

106 Targeted Case Management

Case management services are comprehensive services that assist eligible individuals in gaining access to needed medical, social, educational and other services. Targeted Case Management (TCM) services assist specific eligible recipients, or targeted individuals, to access other services.

Targeted Case Management cannot provide services in total care environments, such as nursing facilities, hospitals, and residential programs unless the recipients are in Adult Protective Services Target Group 7, or this target group includes individuals transitioning to a community setting. Case management services will be available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Letter (SMDL), July 25, 2000). Also excluded are adults 21 and older receiving services in an Institution for Mental Disease (IMD).

Medicaid recipients may receive TCM services in more than one target group, or case management services from another program if the Agency determines this would not present a duplication of services. Refer to the section, "Duplicate Billing" in this chapter for additional information.

<i>Target Group</i>	<i>Recipients</i>	<i>Description</i>
Target Group 1	Mentally ill adults	Medicaid-eligible individuals age 18 and over who have been diagnosed with mental illness
Target Group 2	Intellectually Disabled Adults	Medicaid-eligible individuals age 18 and over who have been diagnosed with an intellectual disability.
Target Group 3	Disabled children	Medicaid-eligible individuals age 0-21 who are considered disabled
Target Group 4	Foster children	Medicaid-eligible individuals age 0-20 or until the individual reaches age 21 who are in the care, custody, or control of the state of Alabama
Target Group 5	Pregnant women	Medicaid-eligible women of any age in need of maternity services
Target Group 6	AIDS/HIV-positive individuals	Medicaid-eligible individuals of any age who have been diagnosed as having AIDS or being HIV-positive
Target Group 7	Adult protective service individuals	Medicaid-eligible individuals age 18 and over who are at risk of abuse, neglect, or exploitation
Target Group 8	Technology Assisted (TA) Waiver for adults	Medicaid-eligible individuals age 21 and over who meet the eligibility criteria for the TA Waiver
Target Group 9	Individuals with a Diagnosed Substance Use Disorder	Medicaid-eligible individuals of any age who have been diagnosed with a substance use disorder.

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Target Group	Recipients	Description
Target 10	Disabled Children with ASD or SED and SMI Adults – High Intensity Care Coordination	Medicaid-eligible individuals age 0-20 or until the individual reaches age 21 who have Autism Spectrum Disorder (ASD) or a Serious Emotional Disturbance (SED) or an adult with a Severe Mental Illness (SMI) and requires High Intensity Care Coordination.

The policy provisions for TCM providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 40.

106.1 Enrollment

Providers/Subcontractors will submit a written request to the State Agency/Contractor for enrollment to the Targeted Case Management (TCM) Services Program. The request must contain the TCM target group to be covered: the name, address, and phone number of the provider agency; the name, address, and phone number of the payee (if different from the provider); the name and phone number of the contact person; and the tax ID number of the payee.

Subcontract providers must have a contract with the primary provider and be certified through the appropriate State Agency. A copy of this contract will be submitted with the request to enroll as a TCM provider.

A memo along with the Provider File Update Request Form must be forwarded to the Targeted Case Management (TCM) Unit with the assigned NPI, procedure code, and rate with the enrollment request information. This information will be sent to the Fiscal Agent Liaison and will be loaded to the pricing file.

The TCM Unit will notify the State Agency/Contractor of the effective date of enrollment in writing when the enrollment process has been completed.

Refer to Chapter 2, *Becoming a Medicaid Provider*, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a TCM provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for case management-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

TCM providers, with the exception of Target Group 9 providers, are assigned a provider type of 21 (Targeted Case Management). The assigned provider type for Target Group 9 is 11 (Mental Health). Valid specialties for TCM providers include the following:

- Mentally Ill Adults (209)

- Intellectually Disabled Adults (229)
- Disabled Children (650)
- Foster Child (217)
- Pregnant Women (210)
- AIDS/HIV Positive Individuals (211)
- Adult Protective Services (640)
- Technology Assisted (TA) Waiver Eligible Adults (590)
- Individuals with a Diagnosed Substance Use Disorder (113)
- Autism Spectrum Disorder – High Intensity Care Coordination (212)

Enrollment Policy for TCM Providers

To participate in the Alabama Medicaid Program, Targeted Case Management providers must meet the following requirements:

- Demonstrate the capacity to provide the core elements of case management, including assessment, care and services plan development, linking and coordination of services, and reassessment and follow-up
- Demonstrate case management experience in coordinating and linking community resources as required by the target population
- Demonstrate experience with the target population
- Provide the administrative capacity to ensure quality of services in accordance with state and federal requirements
- Maintain a financial management system that provides documentation of services and costs
- Demonstrate the capacity to document and maintain individual case records in accordance with state and federal requirements
- Demonstrate the ability to ensure a referral process consistent with Section 1902(a)23 of the Social Security Act, freedom of choice of provider
- Demonstrate the capacity to meet the case management service needs of the target population
- Provide an approved training program certified by Medicaid to address the needs and problems of the recipients served
- Provide a quality assurance program for case management services approved and certified by Medicaid. The quality assurance program includes record reviews at a minimum of every six months.
- Fully comply with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act of 1990
- Fully comply with applicable federal and state laws and regulations

106.1.1 Minimum Qualifications for Individual Targeted Case Managers

Individual Targeted Case Managers for target groups 1, 2, 3, 9, and 10 must meet the following minimum educational qualifications:

- Possess a Bachelor of Arts or a Bachelor of Science degree, preferably in a human services related field or social work program, or possess certification as a registered nurse.

Individual Case Managers for Foster Children (Target Group 4) and Adult Protective Service individuals (Target Group 7) must be employed by DHR and meet the following qualifications:

- Possess a Bachelor of Arts or a Bachelor of Science degree, preferably in a human service field, or
- Possess certification as a registered nurse

In addition to the minimum educational requirements, Targeted Case Managers must complete training in a case management curriculum approved by Medicaid and other applicable state agencies. Specific requirements for each target group are listed in the following paragraphs.

106.1.2 Minimum Qualifications for Each Target Group

Minimum Qualifications for Target Group 1 Providers

TCM providers for Mentally Ill Adults (Target Group 1) must meet the minimum educational qualifications listed in Section 106. 1.1 and must complete training in a case management curriculum approved by Medicaid and the Department of Mental Health.

TCM providers for Mentally Ill Adults (Target Group 1) must be Regional Boards incorporated under Act 310 of the 1967 Alabama Acts & Comprehensive Community Health Centers who have demonstrated the ability to provide targeted case management services directly, or the Alabama Department of Mental Health. TCM providers for Mentally Ill Adults must be certified and provide services through a contract with the Department of Mental Health.

Minimum Qualifications for Target Group 2 Providers

TCM providers for Intellectually Disabled Adults (Target Group 2) must meet the minimum educational qualifications listed in Section 106. 1.1 and must complete training in a case management curriculum approved by Medicaid and the Department of Mental Health.

The Alabama Department of Mental Health (ADMH) case management providers for Intellectually Disabled Adults (Target Group 2) will be Regional Boards incorporated under Act 310 of the 1967 Alabama Acts who has demonstrated the ability to provide targeted case management services directly, be ADMH employees or other contractors of ADMH.

Minimum Qualifications for Target Group 3 Providers

TCM providers for Disabled Children (Target Group 3) must meet the minimum qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

The Alabama Department of Mental Health (ADMH) case management providers for Disabled Children (Target Group 3, Subgroup B-SED) must be Regional Boards incorporated under Act 310 of the 1967 Alabama Acts who have demonstrated the ability to provide targeted case management directly or be ADMH employees. TCM providers for Disabled Children through DMH must be certified and provide services through a contract with "DMH." Act 310 provides for the formation of a public corporation to contract with ADMH in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

The ADMH case management provider for Disabled Children (Target Group 3, Subgroup A- Intellectually Disabled and Target 3, Subgroup D14- Children with Autism Spectrum Disorder) must be Regional Boards incorporated under Act 310 of the 1967 Alabama Act who have demonstrated ability to provide targeted case management services directly, be ADMH employees, or other contractors of ADMH. Act 310 provides for the formation of a public corporation to contract with ADMH in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

Minimum Qualifications for Target Group 4 Providers

TCM providers for Foster Children (Target Group 4) must meet the minimum educational qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Groups 5 and 6 Providers

TCM providers for Pregnant Women (Target Group 5) and AIDS/HIV-Positive Individuals (Target Group 6) must meet the minimum qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Group 7 Providers

TCM providers for Adult Protective Services (Target Group 7) must meet the minimum educational qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Targeted Case Management Service Providers for Adult Protective Service Individuals (Target Group 7) must demonstrate experience with the target population in investigating abuse, neglect, or exploitation in domestic settings and in providing follow-up services to victims of abuse, neglect, or exploitation.

Minimum Qualifications for Target Group 8 Providers

TCM providers for Technology Assisted Waiver eligible adult individuals (Target Group 8) must meet the minimum qualifications listed in Section

106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Group 9 Providers

TCM providers for Individuals with a Diagnosed Substance Use Disorder (Target Group 9) must meet the minimum educational qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid and the Department of Mental Health.

TCM providers for Individuals with a Diagnosed Substance Use Disorder (Target Group 9) must be certified and provide services through a contract with the Department of Mental Health.

Minimum Qualifications for Target Group 10 Providers

TCM providers for Disabled Children with Autism Spectrum Disorder, Disabled Children with Serious Emotional Disturbance, and adults with Severe Mental Illness – High Intensity Care Coordination (Target Group 10) must meet the qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

The Alabama Department of Mental Health (ADMH) case management provider (for Target 10, Autism Spectrum Disorder (ASD)) must be Regional Boards incorporated under Act 310 of the 1967 Alabama Acts who have demonstrated the ability to provide targeted case management services directly, be ADMH employees, or other contractors of ADMH. Providers must be certified by the DMH and provide services through a contract with ADMH. Act 310 provides for the formation of a public corporation to contract with ADMH in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

The ADMH case management provider (for Target 10, Serious Emotional Disturbance (SED) and Severely Mentally Ill (SMI) must be either Regional Boards incorporated under Act 310 of the 1967 Alabama Act who have demonstrated ability to provide targeted case management services directly or be ADMH employees. Providers must be certified by the Alabama Department of Mental Health and provide services through a contract with ADMH. Act 310 provides for the formation of a public corporation to contract with the Alabama Department of Mental Health in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

106.2 Benefits and Limitations

This section describes benefits and limitations for Targeted Case Management providers. It contains the following subsections:

- Core Elements of Targeted Case Management
- Target Group Definitions
- Documentation Requirements
- Limitations
- Billable/Non-Billable Services

106.2.1 Core Elements of Targeted Case Management

Case management services assist Medicaid-eligible recipients in gaining access to needed medical, social, educational, and other services. The case manager provides these services through telephone contact with recipients, face-to-face contact with recipients, telephone contact with collaterals, or face-to-face contact with collaterals. Collaterals are the Medicaid-eligible recipient's immediate family and/or guardians, federal, state, or local service agencies (or agency representatives), and local businesses who work with the case manager to assist the recipient.

Targeted Case Management services consist of the following six core elements, they are considered direct activities and are billable:

- Needs assessment
- Case planning
- Service arrangement
- Social support
- Reassessment and follow-up
- Monitoring

Needs assessment

A TCM provider performs a written comprehensive assessment of the recipient's assets, deficits, and needs. The completed assessment must be maintained in the recipient's file.

The TCM provider gathers the following information:

- Identifying information
- Socialization and recreational needs
- Training needs for community living
- Vocational needs
- Physical needs
- Medical care concerns
- Social and emotional status
- Housing and physical environment
- Resource analysis and planning

Case planning

TCM providers must develop a systematic, recipient-coordinated Plan of Care (POC). The POC lists the recipient's needs, strengths, and goals. The POC also lists the actions required to meet the identified needs of the recipient. It is based on the needs assessment and is developed through a collaborative process involving the recipient, their family or other support system and the case manager. It must be completed in conjunction with the needs assessment within the first **30 days** of contact with the recipient.

Service arrangement

Through linkage and advocacy, the case manager coordinates contacts between the recipient and the appropriate person or agency. These contacts may be face to face, phone calls, or electronic communication.

The POC lists the recipient's needs, strengths, and goals. The POC also lists the actions required to meet the identified needs of the recipient. It is based on the needs assessment and is developed through a collaborative process involving the recipient, their family or other support system and the case manager

A copy of the safety and/or crisis plan must be kept in the recipient's file.

Social Support

Through interviews with the recipient and significant others, the case manager determines whether the recipient possesses an adequate personal support system. If this personal support system is inadequate or nonexistent, the case manager assists the recipient in expanding or establishing such a network through advocacy and linking the recipient with appropriate persons, support groups, or agencies.

Reassessment and Follow-up

Through interviews and observations, the case manager evaluates the recipient's progress toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the case manager contacts persons or agencies providing services to the recipient and reviews the results of these contacts, together with the changes in the recipient's needs shown in the reassessments and revises the case plan if necessary.

Monitoring

The case manager determines what services have been delivered and whether they adequately meet the needs of the recipient. The POC may require adjustments as a result of monitoring.

106.2.2 Target Group Definitions

This section defines the eight target groups served by TCM providers.

Target Group 1 – Mentally Ill Adults

Target Group 1 consists of functionally limited individuals age 18 and over with multiple needs who have been assessed by a qualified professional and have been found to require mental health case management. Such persons

have a diagnosis included in the ICD-10 as appropriate to date of service (other than intellectual/developmental disabilities, autism spectrum disorder, organic mental disorder, traumatic brain injury, or substance abuse), impaired role functioning, and a documented lack of capacity for independently accessing and sustaining involvement with needed services.

Target Group 2 – Intellectually Disabled Adults

Target Group 2 consists of individuals who are 18 years of age or older with a diagnosis of intellectual disability, as defined by the American Association of Intellectually Disabled (formerly AAMD). The individual's diagnosis must be determined by a Qualified Intellectually Disabled Professional (QIDP) and must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to being Intellectually Disabled. Such persons may have other or secondary disabling conditions.

Target Group 3 – Disabled Children

Target Group 3 consists of individuals, age 0-21 considered to be disabled as defined in the following six subgroups:

- Intellectually Disabled/related conditions
- Seriously emotionally disturbed
- Sensory impaired
- Disabling health condition(s)
- Developmentally disabled

Disabled Intellectually Disabled/Related Conditions

All recipients in this subgroup must be age 0-17. A recipient is considered Intellectually Disabled when a diagnosis of an intellectual disability is determined. This determination must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to an intellectual disability.

Recipients with related conditions are individuals who have a severe chronic disability described by all of the following criteria:

- Attributable to Cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to being Intellectual Disabled because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of an intellectual disability persons, and requires treatment or services similar to those required for these persons
- Likely to continue indefinitely
- Results in substantial functional limitations in three or more of the following areas of major life activity:
 - Self-care
 - Understanding and use of language
 - Learning
 - Mobility

- Self-direction or capacity for independent living

Seriously Emotionally Disturbed (SED)

In order to meet the definition of Seriously Emotionally Disturbed, the recipient must meet the following criteria (Diagnosis and Jeopardy of being Separated from Family) or (Diagnosis and Functional Impairment):

Diagnosis:

Must have a DSM/ICD diagnosis. A primary diagnosis of a “Z” code, substance use, autism spectrum disorder, developmental/intellectual disability, organic mental disorder, or traumatic brain injury does not meet the criteria.

Jeopardy of being Separated from Family (Out-of-Home Placement):

Still residing in the community, but in jeopardy of being separated from family as the result of a serious emotional disturbance.

Functional Impairments/Symptoms/Risk of Separation – Must have one of the following as the result of a serious emotional disturbance:

-Functional Impairment – Must have substantial impairment in one of the following capacities to function (corresponding to expected developmental level):

-Autonomous Functioning: Performance of the age appropriate activities of daily living, e.g., personal hygiene, grooming, mobility;

-Functioning in the community – e.g., relationships with neighbors, involvement in recreational activities;

-Functioning in the Family or Family Equivalent – e.g., relationships with parents/parent surrogates, siblings, relatives;

-Functioning in School/work – e.g., relationships with peers/teachers/co-workers, adequate completion of school work.

Symptoms – Must have one of the following:

-Features associated with Psychotic Disorders

-Suicidal or Homicidal Gesture or Ideation

-Risk of Separation: Without treatment, there is imminent risk of separation from the family/family equivalent or placement in a more restrictive treatment setting.

Sensory Impaired

Blind recipients have no usable vision after the best possible correction. They must rely on tactile and auditory senses to obtain information.

Partially sighted recipients have a visual acuity of 20/70 or less in the better eye with the best possible correction. They also have a peripheral field so

restricted that it affects their ability to learn, or a progressive loss of vision which may in the future affect their ability to learn.

Deaf recipients have a hearing impairment that is so severe that they are impaired in processing linguistic information through hearing, with or without amplification. This impairment adversely affects educational performance.

Blind disabled recipients have a visual impairment (either blind or partially sighted as defined above) and a concurring disabling condition.

Deaf disabled recipients have a hearing impairment (deaf as defined above) and a concurring disabling condition.

Deaf-blind recipients have both hearing and visual impairments. The combination of sensory impairments causes such severe communication and other developmental and educational problems that the recipient cannot be properly accommodated in the educational programs offered by the Alabama School for the Blind or the Alabama School for the Deaf.

Disabling Health Condition(s)

Recipients are eligible for Targeted Case Management services if they have the following disabling conditions, which are severe, chronic, and physical in nature and require extensive medical and habilitative/rehabilitative services.

- Central nervous system dysraphic states such as spina bifida, hydranencephaly, and encephalocele
- Cranio-facial anomalies such as cleft lip and palate, Apert's syndrome, and Crouzon's syndrome
- Pulmonary conditions such as cystic fibrosis
- Neuro-muscular conditions such as cerebral palsy, arthrogryposis, and juvenile rheumatoid arthritis
- Seizure disorders such as those poorly responsive to anticonvulsant therapy and those of mixed seizure type
- Hematologic/immunologic disorders such as hemophilia, sickle cell disease, aplastic anemia, and agammaglobulinemia
- Heart conditions such as aortic coarctation, and transposition of the great vessels
- Urologic conditions such as exstrophy of bladder
- Gastrointestinal conditions such as Hirschsprung's Disease, omphalocele, and gastroschisis
- Orthopedic problems such as clubfoot, scoliosis, fractures, and poliomyelitis
- Metabolic disorders such as panhypopituitarism
- Neoplasms such as leukemia, and retinoblastoma
- Multisystem genetic disorders such as tuberous sclerosis, and neurofibromatosis
- Autism Spectrum Disorder for a child or youth ages 0 to 21. In order to meet the definition of ASD, the recipient must meet the following criteria:
 - Must have a diagnosis of Autism Spectrum Disorder.

- The individual has adaptive and/or maladaptive needs identified by established assessment criteria that require a multi-disciplinary service team from more than one eligible child-serving agency and/or are related to one or more co-occurring diagnoses.

Developmentally Disabled

A child age birth to three years is eligible for TCM services if they are experiencing developmental disabilities greater than or equal to 25 percent as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:

- Cognitive development
- Physical development, including vision and hearing
- Language and speech development
- Psychosocial development
- Self-help skills

A recipient is also eligible if they have been diagnosed with a physical or mental condition that has a high probability of resulting in a developmental disability.

Disabled

A disabled individual who has a combination of two or more disabling conditions as described above is considered disabled. Each condition, if considered separately, might not be severe enough to warrant case management, but a combination of the conditions adversely affects development.

Target Group 4 – Foster Children

Target Group 4 consists of children age birth to 21 who receive preventive, protective family preservation or family reunification services from the State, or any of its agencies, as a result of State intervention or upon application by the child's parent(s), custodian(s), or guardian(s).

The group also consists of children age birth to 21 who are in the care, custody, or control of the State of Alabama, or any of its agencies, due to one of the following three situations.

- The judicial or legally sanctioned determination that the child must be protected by the State as dependent, delinquent, or a child in need of supervision as those terms are defined by the Alabama Juvenile Code, Title 12, Chapter 15, Code of Alabama 1975
- The judicial determination or statutorily authorized action by the State to protect the child from actual or potential abuse under the Alabama Juvenile Code, Title 26, Chapter 14, Code of Alabama 1975, or other statute
- The voluntary placement agreement, voluntary boarding house agreement, or an agreement for foster care, between the State and the child's parent(s), custodian(s), or guardian

Target Group 5 – Pregnant Women

Target Group 5 consists of Medicaid-eligible women of any age in need of maternity services.

Target Group 6 – AIDS/HIV-Positive Individuals

Target Group 6 consists of Medicaid-eligible individuals of any age who have been diagnosed with AIDS or are HIV-positive as evidenced by laboratory findings.

Target Group 7 – Adult Protective Service Individuals

Target Group 7 consists of individuals 18 years of age or older who meet either of the following criteria:

- At risk of abuse, neglect, or exploitation
- At risk of institutionalization due to their inability or their caretaker's inability to provide the minimum sufficient level of care in the home

Target Group 8 - Technology Assisted (TA) Waiver for Adults

Target Group 8 individuals consist of Medicaid eligible individuals age 21 and older, who meet the eligibility criteria for the Technology Assisted (TA) Waiver for Adults.

Target Group 9 – Individuals with a Diagnosed Substance Use Disorder

Target Group 9 consists of Medicaid-eligible individuals who have a diagnosed substance use disorder or substance induced disorder, in accordance with criteria set forth by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, and who meet the following additional criteria.

Individuals who:

- Have been unable to independently maintain a sustained period of recovery after repeated treatment episodes; or
- Have little or no access to community resources necessary to support sustained recovery efforts; or
- Have co-morbid conditions, as mental illness, emotional disorders, intellectual disabilities, medical conditions, sensory impairments, or mobility impairments; or
- Have significant responsibility for the care of dependents, as well as themselves

Target Group 10 – High Intensity Care Coordination.

Intensive Care Coordination (ICC)—means a single case manager (and/or a single treatment team) and a treatment plan that guides the provision of all behavioral health and related support services.

Target Group 10 consists of individuals considered to be disabled as defined in the following three subgroups:

- Autism Spectrum Disorder (ASD) consists of individuals with Autism Spectrum Disorder, age 0-21.

- Seriously Emotionally Disturbed (SED) – consists of disabled children with Serious Emotional Disturbance, age 0-21.
- Severely Mentally Ill (SMI) – consists of disabled individuals with Serious Mental Illness, age 18 and older.

The population to be served consists of individuals age 0 to 20 or until the individual reaches age 21 considered to be disabled as defined in the following two subgroups and who require a multi-disciplinary service team from more than one child-serving agency or who have one or more co-occurring diagnoses;

Autism Spectrum Disorder

All recipients in this subgroup consists of individuals age 0 to 20 or until the individual reaches age 21.

In order to meet the definition of Autism Spectrum Disorder, the recipient must meet the following criteria:

- **Must have a diagnosis of Autism Spectrum Disorder.**
- **The individual has adaptive and/or maladaptive needs and caregiver needs identified by established assessment criteria that require a multi-disciplinary service team from more than one eligible child-serving agency and/or are related to one or more co-occurring diagnoses.**

Seriously Emotionally Disturbed

All recipients in this subgroup consists of individuals age 0 to 20 or until the individual reaches 21.

In order to meet the definition of Seriously Emotionally Disturbed, the recipient must meet the following criteria for (Diagnosis and Jeopardy of being Separated from Family) or Diagnosis and Functional Impairment) and require a multi-disciplinary service team from more than one child-serving agency or who have one or more co-occurring diagnoses.

- **Diagnosis:**
 - Must have a DSM/ICD diagnosis. A primary diagnosis of a “Z” code, substance use, autism spectrum disorder, developmental/intellectual disability, organic mental disorder, or traumatic brain injury does not meet the criteria.
- **Jeopardy of being Separated from Family (Out-of-Home Placement):**
 - Still residing in the community but in jeopardy of being separated from family as the result of a serious emotional disturbance:

- **Functional Impairments/Symptoms/Risk of separation** – Must have one of the following as the result of a serious emotional disturbance:
- **Functional Impairment** – Must have substantial impairment in one of the following capacities to function (corresponding to expected developmental level):
 1. **Autonomous Functioning:** Performance of the age appropriate activities of daily living, e.g., personal hygiene, grooming, mobility;
 2. **Functioning in the community** – e.g., relationships with neighbors, involvement in recreational activities;
 3. **Functioning in the Family or Family Equivalent** – e.g. Relationships with parents/parent surrogates, siblings, relatives;
 4. **Functioning in School/work** – e.g., relationships with peers/teachers/co-workers, adequate completion of school/work.

-Symptoms – Must have one of the following:

1. **Features associated with Psychotic Disorders**
2. **Suicidal or Homicidal Gesture or Ideation**
3. **Risk of Separation:**
Without treatment, there is imminent risk of separation from the family/family equivalent or placement in a more restrictive treatment setting.

Severely Mentally Ill

All recipients in this subgroup consists of individuals age 18 and older considered to be disabled as defined in the following subgroup and who require a multi-disciplinary service team from more than one agency or who have one or more co-occurring diagnosis:

- **Severely Mentally Ill (SMI):** The population to be served consists of functionally limited individuals 18 years of age or older with multiple needs who have been assessed by a qualified professional and have been found to require mental health case management. Such persons have a diagnosis included in the ICD-10 as appropriate to date of service (other than primary developmental/intellectual disabilities, autism spectrum disorder, organic mental disorder, traumatic brain injury, or substance abuse), impaired role functioning, and a documented lack of capacity for independently accessing, and sustaining involvement with needed services.

106.2.3 Documentation Requirements

The TCM provider must make available to Medicaid at no charge all information describing services provided to eligible recipients. The provider must also permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of Federal and State agencies.

The TCM provider must maintain complete and accurate medical, psychiatric and fiscal records that fully disclose the extent of the service. **All documented entries must be legible, signed and dated by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must, either personally or electronically sign his or her entry. A stamped signature is not acceptable.**

Record retention for TCM files will remain three years plus the current year. Records for TCM provided through waivers shall be retained for three years during the initial waiver period and five years after renewal of the waivers.

Provider's records must contain the following information:

- Documented Referral Source
- Copy of completed Alabama Child and Adolescent Needs and Strengths Assessment (CANS), when applicable
- Medical and Psychological diagnosis
- Psychological and Medical test results performed by a qualified professional
- A systematic, recipient-coordinated Plan Of Care (POC). The POC should contain all 6 (six) core elements of TCM
- Verification that the recipient's Medicaid Eligibility was checked at admission and at least once a month, thereafter. NOTE: There are times when a recipient's eligibility status may change throughout the month. It is the provider's responsibility to ensure that a recipient has the applicable Alabama Medicaid coverage for the date(s) of service for which services will be provided. Providers may use various resources to verify recipient's eligibility. (For more information, refer to the Provider Manual, Chapter 3: Verifying Recipient Eligibility)
- Family history
- Educational history
- Medical history
- Educational/vocational history
- Psychiatric treatment history
- Legal history
- Substance abuse history
- Mental status exam

TCM providers must maintain the following documentation in the recipient's record when billing for Foster Children (Target Group 4) and Adult Protective Service Individuals (Target Group 7):

- A current comprehensive service plan that identifies the medical, nutritional, social, educational, transportation, housing and other service needs that have not been adequately accessed
- A time frame to reassess service needs

Services must consist of at least one of the following activities:

- Establishment of a comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of -the recipient
- Assistance for the recipient in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan
- Assessment of the recipient and service providers to determine that the services received are adequate in meeting the identified needs
- Reassessment of the recipient to determine services needed to resolve any crisis situation resulting from changes in the family structure, living conditions, or other events

Service Documentation

Documentation in the client's record for each session, service, or activity for which Medicaid reimbursement is requested must include, the following:

- Name of recipient
- Date of service
- Name of provider agency and person providing services
- Nature, extent, and units of services provided
- Place of service
- The identification of the specific services rendered
- The signature of the staff person who rendered the services
- A written assessment of the client's progress, or lack thereof, related to each of the identified clinical issues discussed
- All entries must be legible and complete and must be authenticated and dated (prior to being submitted for reimbursement) by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include handwritten signatures, written initials (for treatment plan reviews), or computer entry (associated with electronic records—not a typed signature). A stamped signature is not acceptable.

NOTE:

The documentation requirements described above will be applied to justify payment by Medicaid when clinical records are audited. Payments are subject to recoupment when the documentation is insufficient to support the services billed.

Service Documentation - Additional Information

Documentation should not be repetitive. Examples include, but are not limited to the following:

- Progress notes that look the same for other recipients.
- Progress notes that state the same words with no evidence of progression, maintenance, or regression.
- Plans of care that look the same for other recipients.
- Plans of care with goals and actions that stay the same and have no progression.

Progress Notes

- Progress notes should not be **preprinted** or predated with the exception that a group therapy note may have a general section that identifies the participants (i.e. the number of participants, etc.), the topic, and a general description of the session which is copied for each participant. However, each participant must also have individualized documentation that is specific to his/her interaction in the group and how it relates to their POC.
- The progress note should match the goals on the Plan of Care and the Plan of Care should match the needs of the recipient. The actions should be appropriate to meet the goals.
- Documentation must provide enough detail and explanation to justify the reimbursement requested.
- If Case Management (CM) services are rendered to more than one eligible recipient in a household on the same day, the case management documentation must include the following information:
 - All documentation must be individualized to each eligible recipient's visit
 - There must be enough documentation in the recipient's file that support that the services rendered are specific to his/hers Person Centered Plan of Care

Authentication

- Authors must always compose and sign their own entries (whether handwritten or electronic). An author should never create an entry or sign an entry for someone else or have someone else formulate or sign an entry for them. If utilizing a computer entry system, the program must contain an attestation signature line and time & date entry stamp. A stamped signature is not acceptable.
- If utilizing a computer entry system, the program must contain an attestation signature line and time & date entry stamp. There must also be a written policy for documentation method in case of computer failure/power outage.

Reimbursements

For Target Group 4 (Foster Children) and Target Group 7 (Adult Protective Service Individuals), reimbursement rates are based on cost as determined by the quarterly Social Services Work Sampling Study. Rates will be adjusted annually based on the results of the previous four quarters. Random Moment Sampling may not be used as a method of documenting services provided to recipients. The Work Sampling Study must provide an audit trail that identifies each recipient whose case is included in the data used for rate formulation and identifies that services have been provided.

106.2.4 Limitations

For Target Group 4 (Foster Children) and Target Group 7 (Adult Protective Service Individuals), an encounter rate consisting of a maximum of one unit of case management services will be reimbursed per month for each eligible recipient receiving case management services. A unit of case management service consists of at least one telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the recipient receives or may receive services.

For Target Group 10 (Disabled Children with ASD, Disabled Children with SED, and Severely Mentally Ill Adults High Intensity Care Coordination), the monthly encounter rate for case management services is limited to one recipient per month. The payment rates were derived from an analysis of caseloads and staffing configurations, productivity, staffing costs and fee-for-service utilization. The caseloads and staffing configuration must adhere to the 1:18 ratio for Target Group 10. (Please refer to DMH policy as it refers to Low/High Intensity Care Coordination). For the provider to bill for a full month case rate, the recipient must maintain eligibility to receive services AND be enrolled with the provider during a period of **20 or more days**.

For all other target groups, a unit of service is reimbursed in increments of five minutes.

All contacts must appear in the recipient's record. Contacts must be for the coordination of services for a specific identified recipient. (Please refer to *Progress Notes* description in the **Service Documentation- Additional Information** section)

Recipients receiving case management services through a waiver are not eligible for targeted case management, except for Target Group 7 (Adult Protective Service Individuals). TCM for Group 7 may be provided in any setting including total care environments.

Case management services for Intellectually Disabled Adults are provided to individuals with a diagnosis of intellectual disability who are 18 years of age or older.

Case management services for all other target groups are not limited to a maximum number of hours per calendar year.

106.2.5 Billable/Non-Billable Services

The following services are Direct and are billable:

Billable units are for time spent delivering a case management service. That service may occur face-to-face with the beneficiary or may consist of telephone contacts or mail or e-mail contacts necessary to ensure that the beneficiary is served.

In Target Group 4, 7 and 10, where payment is cost based, the case management rate can factor in the cost associated with mileage (in a cost-based payment methodology, by allocating such costs among all the productive time increments). It may also include the actual writing of case notes, time documenting social history and writing the information gathered for the case file for the development of a specific care plan; and the gathering of information and the actual documentation. The state may also document non-productive time by providing evidence of State or private agency policies regarding sick leave, vacation leave, paid holidays and training requirements. Any other non-productive time must be documented via use of a CMS approved time study.

Billable Services

The following services are examples of considered billable activities and are reimbursable under the Targeted Case Management Program:

- Meeting with the individual and the individual's team to complete case management plan/ISP/IEP.
- Telephone contact to gather information for an assessment.
- Visiting the day program/resident/community setting to meet with an individual and support staff to assess progress toward objectives.
- Telephone calls and face to face meetings with family, friends, community members, and agencies for the purpose of developing, arranging for, or coordinating formal and informal supports.
- Reviewing records of providers of services to ensure proper documentation is in place.
- Providing an individual with information on advocacy groups, i.e. ADAP, Legal Aid.
- Documentation of assessments.
 - For targeted groups 1, 3, and 10, when providing care coordination services in an inpatient acute facility, psychiatric residential treatment center, Institute of Mental Disease (IMD), or any other facility within

180 consecutive days of discharge from a medical institution, providers must bill the ‘from and to’ dates of the recipient’s hospitalization, if known, in Form Locator 18 under ‘Hospitalization Dates Related to Current Services’ on the CMS-1500 claim for or the 837 equivalent.

- If a provider bills Medicaid for case management services for a recipient with multiple hospital admissions and discharges within a month (for the target groups stated above), the provider must submit a separate claim form for each hospital admission and include the applicable discharge date. The hospitalization “from and to” dates must be indicated on the CMS-1500 Claim Form or the 837 equivalent, under “Hospitalization Dates” area.
- All hospitalization “from and to dates” must be documented in the recipient’s file. The documented hospitalization “from and to” dates documented in the recipient’s file must match the hospitalization “from and to” dates on the submitted claim form.
- A post payment review will be completed by Medicaid every 6 months to determine if payment was made inappropriately based the hospitalization policy described above.
- Claims identified for services provided prior to the 180- day timeframe may be recouped.

Non-Billable Services

The following services are activities that are made on behalf of a group of individuals and not just a specific person, they are non-billable and are not reimbursable under the Targeted Case Management Program:

- Travel
- The actual scheduling of a meeting with an individual/family to complete the History and Profiles/SUN-R.
- Transporting an individual/family.
- Documentation of case notes and social history.
- Completing travel forms, leave slips, or any other general office activities, including copy work and other clerical activities.
- Visiting an individual who is in a hospital or nursing home. (Exception, services will be available for up to **180 consecutive days** of a covered stay in a medical institution).
- Visiting an individual in a prison or jail. ,
- Visiting an individual in an ICF/ID facility.
- Checking an individual’s Medicaid eligibility.

Duplicate Billing

Before providing Targeted Case Management (TCM) services, verify that the recipient is not receiving case management services through another Targeted Group or Waiver. If the recipient receives additional case management services, but the TCM services would not be duplicative, the Provider must document in writing to the Agency how their services would not present a duplication of services from other case management services received. The provider must have written approval from Medicaid prior to submitting the claim to the Agency for reimbursement for Targeted Case

Management services. The Agency will pay for one case management fee per month and will recoup any claims paid in error unless the Agency has determined there is no duplication of services and gives prior approval for the TCM services provided.

In order to prevent duplicate billing, it is the responsibility of the Targeted Case Management Provider to check the recipient's eligibility at admission and monthly, as long as the recipient is receiving TCM services. If a provider requires training on checking the eligibility of recipients, they are encouraged to contact an Gainwell representative for assistance.

106.3 Prior Authorization and Referral Requirements

TCM procedure codes generally do not require prior authorization, except for the target groups noted below.

Targeted Case Management (TCM) providers must obtain prior authorization (PA) from the Alabama Medicaid Agency by submitting a PA request to Gainwell for TCM services in the following target groups:

- Target Group 3: Disabled Children except Target Group 3, Subgroup D14 – Children with Autism Spectrum Disorder
- Target Group 4: Foster Children
- High Intensity Care Coordination SED Children (Target Group 10)
- High Intensity Care Coordination ASD Children (Target Group 10)

Direct all inquiries and requests relating to prior authorization for a specific target group to Gainwell Provider Communication Unit at 1(800) 688-7989.

Interagency Transfers

If a recipient in a target group requiring prior authorization (PA) requests to change service providers from one agency to another, the receiving TCM provider must complete a request for interagency transfer utilizing the *TCM Recipient Transfer Form*. This request authorizes Gainwell to reassign the PA number to the receiving agency providing the continuation of targeted case management services.

The *TCM Recipient Transfer Form* is a PA option in the Secure Provider Portal under the "Trade Files" tab.

106.4 Cost Sharing (Copayment)

The copayment does not apply to services provided for targeted case management.

106.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

TCM providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

106.5.1 Time Limit for Filing Claims

Medicaid requires all claims for TCM providers to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

106.5.2 Diagnosis Codes

See Section 106.5.3 (Procedure Codes and Modifiers) for the allowable diagnosis codes. The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

106.5.3 Procedure Codes and Modifiers

TCM providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional and institutional claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following procedure codes, modifiers, and diagnosis codes apply when filing claims for TCM services for billing purposes only:

Target Group	Procedure Code	ICD-10 Diagnosis Codes	PA Required?
1 MI Adults	G9008-U1	F200 - F2089 F21 - F258 F28 F3011 - F308 F310 F3111 - F312 F3131 - F315 F3161 - F3164 F3171 - F3189 F320 - F328 F330 - F333 F3341 - F338 F340 - F348 F4001 - F4002 F4011 - F408 F410 - F418 F42 F440 - F4489 F450 - F451 F4521 - F4529 F458 F481 F488 F600 - F6089 F6811 - F688 F840 F843 - F848 F20.9 F25.9 F29 F30.10 F30.9 F31.10 F31.30 F31.60 F31.70 F31.9 F32 F32.9 F33.9 F34.9 F39 F40.00 F40.10 R452 R455 - R456	No
2 Intellectually Disabled Adults	G9008-U2	F70 - F78	No
3 Intellectually Disabled Child	G9005-U3	F70 - F73	Yes
3 Disabled Child ASD	G9002-UA	F84.0 F84.1 F84.5 F84.9	Yes
3 SED Child	G9002-U3	F489 R455 - R456	Yes
3 Sensory Impaired Child	G9008-U3	R29818 R29898 R2990 - R2991	Yes
3 Disabling Health	G9008-U3	E035	Yes

<i>Target Group</i>	<i>Procedure Code</i>	<i>ICD-10 Diagnosis Codes</i>	<i>PA Required?</i>
Child		F518 G4700 G4710 G4720 G4730 G478 - G476 R400 - R402344 R403 - R413 R4182 R419 - R42 R440 R442 - R443 R4583 - R4584 R502 - R509 R52 - R5383 R55 - R569 R61 R680 - R6812 R6881 R6883 R6889	
3 Disabled Child	G9008-U3	Q079	Yes
3 DD Child	G9006-U3	F819 - F89	Yes
4 Foster Child	T2023-U4	F849	Yes
5 Pregnant Women	G9008-HD	M830O000 - O9A53	No
6 AIDS/ HIV	G9012-U6	B20 B9735 O98711 - O98713 O9872 - O9873	No
7 APSI	T2023-U7	R4181	No
8 TA Waiver	G9008-U5	Z430	No
9 SUD – Adults and Adolescents	G9008-U9	F1010 - F1099 F1110 - F1199 F1210 - F1299 F1310 - F1399 F1410 - F1499 F1510 - F1599 F1610 - F1699 F1810 - F1899 F1910 - F1999	No
10 Disabled Child ASD	G9003-UA	F84.0 F84.1 F84.5 F84.9	Yes
10 Disabled Child SED	G9003-UA TG	F489 R455 – R456	Yes
10 Adults SMI	G9008-U1 TG	F200 – F2089 F21 – F258 F28 F3011 – F308 F310 F3111 – F312 F3131 – F315 F3161 - F3164 F3171 - F3189 F320 - F328 F330 - F333 F3341 - F338 F340 - F348 F4001 - F4002 F4011 - F408 F410 - F418	No

<i>Target Group</i>	<i>Procedure Code</i>	<i>ICD-10 Diagnosis Codes</i>	<i>PA Required?</i>
		F42 F440 - F4489 F450 - F451 F4521 - F4529 F458 F481 F488 F600 - F6089 F6811 - F688 F840 F843 - F848 F20.9 F25.9 F29 F30.10 F30.9 F31.10 F31.30 F31.60 F31.70 F31.9 F32 F32.9 F33.9 F34.9 F39 F40.00 F40.10 R452 R455 - R456	

For Target Group 10, the provider can use modifier '52' to bill for a partial month.

106.5.4 Place of Service Codes

The following place of service codes apply when filing claims for TCM services:

<i>POS Code</i>	<i>Description</i>
03	School
11	Office
12	Home
21	Inpatient Hospital (Medical)
24	Ambulatory Surgical Center
33	Custodial Care Facility
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
62	Comprehensive Outpatient Rehabilitation Facility
71	State or Local Public Health Clinic
81	Independent Laboratory
99	Other – Other place of service not identified above

Allowed for Target Groups 1, 3, and 10. Claim must be billed with Hospitalization Dates Related to Current Services (CMS-1500 Form Locator 18 or 837 equivalent) completed.

For dates of service beginning December 1, 2020, use POS Code 99 for all claims billed with multiple dates of service (one-line item on a claim for a consecutive date range, i.e. span billing) when the services are provided in multiple locations. The documentation to support these claims must indicate the place of service and all other documentation criteria in Chapter 106.

106.5.5 Required Attachments

There are no required attachments for Targeted Case Management providers.

106.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Alabama Coordinated Health Network (ACHN)	Chapter 40
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

106.7 Covered Services Eligible for Telemedicine

Refer to Chapter 112, Telemedicine Services, for general information and limitations.

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