Florida

Medicaid

CHILD HEALTH SERVICES TARGETED CASE MANAGEMENT

COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

June 2012

AHCA

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

UPDATE LOG
CHILD HEALTH SERVICES TARGETED CASE MANAGEMENT COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at: www.mymedicaid-florida.com. To access the handbooks, select Public Information for Providers, then Provider Support, and then Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as a revised handbook or a completely new handbook.

It is the provider's responsibility to follow correct and current policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update describes the change that was made.

 Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a postcard, electronic notice or letter. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. To access the handbooks, select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 1-800-289-7799.

UPDATE	EFFECTIVE DATE
New Handbook	June 2012

CHILD HEALTH SERVICES TARGETED CASE MANAGEMENT COVERAGE AND LIMITATIONS HANDBOOK

Table of Contents

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- *Provider General Handbook* describes the Florida Medicaid Program;
- *Coverage and Limitations Handbooks* explain covered services, their limits, who is eligible to receive them, and the fee schedules; and
- *Reimbursement Handbooks* describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs and Transportation Services, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Note: All Florida Medicaid Handbooks may be accessed via the internet at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support and then Handbooks.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act;
- Title 42 of the Code of Federal Regulations;
- Chapter 409, Florida Statutes; and
- Chapter 59G, Florida Administrative Code.

The Specific Federal Regulations, Florida Statutes, and Florida Administrative Code, for each Medicaid service are cited for reference in each service-specific coverage and limitations handbook.

In This Chapter

This chapter contains:

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Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to provide the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term "provider" is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	The term "recipient" is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format

The format styles used in the handbooks represent a short and regular way of displaying difficult, technical material.

Information Block

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.

Note

Note is used most frequently to refer the user to important material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an "Update" and the "Effective Date."

Handbook Updates, continued

How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may be: Replacement handbook-Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy. Revised handbook-Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.
Effective Date of New Material	The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.
New Label and New Information Block	A new label and a new information block will be identified with yellow highlight to the entire section.
New Material in an Existing Information Block or Paragraph	New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence and/or paragraph affected by the change.

CHAPTER 1
CHILD HEALTH SERVICES TARGETED CASE MANAGEMENT COVERAGE AND LIMITATIONS HANDBOOK

Overview

Introduction

This chapter describes the Medicaid Targeted Case Management Program for Child Health Services targeted groups, defines eligible providers, and gives the qualifications for provider enrollment.

Legal Authority

Targeted case management services are authorized under Section 1915(g) of the Social Security Act. The Florida Medicaid Targeted Case Management Program is implemented through Chapter 409.906, Florida Statutes (F.S.), and Chapter 59G-8.700, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

Description and Purpose

Purpose

The purpose of targeted case management services is to assist Medicaid eligible recipients in gaining access to needed medical, social, educational, and other support services. Services are not required to be medically necessary as defined in 59G-1.010(166), F.A.C.

A provider must be enrolled as a Child Health Services targeted case manager to provide and be reimbursed for the services. A Medicaid recipient must be in one of the specific target groups in order to receive targeted case management services under this program.

Description and Purpose, continued

Other Handbooks	The handbook is intended for use by a provider who is enrolled as a Medicaid Child Health Services targeted case manager and is a member of an eligible targeted case management group. It must be used in conjunction with the current Florida Medicaid Provider Reimbursement Handbook, CMS-1500 and the Florida Medicaid Provider General Handbook
	Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at: www.mymedicaid-florida.com. To access the handbooks, select Public Information for Providers, then Provider Support, and then Handbooks. The Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C., and the Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C.

Provider Qualifications and Responsibilities

Basic Requirements	Medicaid reimburses only targeted case management services that are provided by enrolled individual treating providers employed by or contracted with an enrolled targeted case management group provider or agency. A provider or agency may not subcontract with another agency for service delivery.
Who Can Be a Group Provider	A Children's Medical Services (CMS) Early Steps local program contractor or a CMS medical foster care provider contractor can be a Medicaid Child Health Services targeted case management group provider.
Targeted Case Management Groups	Medicaid reimburses for targeted case management services for: • Recipients birth to 3 years of age, who are receiving services through the Children's Medical Services (CMS) Early Steps Program; and • Services provided by CMS contracted medical foster care providers.

Provider Qualifications and Responsibilities, continued

Group Provider Qualifications

A Medicaid Child Health Services targeted case management group provider is an entity that demonstrates:

- A capacity to provide all core elements of case management services including:
  - comprehensive individual assessments,
  - comprehensive care or service plan development,
  - linking or coordination of services,
  - monitoring and follow-up of services, and
  - reassessment of the individual's status and needs;
- Case management experience in coordinating and linking such community resources as required by the target population;
- Experience with the target population;
- An administrative capacity to ensure quality of services in accordance with state and federal requirements;
- A financial management capacity and system that provides documentation of services and costs; and
- A capacity to document and maintain individual case records in accordance with state and federal requirements.

Early Steps Individual Provider Qualifications

In order to provide Medicaid Child Health Services Targeted Case Management, an individual must be employed by or under contract with the Early Steps Program group provider serving children birth to 3 years of age, and must:

- Hold a bachelor's degree or higher from an accredited university or college with an emphasis in the areas of psychology, social work, health education, early childhood, child development, special education or interdisciplinary sociology, or
- Hold a bachelor's degree or higher in a field not listed in one of the areas above but with a minimum of 3 years of documented experience in case management or counseling with special needs or developmental delay populations, or
- Hold a Florida license as a registered nurse without a bachelor's degree, and have a minimum of 3 years of documented experience in case management or counseling with special needs or developmental delay populations.

Provider Qualifications and Responsibilities, continued

Early Steps Individual Provider Enrollment Requirements	An individual Early Steps provider must submit with the Medicaid enrollment application, a copy of the Children's Medical Services Local Early Steps (LES) Service Coordinator Attestation Checklist. The checklist attests to meeting the appropriate degree and major requirements; experience; apprenticeship; out of area or field degree; and, completion of Early Steps orientation on-line modules.

Note: One year of professional experience equals 1600 hours of hands-on experience. Time spent in a practicum or internship situation (up to 400 hours) may apply toward the 1600 hours of hands-on experience. Clear documentation must be presented.

Note: Contact the local Department of Health, Children's Medical Service, Early Steps Program for attestation information.

CMS Medical Foster Care Provider Qualifications	If employed by or under contract with a CMS Medical Foster Care Program contracted group provider serving medical foster care children, the individual must:

- Be a Florida licensed registered nurse (RN); or
- Hold a bachelor's degree from an accredited university with emphasis in the areas of psychology, social work, health education, or interdisciplinary sociology; or
- Be able to demonstrate to the CMS Medical Foster Care Program that comparable qualifications are met; and
- Submit a CMS Medical Foster Care Program Targeted Case Management training requirement form; and
- When appropriate, submit a copy of a Florida RN license; and
- Submit a copy of the CMS Child Protection Center certificate; and
- When appropriate, submit the Child Welfare TCM Case Manager Certification for Social Worker.

Note: Contact the local Department of Health, Medical Foster Care Program for appropriate forms and certificates.

Provider Enrollment

Enrollment Process

To enroll as a targeted case management provider, the targeted case management agency must submit a completed Medicaid enrollment application package for the agency and any individual treating provider to the Medicaid fiscal agent.

Providers can obtain a Medicaid enrollment application package from the Medicaid fiscal agent by calling 1-800-289-7799, Option 4, or visiting the Medicaid fiscal agent's Web site at: www.mymedicaid-florida.com.

Enrollment Requirements

Group and individual providers must follow the specific enrollment requirements that are listed in this section and meet the general Medicaid provider enrollment requirements that are contained in the Florida Medicaid Provider General Handbook. Requirements may include submitting a current Florida license, copies of educational degrees or transcripts and documents verifying required training or qualifying experience.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Handbooks.

Medicaid Group Provider Number

The Medicaid fiscal agent will assign the group a nine-digit group provider number. If the group is already enrolled as a group provider for another Medicaid service, the fiscal agent will assign a two-digit locator code (the last two digits of the provider number). To receive Medicaid reimbursement, the agency must enter this number as the pay-to-provider number on the Medicaid claim.

Medicaid Group Provider Type

CMS Targeted Case Management group providers are enrolled as group provider type 91, Case Management Agency.

Provider Enrollment, continued

Individual Treating Provider Number	The Medicaid fiscal agent will assign each individual treating provider a nine-digit provider identification number to identify the case manager who actually performs the targeted case management service, sometimes referred to as the rendering provider. To receive Medicaid reimbursement, the agency must enter this number as the treating or rendering provider on the Medicaid claim.

The agency may only bill for targeted case management services provided directly by an enrolled case manager.

It is the responsibility of the targeted case management agency to inform the Medicaid fiscal agent when personnel enrolled as individual treating providers are no longer employed as targeted case managers.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for additional instructions on entering the provider number on the claim form.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at: www.mymedicaid-florida.com. Select Public Information for Providers then Provider Support, and then Handbooks.

Medicaid Individual Provider Type

Individual treating providers for targeted case management are enrolled as individual provider types:

- 30 Advanced Registered Nurse Practitioner (ARNP),
- 31 (Nurse), or
- 32 (Social Worker or Case Manager).

ARNPs and nurses must submit a copy of their current Florida license with the application. Applicants are required to submit a copy of their degree and appropriate documentation verifying the required experience, as stated on page 1-4 of the handbook.

CMS Early Steps and Medical Foster Care Program Enrollment Requirements

The Department of Health Early Steps Program and the Medical Foster Care Program may require additional information and documents to enroll in their programs. Contact the Department of Health Early Step Medical Foster Care local program offices for their most current requirement information.
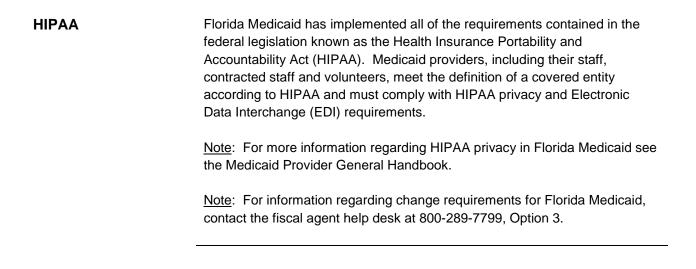
Provider Enrollment, continued

Mailing Instructions	To become a Medicaid Child Health Services targeted case management provider, an agency or individual must submit a completed Medicaid enrollment application package to the Medicaid fiscal agent. Providers can choose to enroll in Medicaid online using the Enrollment Wizard located at the Web site at: www.mymedicaid-florida.com. Select Public information for Providers, then Enrollment and then On-Line Enrollement or mail a paper application with required documentation to:

> Florida Medicaid Provider Enrollment
> P.O. Box 7070
> Tallahassee, Florida 32314-7070

Enrollment Effective Date	Subsection 409.907(9) (a), F.S., states the Agency may "Enroll the applicant as a Medicaid provider upon approval of the provider application. The enrollment effective date shall be the date the agency receives the provider application. With respect to a provider that completes a change of ownership, the effective date is the date the agency received the application, the date the change of ownership was complete, or the date the applicant became eligible to provide services under Medicaid, whichever date is later."

Dual Enrollment	A Medicaid enrolled CMS targeted case manager can enroll as another Medicaid provider type for which he meets the requirements.

Provider Responsibilities

Confidentiality	Names, treatments, payments, and other information about Medicaid recipients are confidential. "Confidential" means that information cannot be released without written consent from the recipient unless:

- You are releasing information to authorized representatives of the Medicaid program, CMS Early Steps program staff or authorized representatives of the CMS Medical Foster Care Program;
- You are billing another insurance carrier; or
- You are releasing information to your billing agent.

Provider Responsibilities, continued

HIPAA

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). Medicaid providers, including their staff, contracted staff and volunteers, meet the definition of a covered entity according to HIPAA and must comply with HIPAA privacy and Electronic Data Interchange (EDI) requirements.

Note: For more information regarding HIPAA privacy in Florida Medicaid see the Medicaid Provider General Handbook.

Note: For information regarding change requirements for Florida Medicaid, contact the fiscal agent help desk at 800-289-7799, Option 3.

CHAPTER 2
CHILD HEALTH SERVICES TARGETED CASE MANAGEMENT COVERAGE AND LIMITATIONS AND EXCLUSION

Overview

Introduction

This chapter describes the general service requirements, covered services, limitations and exclusions for the Child Health Services Targeted Case Management Program. It also identifies recipient eligibility requirements, service limitations and exclusions.

In This Chapter

In This Chapter:

General Service Requirements

Targeted Case Management (TCM) Defined

Case management services are activities performed by the provider to assist a Medicaid eligible individual in gaining access to needed medical, social, educational, and other services. Examples of "other services" may include assisting in gaining access to housing or transportation needs.

Case management services are referred to as targeted case management (TCM) services when case management services are identified for a specific or targeted population.

Recipient needs vary, and a targeted case manager assists the recipient in identifying those needs through a comprehensive assessment process. A case management service plan is then developed, and the provider assists the recipient in obtaining appropriate services for all the identified needs. The provider monitors and reassesses the plan and activities to ensure access, quality and delivery of services.

General Service Requirements, continued

Program Requirement	A targeted case manager must assist the recipient in gaining access to services in all the areas of medical, social, educational, and other services, as identified. A targeted case management provider cannot pick and choose an area for which they will provide services.

Recipient Eligibility

To receive targeted case management services, the individual must:

- Be Medicaid eligible on the date of service, and
- Not be receiving case management services under an approved 1915(c) Home and Community Based Services waiver program, and
- Not be a resident of an institutional facility, nursing home or intermediate care facility for the developmentally disabled, and
- Be of the age birth up to 3 years of age and receiving services from the Children's Medical Services Early Steps Program, or be receiving medical foster care services from a Children's Medical Services medical foster care contracted provider.

Targeted Case Management Services

Targeted case management services include:

- Conducting an assessment of the recipient's medical, social, and functional status and identifying the recipient's service needs;
- Working with the recipient and his natural support system to develop, promote, and coordinate the service plan;
- Referring, coordinating or arranging for service delivery from the individual's chosen provider(s) to ensure access to services;
- Reviewing and reassessing the individual's functional status and service needs;
- Following up to determine that the recipient's planned services have been received and are effective in meeting the recipient's needs;
- Monitoring to ensure access to quality and the delivery of services identified in the plan of care;
- Preparing and maintaining case record documentation to include service plans, forms, reports, narratives, and other documents, as appropriate in assisting with access to care; and
- Explaining to the recipient information regarding the importance of following prescribed treatment or helping with understanding the condition and how to cope with the condition.

General Service Requirements, continued

Activities Excluded as Targeted Case Management Services

Targeted case management is not the direct delivery or hands-on delivery of an underlying medical, educational, social or other service. Examples of services that do not qualify as targeted case management are:

- Activities that are not needed or required to assist the individual in gaining access to needed services;
- Providing or participating in direct services (medical, educational, vocational, transportation, or social services) to which the eligible individual has been referred;
- Providing direct delivery of foster care services, such as the following:
  - o Research, gathering and completion of documentation required by the foster care program;
  - o Assessing adoption placements;
  - o Recruiting or interviewing potential foster care parents;
  - o Serving legal papers;
  - o Home investigations;
  - o Providing transportation;
  - o Administering foster care subsidies;
  - o Making placement arrangements.
- Services rendered prior to the date the individual's Medicaid eligibility began or after the Medicaid eligibility ended;
- Services provided to recipients residing in a nursing home, institutional care facility for the developmentally disabled, state mental hospital or other institution;
- Copying from notes or transcribing an Individualized Family Support Plan (IFSP), unless for the purpose of assisting in gaining access to needed services for the eligible individual;
- Providing required notices to parents or guardians;
- Providing direct hands-on clinical, therapeutic or medical services;
- Transporting of the individual, parent, guardian or provider;
- Escorting or accompanying an individual, parent or guardian anywhere for any event;
- Contacting others for activities that do not relate directly to the identification, access and management of the eligible individual's needs and care;
- Services to a recipient receiving services under a 1915(c) home and community based services waiver program;

General Service Requirements, continued

Activities Excluded as Targeted Case Management Services, continued	• Discharge planning services provided to any institutionalized resident; • Services provided without a current service plan or without a service plan maintained in the case record; • Services provided by non-enrolled targeted case management group providers or ineligible or non-enrolled individual case managers; • Services billed in excess of the daily maximum allowable per day; • Unsuccessful attempts to contact a recipient or other contacts (e.g., home visits where recipient is not home; busy phone; voice mails); • Writing and sending birthday or holiday cards; • Attending or participating in a conference or meeting unless for the specific purpose of assisting the eligible individual in gaining access to needed services; • Clerical duties such as typing letters or reports, faxing, or filing; • Providing training or educational activities; or • Conducting quality assurance activities or completing documents for reimbursement purposes.
Only One Targeted Case Manager Per Recipient	The Centers for Medicare and Medicaid Services requires only one targeted case manager per recipient to ensure that the recipient receives a coordinated and comprehensive effort in accessing needed services.
More Than One Case Manager	If circumstances are such that more than one case manager is involved in providing services to a recipient for any reason, (e.g., targeted case manager and a managed care case manager), Medicaid requires that: • A lead case manager be designated by the recipient, preferably the targeted case manager, who ensures the recipient and other case managers are aware of the designation; • The service plan clearly identifies the lead case manager and clearly identifies responsibility for coordination of services of each of the case managers; • On-going and documented communication and coordination take place between all case managers to ensure that services are not duplicated; and • Services provided are clearly and fully documented to ensure there is no duplication of targeted case management services.

General Service Requirements, continued

HMO or PSN Recipients	Case management services provided by a Medicaid Health Maintenance Organization (HMO) or Provider Service Network (PSN) are medical case management services.

If the recipient is enrolled in a Medicaid HMO or PSN or private pay HMO that includes case management services, the targeted case manager must ensure case management services are coordinated with the managed care case manager(s) to eliminate the possibility of duplication of services. |
| **Temporary Targeted Case Manager** | If an eligible individual's assigned targeted case manager is unavailable for a short period of time, another targeted case manager within the agency may provide targeted case management services. The case management notes must clearly state that the assigned targeted case manager was unavailable and why (e.g., on vacation, sick leave, etc.). |

Targeted Case Management Service Components

Required TCM Service Components	The following components must be performed for each Medicaid eligible TCM recipient:

- **Assessment/Reassessment** – A holistic review of the recipient's emotional, social, behavioral, environmental, medical and developmental functioning within the home, school, and community. The assessment is conducted to identify all the needs of the individual and to develop a comprehensive TCM service plan. The assessment must be updated at least annually. Information cannot be obtained from third party sources without appropriate recipient or guardian consent.
- **Service Plan** – The service plan is built on the information collected through the assessment phase. An individualized service plan is developed to specify goals and identify a course of action to respond to the needs of the individual. The service plan must be adjusted as needs change. |

Targeted Case Management Service Components, continued

Required TCM Service Components, continued

- **Referrals and Related Activities** – This phase includes making referrals and conducting related activities to assist the individual in accessing needed services. Activities may include linking the individual with medical, social, educational providers or other providers and scheduling appointments, referring for or arranging for transportation, housing assistance, or obtaining clothing, or other areas of need.
- **Monitoring and Follow-Up** – This phase includes conducting ongoing monitoring to ensure that the service plan is effectively implemented; adequately addresses the needs of the individual, and services are being provided.

Each of these components is addressed in more detail in the following pages.

Assessment and Reassessment

Assessment Component

The targeted case manager is required to conduct a thorough, comprehensive assessment that identifies all the needs of the recipient, the recipient's strengths, preferences, and interests as well as physical and social environment. The assessment supports the selection of activities and assistance and serves as the basis for the development of the service plan.

Assessment Activities

The assessment should include information on:

- Identifying information, including name, date of birth, Medicaid ID number, and third party liability or insurance;
- Family structure, names of caregivers, individual's current living arrangements, family and individual recreational activities, interaction among family members, family routines, and family strengths;
- Housing, food, clothing, transportation and financial needs;
- Social relationships, including formal and informal support systems, such as health care providers, friends, extended family, and volunteers;
- Physical environment, including the level of safety and accessibility for the individual and the family;
- Recipient's medical history and current medical and emotional issues including diagnosis, medications, health concerns, treatments and level of access to medical care providers including dental services;
- Information from other providers or agencies providing case management services or other types of services;

Assessment and Reassessment, continued

Assessment Activities, continued	• Self-care, such as the ability to complete activities of daily living and to take care of one's own needs relative to the recipient's age and developmental level; • Educational status, including appropriateness of placement, availability of educational programs, prognosis for future educational opportunities; • Legal status, such as guardianship, Department of Children and Families or the Department of Juvenile Justice involvement, foster care, on-going custody or child support issues; and • Physical and developmental concerns relative to the individual and the concerns the individual and family feel should be addressed first.
Time Frame	The assessment must be completed prior to the development of the service plan. The assessment process involves the ongoing collection of information about the child's and the family's needs, strengths, and resources, and must be updated or reassessed at least annually.
Information Sources	The provider must hold a conversation with the recipient and family, preferably a face-to-face meeting, to complete the assessment. The assessment should include information from the following sources, as applicable: • The recipient, family, guardian or legal custodian; • The agency or individual who referred the recipient for services; • Other agencies or organizations that are providing services or case management services; • The school district; and • Previous treatment providers. Note: Information cannot be obtained from third party sources without appropriate client or guardian consent.

Service Plan

Service Plan Requirements and Components

Each Medicaid eligible individual must have a current service plan prior to identified services being provided. The service plan is based on the information collected through an assessment or reassessment and specifies the goals and actions to address the medical, social, education, and other services needed. The service plan must outline a comprehensive strategy for assisting the recipient in achieving identified goals.

The service plan must:

- Be an identifiable, current document;
- Be developed in partnership with the recipient (if applicable) and the recipient's parent, guardian, or legal custodian;
- Describe the individual's service needs and the activities that the targeted case manager will undertake in partnership with the recipient, parents, guardian or legal custodian;
- Contain measurable short and long-term goals and objectives derived from the recipient's assessment;
- Have identified time frames for achievement of goals;
- Include the name of the individual or agency responsible for providing the specific assistance or services;
- Be consistent with the recipient's treatment plan(s);
- Be signed and dated by the recipient (if appropriate), the recipient's parent, guardian, or legal custodian, and the targeted case manager (including title);and
- Be retained in the recipient's case record.

Copies

Copies of the plan should be provided to the recipient or the recipient's parent or guardian, and, with appropriate consent, other service providers involved in the development or implementation of the service plan, as applicable.

Plan Review

The plan must be reviewed and revised as significant changes occur in the recipient's condition, situation, or circumstances, but no less frequently than every six months. The review process ensures that services, goals, and objectives continue to be appropriate to the recipient's needs and assesses the recipient's progress and continued need for targeted case management services.

Service Plan, continued

Plan Review, continued

The recipient (if appropriate), recipient's parent or legal guardian, and the targeted case manager must sign and date the updated or changed plan indicating that a service plan review or change occurred and was agreed upon.

Document

The planning of activities, discussion, review process and resulting plan must be clearly documented in the record to ensure that activities or services meet Medicaid TCM requirements.

Exceptions to Signature Requirements

If the recipient's age or level of development precludes him from participation in the development and signing of the plan, the signature of the parent or legal guardian will suffice. The reason for the recipient's failure to sign should be clearly documented.

Telephonic acceptance or approval of the plan can meet the signature requirement. However, it must be clearly documented who was contacted and who contacted the recipient, parent or guardian, the date and time they were contacted and gave approval for the plan or change to the plan.

For recipients in the care and custody of the Department of Children and Families (DCF), either in foster care or shelter status, the child's DCF contracted caseworker must sign the plan if any medical service decisions or approvals are being made and if it is not possible to obtain the parent's signature. The caseworker and foster parent must participate in the planning. In cases in which DCF is working toward reunification, every effort should be made to include the child's parent or identified future caregiver in the development and signing of the plan.

Combining the Targeted Case Management Assessment and Plan

The assessment and TCM plan may be combined or reflected in one document as long as the following requirements are met:

- All above listed components of both areas are met by the single document, including appropriate time frames for development and review; and
- It is clear upon review of the recipient's record that the two documents have been merged into one.

Referral and Related Activities

Purpose

Referrals and related activities are designed to help a recipient link with medical, social, and education providers, or other programs and services that are capable of providing needed services to address identified needs and achieve specified goals. Referral activities must be documented in the recipient's record.

Monitoring and Follow-up Activities

Activities and Requirements

Monitoring and follow-up activities include activities that are necessary to ensure that the plan is effectively implemented and adequately addresses the needs of the individual. Monitoring must be conducted at least once every six months to determine if the following conditions are met:

- Services are provided in accordance with the individual's plan;
- Services are effectively coordinated through communication with service providers; and
- Services in the plan are adequate in order to meet the needs of the recipient.

Activities include:

- Making adjustments in the plan and service arrangements with providers, as necessary, based on the results of the monitoring;
- Preparing and maintaining case record documentation to include service plans, forms, reports, and narratives as appropriate; and
- Contacting non-eligible individuals that are directly related to the individual's needs and care, for the purpose of:
  o Helping the individual access services;
  o Identifying needs and supports in obtaining services;
  o Explaining the need and importance of services in relation to the recipient's condition;
  o Providing case managers with useful feedback; and
  o Alerting case managers to changes in the individual's needs.
- Activities performed to assist an eligible individual in preparing for a hearing related to the reduction, termination or denial of a service identified on an individual's service or care plan.

General Service Limitations or Exclusions

No Retroactive Payment

Medicaid will not reimburse for targeted case management services prior to the date the individual was determined eligible for the targeted group or prior to the effective enrollment date of the provider.

Recoupment

Claims not supported by documentation or meeting policy requirements are subject to recoupment.

Provider Provision

Medicaid does not reimburse targeted case management services provided by aides, clerks, or other staff who do not qualify for or are not enrolled as targeted case management individual providers, even if they are working under the direction or supervision of a Medicaid enrolled case manager.

No Travel Reimbursement

Time spent by the case manager traveling to provide targeted case management services is considered an inherent part of the service and is not reimbursable by Medicaid. There are no circumstances under which travel is reimbursed under this program.

Documentation Requirements

Introduction

In addition to the general Medicaid record keeping requirements as stated in the Florida Medicaid Provider General Handbook, documentation requirements in the records described in this section apply to all targeted case management services.

A clear delineation between targeted case management services and other services must be made through documentation that ensures the activities or services meet Medicaid TCM requirements.

Required Documentation

The targeted case manager's case notes must include, at a minimum, the following information:

- Date of service, original signature for each day of service and initials for each entry during the day;
- Name of provider agency and name of targeted case manager;
- Recipient's name;

Documentation Requirements, continued

**Required
Documentation**,
continued

- Date and the beginning and ending time on the clock for services provided (e.g., 2:00 p.m. to 3:25 p.m.);
- Location of the service;
- A clear and comprehensible description of the activity provided; and
- Units of service to be billed.

The case notes must:

- Clearly reflect how the targeted case manager's efforts are linked to the services or goals in the recipient's plan and include references to the plan's objectives;
- Provide sufficient and clear detail of the service provided to justify the time spent;
- Clearly indicate all contacts with and on behalf of the recipient; and
- Provide sufficient detail of the coordination between the targeted case manager and other case managers to ensure that there is no duplication of services and that the recipient's needs are being met;
- Clearly reflect if the recipient accepted or declined the service(s) in the service plan;
- Clearly indicate the estimated timeline for obtaining the needed service(s), not to exceed six months;
- Re-evaluate the service plan every six months.

**Freedom of
Choice of Provider**

The recipient has the right to:

- Obtain services from any institution, agency, pharmacy, person, or organization that is qualified to furnish the services within the service delivery area and that is willing to furnish them; and
- Accept or decline a service including targeted case management; and
- Accept or decline to receive services in the plan to address identified needs.

Documentation Requirements, continued

Electronic Documentation and Signatures	Electronic documentation and electronic signatures are allowed, but records must be readily available upon request in the event of an audit. If electronic documentation and signatures are used, written security procedures that prevent unauthorized use must be in place and available for review.

Access to Records

Right to Review Records	Authorized state and federal agencies and their authorized representatives may audit or examine a provider or facility's records. This examination includes all records that the agency finds necessary to determine whether Medicaid payment amounts were or are due. This requirement applies to the provider's records and records for which the provider is the custodian. The provider must give authorized state and federal agencies and their authorized representative access to all Medicaid recipient records and to other information that cannot be separated from Medicaid related records. The provider must send, at his expense, legible copies of all Medicaid related information to the authorized state and federal agencies and their authorized representatives upon request.
Incomplete or Missing Records	Incomplete records are records that lack documentation that all requirements or conditions for service provision have been met. Medicaid may recoup payment for services or goods when the provider has incomplete records or cannot locate the records.
Prepayment Reviews	Medicaid may conduct or contract for prepayment review of the provider's Medicaid claims to ensure cost-effective purchasing, billing and provision of care to Medicaid recipients. The prepayment reviews may be conducted as determined appropriate by the agency, without any suspicion of fraud, abuse, or neglect.

CHAPTER 3
CHILD HEALTH SERVICES TARGETED CASE MANAGEMENT REIMBURSEMENT INFORMATION, PROCEDURE CODES AND FEE SCHEDULE

Overview

Introduction

This chapter identifies the targeted case management procedure codes and the maximum fees that Medicaid reimburses.

Procedure Codes

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. The CPT includes the HCPCS descriptive terms and parameters and numeric identifying codes for reporting services and procedures.

In This Chapter

This chapter contains:

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Appendix A: Procedure Codes and Fee Schedule	A-1

Reimbursement Information

One Targeted Case Manager Requirement per Recipient

The Centers for Medicare and Medicaid Services allows only one targeted case manager per recipient to ensure that the recipient receives a coordinated and comprehensive effort in accessing needed services. Only one targeted case manager can bill per recipient per day.

Units of Service

Targeted case management services are reimbursed in time increments. Each time increment is called a unit of service. Fifteen minutes equals one unit of service.

One Claim Submission per Date of Service

To receive reimbursement, the targeted case management agency must total the amount of time that an individual targeted case manager provided targeted case management services and submit one claim for the appropriate number of units of service.

Reimbursement Information, continued

Calculating the Units of Service	If multiple units are provided on the same date of service, the actual time spent must be totaled and rounded to the nearest 15-minute increment. If the total minutes equal an amount that is 7 minutes or less from the last 15-minute increment, round down. If the minutes equal an amount that is 8 minutes or more from the last 15-minute increment, round up. For example, 22 minutes would be billed as one unit of service; 23 minutes would be billed as two units.

The provider may not round each service episode to the nearest 15-minute increment prior to summing the total. |
| **CMS-1500 Claim Form** | Child Health Services targeted case management must be billed using the CMS-1500 claim form. Please refer to the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for complete instructions on filing a claim for reimbursement. |
| **Medicaid Provider Number** | The targeted case management agency must bill Medicaid by entering on the claim form its targeted case management provider group number as the pay-to-provider and the individual case manager's provider number as the treating provider.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on entering provider numbers on the claim form. |
Service Limitation or Units of Service	Medicaid will reimburse up to 32 units of targeted case management services per recipient, per day. Each unit billed must be justified and clearly documented in the recipient's record.
Medicaid Claim Requirement	Medicaid requires that only one claim per recipient, per targeted case manager, be paid per day.
Procedure Code Table	Each procedure code on the Procedure Codes and Fee Schedule, Appendix A, corresponds to a targeted case management service provided to a specific target group. The descriptor gives a brief description of the service. The maximum fee shows the maximum amount that Medicaid will reimburse for the procedure code, per unit of service.

Reimbursement Information, continued

Definition of a Modifier	For certain types of services, one or two two-digit modifiers must be entered on the CMS-1500 claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.
	The modifiers must be entered in the field next to the procedure code field under Modifier.
	The modifiers listed in Appendix A can only be used with the procedure codes listed. Use of modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.
Third Party Liability	Medicaid is the payer of last resort. If a recipient has other insurance coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, the provider must bill the primary insurer prior to billing for Medicaid. Attempts to bill or denials for payment from third party sources must be documented in the record. If there is no documentation of good faith attempts or a denial, Medicaid reimbursements may be recouped.
	Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at: www.mymedicaid-florida.com. Select Public Information for Providers then Provider Support, and then Handbooks.

APPENDIX A

CHILD HEALTH SERVICES TARGETED CASE MANAGEMENT PROCEDURE CODES AND FEE SCHEDULE

APPENDIX A

CHILD HEALTH SERVICES TARGETED CASE MANAGEMENT PROCEDURE CODES AND FEE SCHEDULE

Code	Description of Service	Maximum Fee
T1017 TL	Targeted Case Management for Children's Medical Services – Early Steps Providers	$ 9.25/unit
T1017 SE	Targeted Case Management for Children's Medical Services-Medical Foster Care Contractors	$ 9.25/unit