SECTION 2

TARGETED CASE MANAGEMENT FOR THE CHRONICALLY MENTALLY ILL

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1 GENERAL POLICY

Targeted case management is a service that assists eligible clients in the target group to gain access to needed medical, social, educational, and other services. The overall goal of the service is not only to help Medicaid recipients to access needed services, but to ensure that services are coordinated among all agencies and providers involved.

1 - 1 Authority

The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272, COBRA) added targeted case management to the list of optional services which can be provided under the State Medical Plan.

1 - 2 Definitions *(Updated 1/1/12)*

CHEC: Child Health Evaluation and Care is Utah's version of the federally mandated Early Periodic screening Diagnosis and Treatment (EPSDT) program. All Medicaid eligible clients from *birth through age twenty* are enrolled in the CHEC program. Individuals enrolled in the CHEC program are enrolled in the Traditional Medicaid Plan. The Medicaid Identification Cards specify that the individual is enrolled in this plan.

The only exception to this policy is that adult Medicaid clients age 19 and older enrolled in the Non-Traditional Medicaid Plan are **not** eligible for the CHEC program. The Medicaid Identification Cards for individuals enrolled in the Non-Traditional Medicaid Plan are blue in color and specify that the individual is enrolled in this plan.

Chronically mentally ill: refers to individuals who meet criteria specified in the *Utah Scale on the Seriously and Persistently Mentally Ill (SPMI) or the Utah Scale for Children/Adolescents with Serious Emotional Disorders (SED).*

Non-Traditional Medicaid Plan: means the reduced benefits plan provided to Medicaid-eligible adults age 19 through age 64 who:

1) are not blind, disabled, or pregnant;

2) are in a medically needy aid category and are not blind, disabled, or pregnant; or

3) are in a transitional Medicaid aid category.

Non-Traditional Medicaid Plan enrollees are in Utah's Section 1115 Primary Care Network Demonstration Program. These individuals' Medicaid cards specify they are enrolled in the Non-Traditional Medicaid Plan. Services covered under this reduced benefit plan are similar to the Traditional Medicaid Plan with some limitations and exclusions.

Prepaid Mental Health Plan (PMHP): means the Department of Health's mental health freedom-of-choice waiver approved by Centers for Medicare and Medicaid Services (CMS) that

allows the Department to require Medicaid eligible individuals in certain counties of the state to obtain PMHP-covered mental health services from specified contractors. PMHP contractors are responsible to provide covered inpatient and outpatient mental health services to Medicaid eligible individuals.

1 - 3 Target Group

A. Targeted case management services may be provided to seriously and persistently mentally ill (SPMI) adults and seriously emotionally disturbed (SED) children for whom the service is determined to be medically necessary. Targeted case management services will be considered medically necessary when a needs assessment completed by a qualified targeted case manager documents that:

1. the individual requires treatment and/or services from a variety of agencies and providers to meet his or her documented medical, social, educational and other needs; and

2. there is reasonable indication that the individual will access needed treatment/services only if assisted by a qualified targeted case manager who (in accordance with an individualized case management service plan) locates, coordinates and regularly monitors the services.

B. Currently, the Utah Medicaid program provides coverage of targeted and home and community-based waiver services (HCBS) case management for a variety of other groups:

1. Individuals with Substance Abuse Disorders;
2. Early Childhood (Ages 0-4);
3. Individuals with Physical Disabilities (HCBS Waiver);
4. Individuals with Mental Retardation/Related Conditions (HCBS Waiver);
5. Individuals Age 65 and over (HCBS Waiver);
6. Technology-Dependent Children (HCBS Waiver); and
7. Individuals with Traumatic Brain Injury (HCBS Waiver).

There are separate rules and provider manuals to address the scope of services and reimbursement methods for the other target groups. Since a Medicaid client may qualify for targeted or waiver case management services under other target groups, it is imperative that before providing services, the case manager determine if other agencies are already providing targeted or waiver case management for the client to ensure there is no duplication of case management activities.

1 - 4 Qualified Targeted Case Management Providers *(Updated 1/1/12)*

Targeted case management for the chronically mentally ill may be provided by or through a mental health center (or other entity) or PMHP under contract with or directly operated by a local county mental health authority.

Qualified providers are:

1. Licensed mental health therapist practicing within the scope of his or her license in accordance with Title 58 of the Utah Code:

    a. licensed physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;

b. licensed psychologist qualified to engage in the practice of mental health therapy;

c. licensed clinical social worker;

d. licensed certified social worker;

e. licensed advanced practice registered nurse (APRN), either as a nurse specialist or a nurse practitioner, with psychiatric mental health nursing specialty certification;

f. licensed marriage and family therapist;

g. licensed professional counselor; or

2. An individual who is working within the scope of his or her certificate or license in accordance with Title 58 of the Utah Code:

   a. certified psychology resident;

   b. licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours;

   c. licensed APRN intern formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours;

   d. associate marriage and family therapist; or

   e. associate professional counselor.

3. An individual exempted from licensure:

   a. Student enrolled in an education/degree program leading to licensure in one of the professions above, not currently licensed but exempted from licensure under Title 58 of the Utah Code, because of enrollment in qualified courses, internship or practicum, and under the supervision of qualified faculty, staff, or designee. [See Title 58-1-307(1)(b).]; or

   b. Individual who was employed as a psychologist by a state, county, or municipal agency or other political subdivision of the state prior to July 1, 1981, and who subsequently has maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of his official duties for that agency or political subdivision. [See Title 58-61-307(2)(h)].

4. One of the following individuals working within the scope of his or her certificate or license in accordance with Title 58 of the Utah Code:

   a. Licensed physician and surgeon or osteopathic physician regardless of specialty, or other medical practitioner licensed under state law (e.g., licensed physician assistants when practicing within their scope of practice);

   b. Licensed APRN and licensed APRN intern regardless of specialty;

c. Licensed social service worker, or individual working toward licensure as a social service worker under supervision of a licensed mental health therapist identified in #1 above;

d. Licensed registered nurse; or

e. Licensed practical nurse.

5. A student enrolled in an education/degree program leading to licensure not currently licensed but exempted from licensure under Title 58 of the Utah Code, because of enrollment in qualified courses, internship or practicum, and under the supervision of qualified faculty, staff, or designee. [See Title 58-1-307(1)(b).]

6. A non-licensed individual who does not meet qualifications above who has successfully completed the requirements in Chapter 1-5 under the supervision of an individual identified in #1, #2, #3b or #4 a-d above.

Supervision (when applicable) of individuals in 2 through 5 above must be provided in accordance with requirements set forth in Title 58 of the Utah Code, and the applicable profession's practice act rule as set forth by the Utah Department of Commerce and found at the Department of Administrative Services, Division of Administrative Rules, www.rules.utah.gov/publicat/code.htm.

In addition, all individuals providing targeted case management services must know Medicaid regulations pertaining to targeted case management as described in this provider manual.

1 - 5 Targeted Case Management Training Curriculum *(Updated 1/1/12)*

A. To meet the State Division of Substance Abuse and Mental Health's (DSAMH's) training standards and become certified to provide targeted case management services, all non-licensed individuals will be required to:

1. successfully complete the DSAMH's training curriculum and pass a written examination which tests basic knowledge, attitudes, ethics, and skills related to the provision of targeted case management services; and

2. successfully complete the DSAMH's targeted case management practicum requirement.

B. To continue to be a qualified provider of targeted case management services, the individual must successfully complete the DSAMH's recertification requirements.

1 - 6 Client Rights

A. Targeted case management services may not be used to restrict the client's access to other services available under the Medicaid State Plan.

B. The client (or the client's guardian if applicable) must voluntarily chose targeted case management services, and be given a choice in the selection of their targeted case manager.

C. The case manager will not condition receipt of targeted case management services on the receipt of other Medicaid-covered services, or condition receipt of other Medicaid-covered services on receipt of targeted case management services.

2 SCOPE OF SERVICE

2 - 1 General Limitations

Medicaid adult clients age 19 and over in the TANF and Medically Needy Medicaid eligibility categories have a reduced benefits package. These clients are enrolled in the Non-Traditional Medicaid Plan. Medicaid clients with the reduced benefits package will have the following service limitations:

Outpatient mental health services/visits– There is a maximum of 30 outpatient days per client per calendar year for outpatient mental health care. Targeted case management services for the chronically mentally ill also count toward the outpatient maximum. See *Utah Medicaid Provider Manual for Mental Health Centers/Prepaid Mental Health Plans,* Chapter 2 - 1, General Limitations, for additional service limitations.

2 - 2 Covered Services / Activities *(Updated 1/1/12)*

A. Targeted case management is a service that assists eligible clients in the target group to gain access to needed medical, social, educational, and other services. The overall goal of the service is not only to help Medicaid recipients to access needed services, but to ensure that services are coordinated among all agencies and providers involved.

In accordance with Chapter 1-4, individuals who are hired or subcontracted solely or as part of their duties to provide targeted case management services may assist individuals to gain access to needed medical services, including rehabilitative mental health services provided by the mental health center (or other entity) or PMHP.

However, treatment providers (e.g., physicians, mental health therapists, nurses, etc.) who provide rehabilitative mental health treatment to clients in accordance with the Chapter 2 of the *Utah Medicaid Provider Manual, Mental Health Centers/Prepaid Mental Health Plans*, may not bill or report day-to-day discussions with other internal mental health treatment providers regarding coordination of a client's mental health treatment/needs as targeted case management. Treatment providers' discussions regarding coordination of a client's mental health services are considered an integral part of the mental health service delivery. (See Chapter 2-4, paragraph E, below.)

B. Medicaid reimbursement for targeted case management is dictated by the nature of the activity and the purpose for which the activity was performed. When billed in amounts that are reasonable (given the needs and condition of the particular client), the following activities/services are covered by Medicaid under targeted case management:

1. Assessing the client to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Assessment activities include: taking client history, identifying the needs of the client and completing related documentation, gathering information from other sources such as family members, medical providers, social workers, other providers, and educators, if necessary, to form a complete assessment of the client;

2. Developing a written, individualized, and coordinated case management service plan based on the information collected through an assessment that specifies the goals and actions to address the medical, social, educational, and other services needed by the client, with input from the client, the client's authorized health care decision maker, and others (e.g., the client's family, other agencies, etc.) knowledgeable about the client's needs, to develop goals and identify a course of action to respond to the assessed needs of the client;

3. Referral and related activities to help the client obtain needed services, including activities that help link the client with medical (including mental health), social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers of needed services and scheduling appointments for the client;

4. Assisting the client to establish and maintain eligibility for entitlements **other than Medicaid**;

5. Coordinating the delivery of services to the client, including CHEC screenings and follow-up;

6. Contacting non-eligible or non-targeted individuals when the purpose of the contact is directly related to the management of the client's care. For example, family members may be able to help identify needs and supports, assist the client to obtain services, provide case managers with useful feedback and alert them to changes in the client's status or needs;

7. Instructing the client or caretaker, as appropriate, in independently accessing needed services;

8. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the targeted case management service plan is effectively implemented and adequately addressing the needs of the client, which activities may be with the client, family members, providers or other entities, and conducted as frequently as necessary to help determine such matters as whether services are being furnished in accordance with the client's case management service plan, whether the services in the case management service plan are adequate, whether there are changes in the needs or status of the client, and if so, making necessary adjustments in the case management service plan and service arrangements with providers; and

9. Monitoring the client's progress and continued need for targeted case management and other services.

C. Covered targeted case management services provided to patients in a hospital or nursing facility may be covered only during the 30-day period prior to the patient's discharge into the community, and are limited to five hours of reimbursement per admission. This provision does not apply to patients at the Utah State Hospital; no targeted case management services are reimbursable.

2 - 3 Non-Covered Services / Activities *(Updated 1/1/12)*

In accordance with federal Medicaid guidelines, **the following services and activities are not considered targeted case management and may not be billed to Medicaid:**

In accordance with federal Medicaid guidelines, **the following services and activities are not considered targeted case management and may not be billed to Medicaid:**

A. Documenting targeted case management services - with the exception of the time spent developing the written needs assessment, service plan, and 180-day service plan review - is not reimbursable as targeted case management. (See Chapter 3-2, Required Documentation.)

B. Teaching, tutoring, training, instructing, or educating the client or others, except in so far as the activity is specifically designed to assist the client, parent, or caretaker to independently obtain needed services for the client.

For example, assisting the client to complete a homework assignment, creating chore or behavioral charts and other similar materials for clients or families, or instructing a client or family member on nutrition, budgeting, cooking, parenting skills or other skills development is not reimbursable as targeted case management;

C. Directly assisting with personal care or activities of daily living (bathing, hair or skin care, eating, etc.) or instrumental activities of daily living (assisting with budgeting, cooking, shopping, laundry, home repairs, apartment hunting, moving residences, or acting as a protective payee) are not reimbursable activities under targeted case management;

D. Performing routine services including courier services. For example, running errands or picking up and delivering food stamps or entitlement checks are not reimbursable as targeted case management;

E. Direct delivery of an underlying medical, educational, social or other service to which the client has been referred, or provision of a Medicaid-covered service. For example, providing medical and psycho-social evaluations, treatment, therapy and counseling that are otherwise billable to Medicaid under other categories of service, are not reimbursable as targeted case management;

F. Direct delivery of foster care services, including but not limited to research gathering and completion of documentation required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster care placements, serving legal papers, home investigations, providing transportation, administering foster care subsidies or making foster care placement arrangements.

Additionally, children in state custody have Department of Human Services (DHS) case workers, and may also have case management services through Department of Health case managers. Therefore, if a child in state custody has been referred to the mental health center/Prepaid Mental Health Plan provider for services outlined in the Utah Medicaid Provider Manual, Mental Health Centers/Prepaid Mental Health Plans, the mental health center/Prepaid Mental Health Plan provider is the provider of medical (mental health) services that the DHS case manager assisted the child to access. Therefore, there should be few circumstances where the mental health center/Prepaid Mental Health Plan provider would also provide targeted case management services to a child in state custody. If the mental health center/Prepaid Mental Health Plan treatment provider determines there is a case management need, this should be communicated to the child's DHS case manager. If DHS agrees that in addition to providing medical (mental health) services, the mental health center/Prepaid Mental Health Plan provider also should provide some of the case management services the child requires (and the services will not constitute the direct delivery of foster care services as specified in the first paragraph of this subsection F), this agreement must be clearly documented in the child's targeted case management record;

G. Traveling to the client's home or other location where a covered case management activity will occur is not reimbursable, nor is time spent transporting a client or a client's family members;

H. Providing services for or on behalf of other family members that do not directly assist the client to access needed services. For example, counseling the client's sibling or helping the client's parent obtain a mental health service are not reimbursable as targeted case management;

I. Performing activities necessary for the proper and efficient administration of the Medicaid State Plan, including assisting the client to establish and maintain Medicaid eligibility. For example, locating, completing and delivering documents to the Medicaid eligibility worker is not reimbursable as targeted case management;

J. Recruitment activities in which the center or case manager attempts to contact potential recipients of service are not reimbursable as targeted case management;

K. Time spent assisting client to gather evidence for a Medicaid hearing or participating in a hearing as a witness is not reimbursable as targeted case management;

L. Time spent coordinating between case management team members for a client is a non-billable activity;

M. When there is a failed face-to-face or telephone contact, time spent leaving a note or message noting the failed attempt is not reimbursable as targeted case management; and

N. Time spent by two or more mental health center (or other entity) or PMHP treatment providers arranging or coordinating treatment services are not reimbursable as targeted case management. (In accordance with Chapter 2 – 2, paragraph A, above, treatment providers are individuals who are delivering rehabilitative mental health treatment to the client.) Also see Chapter 2-4, paragraph E, below.

2 - 4 Limitations on Reimbursable Services *(Updated 1/1/12)*

A. The agency may bill Medicaid for the covered services and activities specified in Chapter 2-2, paragraph B, only if:

1. the services and activities are identified in the targeted case management service plan;

2. the time spent in the service or activity involves a face-to-face encounter, telephone or written communication with the client, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring the client obtains the necessary services documented in the targeted case management service plan;

3. there are no other third parties liable to pay for such services, including reimbursement under a medical, social, education, or other program;

4. activities are not an integral and inseparable component of another covered Medicaid service; and

5. activities do not constitute the direct delivery of underlying medical, education, social, or other services to which an eligible individual has been referred including foster care

programs.

B. The agency may not bill Medicaid for the covered services and activities specified in Chapter 2-2, paragraph B, if no payment liability is incurred. Medicaid reimbursement is not available for services provided free-of-charge to non-Medicaid recipients.

C. Payment for targeted case management services may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

D. Team Case Management

Targeted case management services provided to a client by more than one mental health center/Prepaid Mental Health Plan targeted case manager are reimbursable only under the following conditions:

1. all members of the team meet the qualifications described in Chapter 1 - 4;
2. all team members coordinate with one another to ensure only necessary, appropriate, and unduplicated services are delivered by all team members;
3. time spent by two or more members of the team in the same targeted case management activity may be billed only by one team case manager; and
4. the recipient is informed of and understands the roles of the team members.

E. Mental Health Services

Targeted case management services may be billed only if the service would not ordinarily be considered an integral part of the mental health service delivery. Services described in the *Utah Medicaid Provider Manual, Mental Health Centers/Prepaid Mental Health Plans* would be billed as mental health services. Indirect mental health center/Prepaid Mental Health Plan provider activities (i.e., supervision of treatment providers, interdisciplinary team conferences for the development of rehabilitative treatment plans and time spent by mental health treatment providers [i.e., individual practitioners] arranging/coordinating mental health treatment with other internal mental health treatment providers (see Chapter 2-2, paragraph A and Chapter 2-3, paragraph N above) must not be billed as case management activities. These indirect activities are included as an administrative cost in establishing the cost of mental health services.

3 RECORD KEEPING

3 - 1 General Requirements

As specified in 3 – 2 below, documentation of actual time of the service is required. However, an acceptable practice is to round to the nearest five minute interval to determine the time and duration of the service.

The case management record must be kept on file, and made available for state or federal review, upon request.

3 - 2 Required Documentation

A. The following documents must be contained in each client's case file:

1. a written individualized needs assessment which documents the client's need for targeted case management services;

2. a written, individualized targeted case management service plan that identifies the services (i.e., medical, social educational, and other services) the client is to receive, who will provide them, and a general description of the targeted case management activities needed to help the client obtain or maintain these services; and

3. a written review of the service plan, at a minimum every 180-days, summarizing the client's progress toward targeted case management service plan objectives. The service plan review must be completed within the month due, or more frequently as required by the client's condition. If changes are required in the written service plan, a revised service plan must also be developed.

B. The case manager must develop and maintain sufficient written documentation for each unit of targeted case management services billed.

Record: Documentation must include for each date of service:

1. name of client;

2. date;

3. actual time and duration of each service (time may be rounded to the nearest five minute interval);

4. at the end of the day, total number of minutes of targeted case management services based on the rounding rules specified in the 'Unit' section below;

5. setting in which the service was rendered;

6. at a minimum, one note summarizing all of the targeted case management activities performed during the day, or a separate note summarizing each targeted case management activity. Notes must document how the activities relate to the targeted case management service plan and be sufficient to support the number of units billed or reported; and

7. signature and licensure or credentials of individual who rendered the targeted case management service(s).

Unit: **T1017 - Targeted Case Management -**per 15 minutes

When billing or reporting this procedure code, follow the rounding rules specified below for converting the total duration of targeted case management services provided in a day to the specified unit.

The number of 15-minute units of service billed or reported cannot exceed four units in an hour as targeted case managers cannot exceed in total billings in a day, the number of hours worked (e.g., eight-hour work day).

If the total duration of targeted case management activities provided in a day total less than 15 minutes, then there must be a minimum of eight minutes in order to bill one 15-minute unit.

If the total duration of targeted case management activities provided in a day are in excess of 60 minutes, divide the total number by 15 to determine the number of 15-minute units that can be billed or reported. If there are minutes left over, apply the following rules:

1-7 minutes equal 0 units; and

8-14 minutes equals one 15-minute unit.

For example, the targeted case manager performed five separate targeted case management activities for the client during the day for a total duration of 70 minutes. When divided by 15 this would result in five units of service.

Limits: See Chapters 2-2, 2-3 and 2-4 for limitations on this service.

4 SERVICE PAYMENT

A. Payment for targeted case management services is made on a fee-for-service basis.

B. Rates are based on a 15-minute unit of service.

5 PROCEDURE CODES FOR TARGETED CASE MANAGEMENT FOR THE CHRONICALLY MENTALLY ILL

For each date of service, enter the appropriate five-digit procedure code as indicated below:

Procedure Code	Service and Units	Limits per Patient
T1017	Targeted Case Management - per 15 minutes	5 hours per patient per inpatient admission*

*This is not allowed for patients in the Utah State Hospital.

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