SECTION 2

TARGETED CASE MANAGEMENT FOR EARLY CHILDHOOD

Contents

1 General Information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to Section I: General Information, *Chapter 1, General Information*.

1-1 Targeted Case Management for Early Childhood

Targeted Case Management services (TCM) are available for Medicaid eligible children birth through age three, to assist members in accessing needed medical, social, educational, or other services and ensure that services are coordinated among all agencies and providers involved. Targeted case management regulations, as described in 42 CFR 440.169, require that case managers assist eligible members to obtain coordinated services by conducting a comprehensive assessment of needs, developing a care plan, providing referrals to services, and performing monitoring and follow-up activities.

2 Health Plans

For more information about Accountable Care Organizations (ACOs), refer to Section I: General Information, *Chapter 2, Health Plans*.

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information, *Chapter 2-1.2*, Prepaid Mental Health Plans, and the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual.

A list of ACOs and PMHPs with which Medicaid has a contract to provide health care services is found on the Medicaid website Managed Care: Accountable Care Organizations.

3 Provider Participation and Requirements

Refer to Section I: General Information, *Chapter 3, Provider Participation and Requirements*.

3-1 Provider Credentials

Medicaid providers of targeted case management services to EPSDT eligible members ages 0 through 4 must meet additional criteria defined by the State Plan or as outlined in contractual agreements between the Department of Health and Human Services and contracted parties, such as Local Health Departments.

4 Record Keeping

Refer to Section I: General Information, Chapter 4, Record Keeping.

4-1 Record Keeping Requirement for Targeted Case Management

The case manager must maintain sufficient documentation for targeted case management services billed. Documentation should include the date of service, member name, name of provider agency and signature of provider, place of service, units of service, and a description of the case management activity. Follow-up targeted case management services must be documented in 15-minute intervals.

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. An initial assessment should be documented in the Initial Assessment form, with plan for follow-up services.
2. A written individualized targeted case management service plan which identifies the services the client is to receive and who will provide them

5 Provider Sanctions

Refer to Section I: General Information, *Chapter 5, Provider Sanctions*.

6 Member Eligibility

It is the responsibility of the provider to verify the member's eligibility prior to every rendered service. For additional information regarding member eligibility refer to Section I: General Information Chapter 6, *Member Eligibility*.

Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member Responsibilities

For information on member responsibilities, including establishing eligibility and co-payment requirements, refer to Section I: General Information, *Chapter 7, Member Responsibilities*.

8 Programs and Coverage

For additional information regarding services provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, see 42 CFR 441 Subpart B Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under 21. For information regarding case management services, see 42 CFR 440.169 Case Management Services. Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

8-1 Definitions

Case Management Services: means services that assist individuals eligible under the State Plan in gaining access to needed medical, social, educational, and other services.

Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT): means a federally mandated program that provides comprehensive and preventive health care services for children age birth through 20 years who are enrolled in Traditional Medicaid.

Early Childhood: means Medicaid eligible members ages 0 through 4.

Medical Home: means an approach to providing comprehensive primary care that facilitates partnerships between patients, clinicians, medical staff, and families. A medical home may extend beyond a clinical practice to include specialty care, educational services, family support, and more.

Targeted Case Management Services: means case management services furnished to defined target groups without regard to requirements related to statewide provision of services or comparability.

8-2 Target Group

Targeted case management services are a covered benefit for Medicaid-eligible children ages birth to four, for whom the service is determined to be medically necessary. Case management services begin when the family is contacted and accepts services. Services continue until the case manager determines they are no longer needed or until the family voluntarily terminates services. Services are considered medically necessary when a needs assessment is completed by a qualified case manager and criteria defined by State Plan Supplement to Attachment 3.1-A, Section E - Target Group and Supplement to Attachment 3.1-B, Section E - Target Group are met and documented.

The Utah Medicaid program provides coverage of targeted and home and community-based waiver services (HCBWS) case management for a variety of other target groups. 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, as only one targeted case management provider will be reimbursed for the same or overlapping dates of service. Coordination of all services is an essential component of targeted case management.

8-3 Additional Participation Requirements for Case Management Providers

Refer to *Section 3 Provider Participation and Requirements* and *Section 3-1 Provider Credentials* for general information regarding provider participation and credentialing. Additional participation requirements for Medicaid providers of targeted case management services to EPSDT eligible members may be found in State Plan Supplement to Attachment 3.1-A, Page 2, Section E and Supplement to Attachment 3.1-B, Page 2, Section E.

8-4 Coordination of Targeted Case Management Training Curriculum with Local Health Departments

Licensed providers or non-licensed individuals employed or contracted with agencies that specialize in providing case management services to children, such as local health departments, are subject to training requirements developed in coordination with the

Department of Health and Human Services. Such training requirements may be outlined in contractual agreements between the Department and individual local health departments.

Non-licensed individuals who provide targeted case management services must complete a targeted case management course approved by the Division of Integrated Healthcare, which fulfills training curriculum requirements outlined in State Plan Supplement to Attachment 3.1-A, Page 2, Section E and Supplement to Attachment 3.1-B, Page 2, Section E.

8-5 Referrals

Case managers may utilize reports provided by the Division of Integrated Healthcare, which detail demographic information and recent claim history for eligible members in each county, to facilitate case management services.

Case management services may include referrals to community resources, focusing on linking the child with necessary medical, social, educational, and other resources that address unmet needs. Local community resources, if available, are preferable to out-of-area providers. Referrals may be issued after an initial assessment.

8-6 Scope of Service

The Code of Federal Regulations Title 42 Part 440.169 defines activities that case managers provide in assisting eligible individuals obtain coordinated services, which includes:

- Performing a comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services, to include activities such as taking client history, completing documentation, and gathering information from other sources knowledgeable about the individual's needs.
- Developing a care plan based on information collected through the assessment, which includes goals, and a course of action.
- Referrals and related activities, such as scheduling appointments for the individual
- Monitoring and follow-up activities to ensure the quality and appropriateness and determine whether adjustments in the care plan or service arrangements with providers are necessary.

The State Plan, under Supplement to Attachment 3.1-A, Attachment #4b, Page 2, Section H - Definition of Services and Supplement to Attachment 3.1-B, Page 1, Section H - Definition of Services identifies additional covered services under the targeted case management service benefit for Medicaid eligible children ages 0 – 4, which includes:

- Assisting the member to establish and maintain eligibility for entitlements other than Medicaid.
- Coordinating delivery of services for the member, including EPSDT screenings and follow-up.

Contractual agreements for targeted case management services between the Department of Health and Human Services and individual local health departments define additional service agreements, which may include visits to the home of the child to facilitate case management activities, providing information to families about the establishing a "medical home" for the child, and/or maintaining communication with the child's primary care provider.

9 Non-Covered Services and Limitations

Certain services are non-covered by Medicaid because medical necessity, appropriateness, and cost-effectiveness cannot be readily determined or justified for medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

For more information on non-covered services and limitations, see Utah Administrative Code R414-1 - Utah Medicaid Program, and Section I: General Information, *Chapter 9, Non-Covered Services and Limitations*.

9-1 Non-Covered Activities for Targeted Case Management

Medicaid case management services do not include direct services, such as medical, educational, or social services to which a child has been referred. For example, if a child is linked to a Medical Home, any services provided by the Medical Home, such as a physical exam, would not be billed as part of case management activities. In accordance with federal Medicaid guidelines, the following activities are not considered targeted case management and should not be billed to Medicaid:

- Documenting targeted case management services, except for time spent developing the written needs assessment, service plan, and progress notes.
- Providing training or instruction to the child or others, unless the activity is specifically designed to assist the child, parent, or caretaker to independently obtain needed services for the child.
- Directly assisting with personal care, activities of daily living, or providing routine services (including courier services).
- Direct delivery of an underlying medical, educational, social, or other service to which an eligible individual 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.
- 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.

- Traveling to the child's home or other location where a covered case management activity will occur, or time spent transporting a child or a child's family members.
- Providing services for or on behalf of other family members who do not directly assist the child to access needed services. For example, counseling the child's sibling or helping the child's parent obtain a mental health service are not reimbursable.
- Recruitment activities in which the agency or case manager attempts to contact potential recipients of case management services.

9-2 Limitations on Reimbursable Services

9-2.1 Team Case Management

Targeted case management services provided to an eligible member by more than one case manager employed by or contracted with the same agency or program is reimbursable only when all the following conditions are met:

- All members of the team meet the qualifications described in *Chapter 3 – Provider Participation Requirements* and *Chapter 8.3 – Additional Participation Requirements for Case Management Providers.*
- Documentation of billed services is maintained in a single case file.
- All services are delivered under a single case management service plan.
- Team members coordinate with one another to ensure only necessary, appropriate, and unduplicated services are delivered by the case management team.
- Time spent by two or more members of the team on the same targeted case management activity may be billed only by one team case manager.
- The family understands the roles of individual team members.

9-2.2 Shared Case Management

Targeted case management services billed by case managers from more than one agency or program during the same or overlapping dates of service for the same child will be considered for reimbursement only if the Division has received documentation to support the need for the expertise of two case management providers. A letter signed by the case managers of both agencies must be submitted to the Division, which must (1) fully explain the need for shared case management, (2) document the specific and non-duplicative services to be provided by each case manager, (3) specify the time period during which shared case management will be required, and (4) include a copy of the needs assessments and service plans from both case managers and a written statement from the Local Interagency Council (LIC) or the Local Interagency Coordinating Council (LICC) if a council has reviewed the child's need for shared case management services. If approved by the Division, case managers sharing case management responsibilities for a child may bill for their participation in LIC/LICC meetings for the time during which the child's needs are addressed.

NOTE: The Home and Community Based Services program must ensure that State Plan benefits are utilized before targeted case management services can be billed by waiver case managers.

Payment cannot be made for targeted case management services for which another payer is liable, nor for services for which no payment liability is incurred. Medicaid reimbursement is not available for services provided free of charge to non-Medicaid recipients, except as permitted for the State's Title V, Maternal and Child Health program under Section 1902 (a)(11)(B) of the Social Security Act.

10 Prior Authorization

For Medicaid medical or surgical services requiring prior authorization, the physician must obtain approval from Medicaid before service is rendered to the patient. For information regarding prior authorization, see Section I: General Information, *Chapter 10, Prior Authorization*. Additional resources and information can be found on the Utah Medicaid Prior Authorization website.

For information on codes requiring prior authorization, manual review, or non-covered status, refer to the Coverage and Reimbursement Code Lookup.

10-1 Retroactive Authorization

There are limited circumstances in which a provider may request authorization after service is rendered. These limitations are described in Section I: General Information, *Chapter 10-3 Retroactive Authorization*.

11 Billing Medicaid

Refer to Section I: General Information, *Chapter 11, Billing Medicaid*, for general information about billing instructions.

The agency may bill Medicaid for targeted case management services if the following criteria are met:

- The activities are delineated in the member's case management service plan, and
- The time spent in the activity involves a face-to-face encounter, telephone or written communication with the child, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring the child obtains the necessary services documented in the targeted case management service plan.

Service payment determination for targeted case management services are described in State Plan Attachment 4.19-B Page 29B Payment for Targeted Case Management Services for EPSDT Eligibles, and additional payment arrangements are described in contractual agreements between the Department of Health and Human Services and individual contracted agencies.

Targeted case management services, when coded according to guidelines described in *Section 12 Coding*, is considered a carved-out service. A Medicaid member's ACO is not responsible for payment of these services; services should be billed directly to the State.

12 Coding

Refer to the Section I Provider Manual, *Chapter 12, Coding*, for information about coding, including diagnosis, procedure, and revenue codes.

For coverage and reimbursement information for specific procedure codes, see the Coverage and Reimbursement Code Lookup. Generally, the fees represented on the Coverage and Reimbursement Code Lookup are only for fee-for-service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.).

12-1 Targeted Case Management Codes

Providers of targeted case management for Medicaid eligible children ages 0-4 should use the following codes when reporting case management services:

CODES	DESCRIPTION	AGE	LIMITS
T1023	Program intake assessment, per encounter	0 - 4 years	1
T1017	Targeted case management, each 15 minutes	0 - 4 years	99