the form. All pre-enrollment assessment activities must be supported by progress notes describing those activities or the completed assessments as described on Form 6503, DBMD Summary of Services Delivered.

The service authorization will include the total number of hours documented on Form 6503, DBMD Summary of Services Delivered. The provider must indicate on the form the specific dates during which the pre-enrollment assessment activities occurred. This allows DADS to create a pre-authorized date range that includes the total number of hours during which pre-enrollment activities were performed by the DBMD provider. Each Form 6503, DBMD Summary of Services Delivered must only contain pre-enrollment assessment activities performed within one calendar month. Additional copies of Form 6503, DBMD Summary of Services Delivered must be provided for activities that occurred during a different calendar month.

The provider may request reimbursement for pre-enrollment assessment activities at the rate specified for case management activities. Current rates for all DBMD services may be located on the HHSC Rates Analysis website.

If you have any questions about this IL, please contact the DBMD mailbox at dbmd@dads.state.tx.us.

Sincerely,

[signature on file]

S. Michelle Martin
Director
Center for Policy and Innovation

[signature on file]

Elisa J. Garza
Assistant Commissioner
Access and Intake