SECTION 2

TARGETED CASE MANAGEMENT FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS

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1 GENERAL POLICY

Targeted case management is a service that assists Medicaid recipients 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 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 Target Group *(Updated 10/1/16)*

A. This target group is comprised of Medicaid recipients with serious mental illness and includes adults with serious mental illness and children with serious emotional disorders, and individuals with substance use disorders (including their Medicaid eligible children who are at risk for the development of a substance use disorder). Targeted case management is not a covered service for Medicaid recipients who have Non-Traditional Medicaid if they are receiving rehabilitative services for a substance use disorder only. See Chapter 1-4, General Limitations.

B. Currently, Utah Medicaid also covers targeted case management to the following target group or case management through the following home and community-based (HCBS) waivers:

   Targeted Case Management Target Group
   Early Childhood (Ages 0-4)

   HCBS Waivers (Providing Case Management Services)
   1. Physical Disabilities Waiver;
   2. Community Supports Waiver for Individuals with Intellectual Disabilities or Other Related Conditions;
   3. New Choices Waiver (for individuals who are deinstitutionalized);
   4. Waiver for Individuals Age 65 or Older;
   5. Waiver for Technology-Dependent Children;
   6. Acquired Brain Injury Waiver; and
   7. Medically Complex Children's Waiver

There are separate rules and provider manuals to address the scope of services and reimbursement methods for the other case management groups. Since a Medicaid recipient may qualify for targeted or waiver case management services under other case management groups, it is imperative that before providing targeted case management services under this targeted case management program, 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 - 3 Definitions

Child Health Evaluation and Care (CHEC) means Utah's version of the federally mandated Early Periodic screening Diagnosis and Treatment (EPSDT) program. All Medicaid recipients from *birth through age twenty* who have Traditional Medicaid qualify for CHEC Services. 19 and 20 year olds who have Non-Traditional Medicaid do **not** qualify for CHEC Services.

Division of Occupational and Professional Licensing (DOPL) means the division within the Utah State Department of Commerce responsible for occupational and professional licensing.

Healthy Outcomes Medical Excellence Program (HOME), operated by the University of Utah, means a voluntary managed care program for Medicaid recipients who have a developmental disability and mental health or behavioral challenges. HOME is a coordinated care program that provides to its enrollees medical services, mental health/substance use disorder services and targeted case management services. When Medicaid recipients enroll in HOME, they are removed from their PMHP and physical health plan enrollment, if enrolled.

Health Plan means a federally defined plan under contract with the Department of Health to provide specified physical health care services to Medicaid recipients enrolled in the plan.

Inmate of a public institution means, pursuant to 42 CFR §435.1010, a person who is living in a public institution. An individual is not considered an inmate if-- (a) He is in a public educational or vocational training institution for purposes of securing education or vocational training; or (b) He is in a public institution for a temporary period pending other arrangements appropriate to his needs.

Institution for Mental Diseases (IMD) means, pursuant to 42 CFR §435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services…. An institution for the mentally retarded is not an institution for mental diseases.

Non-Traditional Medicaid means, pursuant to the 1115 Primary Care Network Demonstration Waiver, the reduced benefits plan provided to Medicaid recipients age 19 through 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.

Services covered under Non-Traditional Medicaid are similar to Traditional Medicaid 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 recipients in certain counties of the state to obtain PMHP-covered services from specified contractors. PMHP contractors are responsible to provide covered inpatient and outpatient mental health services and covered outpatient substance use disorder services to enrolled Medicaid recipients.

Public institution means, pursuant to 42 CFR §435.1010, an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control....

Traditional Medicaid Plan means the scope of services contained in the State Plan provided to Medicaid recipients who fall under one of the following Medicaid aid groups:

1) Section 1931 children and related poverty-level populations under age 19; Section 1931 pregnant women;
2) Blind or disabled children and related populations;
3) Blind or disabled adults and related populations under age 65;
4) Aged adults age 65 and older and related populations (SSI, QMB and Medicaid, Medicare and Medicaid);
5) Children in foster care;
6) Individuals who qualify for Medicaid by paying a spenddown and are under age 19; or
7) Individuals who qualify for Medicaid by paying a spenddown and are also blind or disabled.

1 - 4 General Limitations

A. The target group does not include individuals between ages 22 and 64 who are served in IMDs or individuals who are inmates of public institutions.

B. Medicaid recipients with Non-Traditional Medicaid have a reduced benefits package including the following limitation.

   There is a maximum of 30 outpatient days of mental health services per Medicaid recipient per year for a mental health diagnosis (not including substance use disorder diagnoses). Targeted case management services for the seriously mentally ill for Medicaid recipients receiving rehabilitative services for a mental health disorder (not including substance use disorders) also count toward the outpatient maximum. See the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services,* Chapter 2 - 1, General Limitations.

C. As stated in Chapter 1-2, A., above, targeted case management is not a covered service for Medicaid recipients who have Non-Traditional Medicaid and are receiving rehabilitative services for a substance use disorder only.

1 - 5 Qualified Targeted Case Management Providers *(Updated 7/1/15)*

A. Qualified providers of targeted case management services to recipients in this target group are employed by or under contract with one of the following:

   1. a local mental health and/or substance abuse authority (usually PMHP contractors);

   2. a local authority's designated mental health and substance use disorder services provider (usually PMHP contractors);

   3. the Department of Human Services; or

   4. a program providing Medicaid-covered services, including targeted case management services for individuals with serious mental illness, under the authority of 1915(a) of the Social Security Act (i.e, HOME). Providers authorized under Section 1915(a) of the Social Security Act provide targeted case management services only to Medicaid recipients enrolled in the 1915(a) program.

B. Primary providers of targeted case management services are:

   1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;

2. licensed advanced substance use disorder counselor (ASUDC) or substance use disorder counselor (SUDC) under the general supervision of a licensed mental health therapist identified in C.1 of this Chapter;

3. certified advanced substance use disorder counselor (CASUDC) or a certified advanced substance use disorder counselor intern (CASUDC-I) under direct supervision of a licensed mental health therapist identified in C.1 of this Chapter, or a licensed ASUDC qualified to provide supervision;

4. certified substance use disorder counselor (CSUDC) or a certified substance use disorder counselor intern (CSUDC-I) under direct supervision of a licensed mental health therapist identified in C.1 of this Chapter, or a licensed ASUDC or SUDC qualified to provide supervision;

5. licensed registered nurse;

6. licensed practical nurse under the supervision of a licensed registered nurse or a licensed mental health therapist identified in C. 1 of this Chapter;

7. individual who is not licensed who is at least 18 years old and under the supervision of a an individual identified in C.1., C.2., or C.3.b. of this Chapter, a licensed social service worker or a licensed registered nurse; or a licensed ASUDC or licensed SUDC when targeted case management services are provided to individuals with a substance use disorder who have Traditional Medicaid.

   Non-licensed individuals must complete the training curriculum and certification requirements specified in Chapter 1-6; or

8. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, or individual enrolled in a qualified substance use disorder counselor education program, exempted from licensure in accordance with Section 58-1-307 of the Utah Code and under required supervision.

C. In addition to the primary service providers specified in B. above, individuals in C.1., C.2., and C.3., below, may also provide this service:

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

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

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

   c. certified psychology resident qualifying to engage in the practice of mental health therapy under the supervision of a licensed psychologist;

   d. clinical social worker;

   e. certified social worker; or certified social worker intern under the supervision of a licensed clinical social worker;

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

g. marriage and family therapist;

h. associate marriage and family therapist under the supervision of a licensed marriage and family therapist;

i clinical mental health counselor; or

j. associate clinical mental health counselor under supervision of a licensed mental health therapist.

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

   a. 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 under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification;

   b. licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty nursing certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification;

   c. licensed physician and surgeon or osteopathic physician regardless of specialty, or other medical practitioner licensed under state law (most commonly licensed physician assistants when practicing within their scope of practice and under the delegation of services agreement required by their practice act); or

   d. licensed APRN or licensed APRN intern regardless of specialty.

3. An individual exempted from licensure (as a mental health therapist), including:

   a. in accordance with Section 58-1-307 of the Utah Code, a student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL to the extent the activities are supervised by qualified faculty, staff, or designee and the activities are a defined part of the training program; or

   b. in accordance with Subsection 58-61-307(2)(h) of the Utah Code, an 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.

Supervision (when applicable) of individuals 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 - 6 Targeted Case Management Training Curriculum

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.

1-7 Client Rights

A. Targeted case management services cannot 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 choose targeted case management services, and be given a choice in the selection of their targeted case manager. Clients can also choose to discontinue targeted case management services at any time.

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.

D. Targeted case management clients will have free choice of any qualified Medicaid providers of other medical care unless restricted due to enrollment in a Health Plan, the PMHP, or a program providing services authorized under 1915(a) of the Social Security Act (i.e., HOME).

2 SCOPE OF SERVICE

2 – 1 Covered Services / Activities

A. Targeted case management is a service that assists Medicaid recipients 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.

Individuals who are employed by or contracted with an entity specified in Chapter 1-5, A. solely or as part of their duties to provide targeted case management services, may assist clients to gain access to needed medical services, including rehabilitative mental health/substance use disorder services provided by that entity.

The entity's providers (e.g., physicians, mental health therapists, nurses, etc.) who provide rehabilitative mental health/substance use disorder services to clients in accordance with Chapter 2 of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*, or other medical services, may not bill day-to-day discussions with other internal treatment providers regarding coordination of their respective services as targeted case management. These discussions are considered an integral part of the entity's services delivery. (See Chapter 2-2, N.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 well-child health exams and follow-up (see the *Utah Medicaid Provider Manual for CHEC Services*);
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 Medicaid recipients transitioning to a community setting will be made available for up to 30 consecutive days of a covered stay in a medical institution. Medical institutions do not include IMDs when the individual is between ages 22 and 64 and is being served in an IMD and do not include public institutions.

2 - 2 Non-Covered Services / Activities

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

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 (e.g., services described in the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services)*, 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.

Children in state custody (foster care) have Department of Human Services (DHS) case workers, and may also have case management services through Department of Health case managers. When DHS case workers or Department of Health case managers refer a child to a local mental health and/or substance abuse authority/PMHP or to the local authority's designated mental health and substance use disorder services provider/PMHP, the purpose is for the provision of rehabilitative services outlined in the *Utah Medicaid Provider Manual f Rehabilitative Mental Health and Substance Use Disorder Services.*

Therefore, there should be few circumstances where the local mental health and/or substance abuse authority/PMHP or the local authority's designated mental health and substance use disorder services provider/PMHP would also provide targeted case management services to a child in state custody.

If the local mental health and/or substance abuse authority/PMHP or the local authority's designated mental health and substance use disorder services provider/PMHP determines there is a case management need, this should be communicated to the child's DHS case manager. If DHS agrees that the treatment provider also should provide some of the targeted 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, then the entity may do so. This agreement must be clearly documented in the child's targeted case management record;

G. time spent 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 are 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. in accordance with Chapter 2-1, A., time spent by two or more treatment providers of an entity specified in Chapter 1-5, A., arranging or coordinating their treatment services, and indirect activities of the entity (i.e., supervision of treatment providers, and interdisciplinary team conferences for the development of rehabilitative treatment plans) may not be billed as targeted case management activities.

2 - 3 Limitations on Reimbursable Services

A. The agency may bill Medicaid for the covered services and activities specified in Chapter 2-1, 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 2-1 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 targeted case manager employed by or under contract with the same entity are reimbursable only under the following conditions:

1. all targeted case managers on the team meet the qualifications described in Chapter 1 - 5;
2. all targeted case managers on the team coordinate with one another to ensure only necessary, appropriate, and unduplicated case management services are delivered by all team members;
3. time spent by two or more targeted case managers on the team in the same targeted case management activity may be billed by one case manager team member only; and
4. the client is informed of and understands the roles of the team members.

3 RECORD KEEPING

3 - 1 General Requirements

The case management record must be maintained on file in accordance with any federal or state law or state administrative rules, and made available for state or federal review, upon request.

3 - 2 Required Documentation

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.

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

Record:

For each date of service, documentation must include:

1. date, start and stop time and duration of each service;
2. setting in which the service was rendered;
3. at the end of the day, total number of minutes of targeted case management services based on the rules specified in the 'Unit' section below;
4. 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
5. signature and licensure or credentials of the individual who rendered the targeted case management service(s).

Unit:

T1017 - Targeted Case Management for Clients with Mental Health Disorders - per 15 minutes

H0006 - Targeted Case Management for Clients with Substance Use Disorders - per 15 minutes

1. When billing these procedure codes, follow the rules specified below for converting the total duration of targeted case management services provided in a day to the specified unit.
2. The number of 15-minute units of service billed or reported cannot exceed four units in an hour and cannot exceed in total billings in a day, the number of hours the case manager worked (e.g., eight-hour work day).

3. 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.

4. 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

   8-15 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.

5. A range of dates should not be billed on a single line of a claim (e.g., listing on the claim the 1st through the 30th or 31st as the service date). Each date of service should be billed on a separate line of the claim.

4 PROCEDURE CODES FOR TARGETED CASE MANAGEMENT FOR THE SERIOUSLY 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 – Mental Health - per 15 minutes	Available for up to 30 consecutive days of a covered stay in a medical institution, not including IMDs when the individual is between ages 22 and 64 and not including public institutions.
H0006	Targeted Case Management – Substance Use - per 15 minutes	