ND Medicaid Policy
Targeted Case Management for Behavioral Health

TARGETED CASE MANAGEMENT SERVICES

Definition

Targeted case management (TCM) services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services necessary for appropriate care and treatment.

Targeted Case Management includes the following assistance:

A. Comprehensive assessment and periodic reassessment of individual needs to determine the need for medical, educational, social or other services. These assessment activities include:

- taking individual's history;
- identifying the individual's needs and completing related documentation; and
- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

B. Development (and periodic revision) of a specific care plan based on the information collected through the assessment that:

- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals;
- identifies a course of action to respond to the assessed needs of the eligible individual; and

C. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:

- activities that help link the individual with medical, social, educational providers, or other programs and services that can provide needed services to address identified needs and achieve goals specified in the care plan.

D. Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate;
    - changes in the needs or status of the individual are reflected in the care plan; and
    - monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Review Requirements: The care plan is reviewed and updated at least every six months to reflect the accomplishments and changing needs.

E. Collateral Contacts: Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of:
1) helping the eligible individual access services;
2) identifying needs and supports to assist the eligible individual in obtaining services;
3) providing case managers with useful feedback; and
4) alerting case managers to changes in the eligible individual's needs (42 CFR 440.169(e)).

Case management services are coordinated with and do not duplicate activities provided as part of institutional services and discharge planning activities.

TCM DOES NOT INCLUDE

TCM does not include, and Federal Financial Participation (FFP) is not available for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

See Addendum for common questions and answers.

INDIVIDUAL ELIGIBILITY FOR SERVICES

Target Group

To be eligible for this service,

(A) Adults must:

- Be Medicaid eligible; and
- Be 18 years of age or over.
- Have a behavioral health condition expected to last a year or longer; and
- Demonstrate at least a moderate level of functional impairment that interferes with or limits one or more major life activities, as measured by the Daily Living Activities assessment (DLA-20) or World Health Organization Disability Assessment Schedule; and
- Meets at least one of the following:
    - Undergone psychiatric treatment more intensive than outpatient services more than once related to their behavioral health condition; or
    - Has a history of documented problems resulting from their behavioral health condition for at least one year verified by family or local provider; or

- Has experienced a single episode of continuous structured supportive residential care other than hospitalization for at least two months.

(B) Children must:

- Be Medicaid eligible; and
- Be less than 21 years of age; and
- Have a behavioral health condition expected to last a year or longer; and
- Demonstrate at least a moderate level of functional impairment which substantially limits the child's role or functioning in family, school or community activities, as measured by the Daily Living Activities assessment (DLA-20) or World Health Organization Disability Assessment Schedule; and
- Be determined:
  a. To be having a psychiatric crisis or emergency which requires emergency intervention to prevent institutional placement; or
  b. To need long-term behavioral health services.

Exclusions for the Target Populations
Functional impairments that are temporary and expected responses to stressful events in the environment are not included.

For case management services provided to the target populations in medical institutions:
Target group is comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the 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 Directors Letter (SMDL), July 25, 2000)

Freedom of choice (42 CFR 441.18(a) (1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

PROVIDER QUALIFICATIONS

For dates of service on or after May 1, 2020, an agency must meet all the following criteria:

1. Demonstrate the ability to be available 24 hours, 7 days a week to individuals who need emergency case management services; and
2. Ensure supervisors of case management staff have a bachelor's degree and experience with case management.
3. Attest that individuals providing targeted case management have reviewed the competencies or standards of practice in one of the following:
   - The Substance Abuse and Mental Health Services Administration (SAMHSA) Core Competencies for Integrated Behavioral Health and Primary Care; or
   - The Case Management Society of America standards of practice.

4. Ensure that individuals providing case management have general knowledge, training and/or experience working with individuals with behavioral health conditions.
5. For North Dakota federally recognized Indian Tribes or Indian Tribal Organizations, attest that individual case managers enrolled with ND Medicaid possess the necessary cultural sensitivity and background knowledge to provide appropriate services to the Native American population served.

Individuals providing TCM:

- Must have a bachelor's degree.
- If the individual does not have a bachelor's degree, they will be allowed to enroll to provide TCM if they have at least five years of supervised experience working with individuals with behavioral health conditions in a role with case management functions such as individual assessment, care plan development and maintenance, referral and appointment scheduling, monitoring and follow-up activities.
- Individuals enrolled prior to May 1, 2020, will be allowed to remain enrolled and eligible to provide targeted case management, if they remain actively providing targeted case management services.

DOCUMENTATION REQUIREMENTS

The following list contains the minimum contents required for the care plan for each individual receiving TCM services.

- Name
- Age
- Family composition
- Current residency
- Education level or current educational setting
- Work status/employment
- Placement history (including facility, admission and discharge date)
- Narrative history or background of individual
- Presenting concerns
- Diagnosis (if applicable-all Axes)
- Behavioral patterns
- Names of Practitioners that are providing care/services to the individual
- Legal responsible party
- Treatment goals/primary plan of action
- Summary of progress/goals
- Medical needs (if available)
- Current health status (if available)
- Medication list (if available)
- Immunization record (if available)
- Recent medical appointments (if available)

Each individual should have a primary point of contact. The primary point of contact should be delineated and easily identifiable in the individual's care plan.

Providers delivering and billing for TCM must maintain case records that include the following items to support services billed. TCM activity must be documented as follows:

- The individual's name;
- The date of the TCM service;
- Each note or note page must include the provider of the TCM service;
- The nature, content, and time units (total time) of the TCM services received;
- Whether goals specified in the care plan have been or are being achieved;
- The need for and occurrences of coordination with other case managers;

- A timeline for obtaining needed services;
- A timeline for reevaluation of the plan,
- Whether the individual has declined services in the care plan.

General Documentation Checklist

- Do the contents link to the eligible individual's care plan?
- Are any abbreviations used standardized and consistent?
- Does the narrative support the units of TCM claimed?
- Would someone unfamiliar with a case be able to read the note and understand exactly what has occurred in TCM?
- Is the activity documented, consistent with the intent of this ND Medicaid TCM service? (refer to page one, definition)

Reimbursement is based on the factors above. Documentation must be rooted in the official electronic record, if applicable or official record format of the agency.

ND Medicaid or its federal oversight agencies may conduct pre or post payment documentation review to ensure that the above criteria are met. Handwriting on printed documentation is not an accepted practice to fulfill documentation requirements if an audit is done. Such actions could be construed as alteration of a medical record.

Failure to comply with above criteria may result in claim denial and recoupment of Medicaid payment.

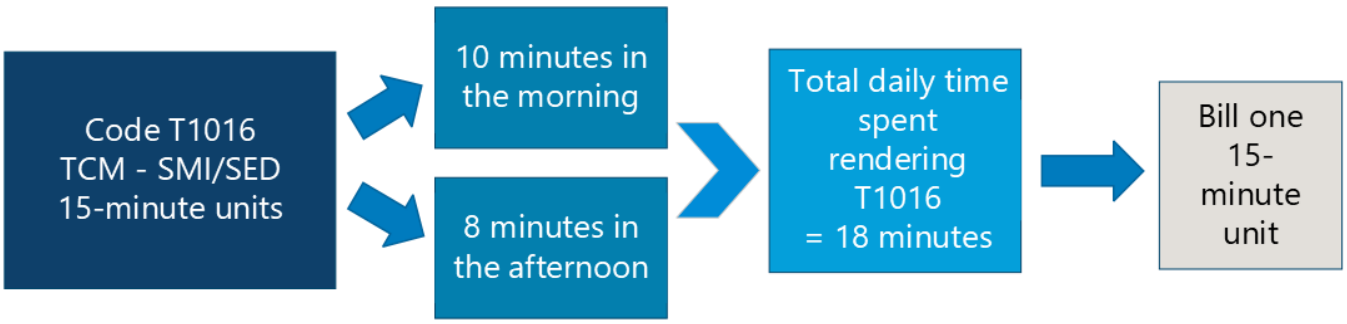
TCM SERVICES CODES

T1016 is the only code allowed for North Dakota Medicaid TCM for behavioral health.

15 minutes = 1 unit of service
8 – 15 minutes = 1 unit of service
7 minutes or less are not billable

Services are limited to four hours per day. If additional services are medically necessary, the provider may request service authorization from the North Dakota Medicaid Program.

When billing for one code that is billed in units (i.e. 15 minutes) throughout a day, report the total amount of units on one claim line.



USE OF THE WHODAS 2.0

The WHODAS is an assessment instrument for health and disability and can be used across all diseases, including mental, neurological and addictive disorders. It is short, simple and easy to administer and is applicable across cultures. It covers six domains of functioning, including cognition, mobility, self-care, getting along, life activities and participation.

To use the WHODAS 2.0, you must read the user manual at https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health/who-disability-assessment-schedule. More information and resources on the WHODAS can be accessed on the WHO website.

The WHO has provided guidance to the North Dakota Department of Human Services regarding use of the WHODAS in children. The WHO guidance states that the existing WHODAS 2.0 is suitable for individuals across the lifespan. There have been discussions about the applicability of questions of questions such as D4.5 (sexual activities) and those related to work/school as they may, naturally, not be applicable to young children. However, it is important to note that there may be many individuals, regardless of age, for whom a given question is not applicable, and there is a mechanism outlined in the user manual (http://apps.who.int/iris/bitstream/10665/43974/1/9789241547598_eng.pdf?ua=1) for how to calculate the score in the case of dropping a question or two.

In children who are not yet attending school, their work/school activities are best represented by "play", as this is how they learn. When administering the WHODAS with a child who is not yet attending school, use the following language for the instructions:

- 'Think back over the past 30 days and answer these questions thinking about how much difficulty you had doing the following:'
- For children, work/school activities may best be represented by "play".

ADDENDUM – Questions and Answers

1. **Is providing transportation for an individual an allowed TCM billable service?**
   No, however, if while transporting an individual to a visit, appointment, therapy, etc., and there is discussion about their care plan goals, tasks, updating information, this specific time can be billed for TCM. Documentation must be clear that while transporting the specified TCM activities occurred.

   The TCM activity must occur during the transportation time to bill for TCM. Example: If TCM services were provided and then transportation occurred, this transportation time is **not** billable. However, if while transporting an individual to a medical appointment, coordination, monitoring, and assessment of individual's current needs occurred to determine if a change in care plan is warranted, that specific time is billable for TCM.

   Billable time is commensurate with the time spent providing TCM activities and is not linked to the time spent traveling or providing transportation.

2. **Can TCM be billed for providing activities such as picking up medication boxes, helping an individual move living locations, taking an individual shopping, waiting for**

an individual while they are in an appointment, or participating with an individual in an activity such as fishing, bowling?
No, these activities are not allowable TCM activities. If during these activities, allowable TCM services were provided, with clear documentation of the context and time spent on these services, the specific TCM time is billable.

Billable time during these events is commensurate with the time spent providing TCM activities and not tied to the length of the event/activity. Example: During a bowling activity, the case manager spent time discussing with the individual an upcoming medical appointment and was assessing whether the service continued to be appropriate plus a plan to make a referral for physical therapy was discussed and detailed. This excursion resulted in two hours of time (8 units) spent bowling and TCM was provided for two (2) units during this time. Appropriate TCM billing is for two (2) units.

If a case manager attends an individual's medical appointment, the necessity to be present during the appointment must be documented and the TCM service provided during the appointment must be documented. The focus of the case manager's documentation must be the TCM services provided and how it ties back to the individual's care plan.

3. **Is the time spent entering, <u>while developing</u>, the care plan into the computerized system by a provider billable for TCM?**
   Yes, but straight data entry of the plan is not billable for TCM.

4. **Is completing applications and referral paperwork and reviewing documents (evaluations, IEP's, SSI) allowed TCM billable services?**
   Yes, if the time relates to the development, monitoring or evaluation of the care plan or is assisting in linking the individual to needed services.

5. **Is making collateral contacts an allowed TCM billable activity?**
   Yes, in the form of telephone, in-person, and e-mail contacts. Content of the collateral contact must pertain to the Medicaid individual. Copies of emails must be included in file and time spent must be included. If the cumulative time for one day is more than 8 minutes, one unit can be billed. Documentation must show how time was accumulated to arrive at total time billed.

6. **If a case manager is making telephone calls and coordinating services, for example a half dozen phone calls to providers are made and each take two to three minutes, can the time be combined and billed as 1 unit?**
   Assuming the content of the calls relates to the TCM allowed activities, if several calls are in made on the same day for the same individual, they can be claimed as one unit of TCM. If the cumulative time for one day is greater than 8 and 15 minutes or less, one TCM unit can be billed. Documentation must show how time was accumulated to arrive at the total time billed. A telephone call that does not result in a contact is not a billable TCM activity.

7. **Is supervision time an allowed TCM billable service?**
   Yes, if the time billed is focused on assisting a staff person in the development, monitoring or evaluation of the care plan for the individual. However, the supervising practitioner must be enrolled with ND Medicaid and the two practitioners <u>are not</u> allowed to bill for the same service at the same time.

8. **Is TCM allowed for court related time?**
   Only the time spent with the individual/family discussing the planning process either before or after court involvement activity is billable. Time spent in the courtroom is not billable. Documentation must define the TCM-specific time and be separated from time in court. Activities directed toward investigation and evaluating facts involving a petition for involuntary treatment are allowable TCM activities.

9. **Is coordinating services for other individuals in the individual's home billable for TCM?**
   No. Centers for Medicare and Medicaid Services (CMS) guidance is very clear that services must be provided to, or directed exclusively toward, the treatment of the Medicaid individual.

10. **If multiple agencies and case management staff attend the same meeting for an eligible individual, who bills for TCM?**
    The TCM provider is the only provider able to bill for this service.

11. **There are occasions where the case manager assists a person to acquire or renew skills to aid in the individual gaining independence and increasing their ability to live successfully in a community; are these allowable TCM activities?**
    No. These activities, while valuable, are not allowable TCM activities. The agency must ensure that the agency and its staff are appropriately enrolled with ND Medicaid for the service they are providing.

12. **Case managers may provide assistance to individuals that doesn't fit allowable TCM activities; how should these activities be documented and billed?**
    Examples of some of these activities are delivering medication boxes, picking up groceries or helping an individual move to another location. These types of activities are not billable under TCM.

13. **If a case manager provides transportation for an individual and no TCM services are delivered, what code should be used?**
    Providing transportation alone is not billable under TCM. The agency must ensure that the agency and its staff are appropriately enrolled with ND Medicaid for the service they are providing.

14. **Case managers can be in situations where they need to provide crisis intervention to the Medicaid individual. Is this an allowable TCM activity?**
    No, this is not an allowable TCM activity. The agency must ensure that the agency and its staff are appropriately enrolled with ND Medicaid for the service they are providing.

Please note, these answers are subject to change and practices will need to be modified if future federal/state guidance alters the answers provided.

Questions about this policy may be sent to dhsmed@nd.gov.