Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

Targeted Case Management for Individuals with Serious Mental Illness

Division of Integrated Healthcare

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1 General policy

Targeted case management (TCM) is a service that assists qualified Medicaid members of a designated target group in gaining access to needed medical, social, educational, and other services and ensures that services are coordinated among all agencies and providers involved.

1-1 Definitions

DHHS means the Utah Department of Health and Human Services.

Division of Integrated Healthcare (DIH) means the organizational unit in DHHS that administers the Medicaid program in Utah.

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

SUMH means the Office of Substance Use and Mental Health within the Division of Integrated Healthcare.

1-2 General information

Target group

1. Targeted Case Management (TCM) services are available to Medicaid members who meet the requirements of a designated target group. TCM services for individuals with serious mental illness means services provided to:

    a) Adults who have been diagnosed with a serious mental illness
    b) Children with serious emotional disorders
    c) Individuals with substance use disorders (SUD) including youth and adults
    d) Children at risk of developing a SUD

2. Currently, Utah Medicaid also covers TCM for the following target groups or case management services through the following Home and Community-Based services (HCBS) waivers:

    TCM Target Groups

    a) Early childhood (Ages 0-8)

b) Pregnant members

HCBS Waivers (providing case management services)

a) Acquired Brain Injury Waiver
b) Aging Waiver (for individuals aged 65 or older)
c) Community Supports Waiver for Individuals with Intellectual Disabilities or Other Related Conditions
d) Community Transitions Waiver
e) Medically Complex Children's Waiver
f) New Choices Waiver
g) Physical Disabilities Waiver
h) Waiver for Technology Dependent Children
i) Limited Supports Waiver

There are separate rules and provider manuals to address the scope of services and reimbursement methods for the other case management groups.

A Medicaid member may qualify for TCM services under another target group, or for waiver case management services. Therefore, to ensure there is no duplication of case management services, prior to providing services under this targeted case management program, the case manager must determine if other agencies are also providing targeted or waiver case management services to the member.

1-3 Provider participation

1. Qualified providers of Targeted Case Management services are:

a) licensed mental health therapist as defined by the Mental Health Practice Act,
b) licensed social service worker under the supervision of a licensed mental health therapist,
c) individual who has a qualifying bachelor's degree and is actively engaged in meeting DOPL requirements to obtain license as a social service worker in accordance with state law, and is under the supervision of a licensed mental health therapist,
d) physician or physician assistant,
e) licensed registered nurse,

f) licensed practical nurse,
g) licensed registered nursing apprentice,
h) substance use disorder counselor licensed as an advanced substance use disorder counselor (ASUDC), certified advanced substance use disorder counselor (CASUDC), certified advanced substance use disorder counselor intern (CASUDC-I), substance use disorder counselor (SUDC), certified substance use disorder counselor (CSUDC), or certified substance use disorder counselor intern (CSUDC-I),
i) licensed behavioral health coach,
j) Students exempted from licensure:
    a. in accordance with Section 58-1-307 of the Utah Code, a student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL to the extent the activities are supervised by qualified faculty, staff, or designee and the activities are a defined part of the training program; and
    b. individual enrolled in a qualified substance use disorder counselor education program, who is exempted from licensure in accordance with State law, and under DOPL-required supervision.
k) individuals who were employed as a psychologist by a state, county or municipal agency or other political subdivision of the state prior to July 1, 1981, and who subsequently have maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of his official duties for that agency or political subdivision.
l) An unlicensed individual at least 18 years of age who has certification as a targeted case manager and is under the supervision of a licensed mental health therapist, a licensed social service worker, or a licensed registered nurse, or a licensed ASUDC or a licensed SUDC when the service is provided to individuals with a SUD.

1-4 Becoming a certified case manager

1. Unlicensed individuals seeking certification must adhere to the requirements of Rule R523-7-1, Certification of Designated Examiners and Certified Case Managers and are required to:

a) Successfully complete SUMH's training curriculum and pass an examination which tests basic knowledge, attitudes, ethics, and skills related to the provision of case management services; and
b) Successfully complete SUMH's case management practicum requirement.

To continue to be a qualified provider of case management services, certified targeted case managers must be in good standing and comply with SUMH's recertification requirements.

2 General

2-1 Covered services

Individuals who are qualified to provide Targeted Case Management (TCM) services may assist members to gain access to needed medical services, including behavioral health services provided by that entity.

1. Medicaid reimbursement for TCM is dictated by the nature of the activity and the purpose for which the activity was performed. When reported in amounts that are reasonable and medically necessary, the following activities/services are covered by Medicaid under TCM:
    a) Assessing the member to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Assessment activities include: taking member history, identifying the needs of the member and completing related documentation, gathering information from other sources such as family members, medical providers, social workers, other providers, and educators, if necessary, to form a complete assessment of the member;
    b) Developing a written, individualized, and coordinated case management service plan based on the information collected through an assessment that specifies the goals and actions to address the medical, social, educational, and other services needed by the member. The assessment should include input from the member, the member's authorized health

care decision maker, and others (e.g., the member's family, other agencies, etc.) who are knowledgeable about the member's needs, in order to develop goals and identify a course of action to respond to the assessed needs of the member;

c) Referral and related activities to help the member obtain needed services, including scheduling appointments or other activities that help link the member with medical services (including mental health and substance use disorder), social services, educational providers or other programs that are capable of providing needed services;

d) Assisting the member to establish and maintain eligibility for entitlements;

e) Coordinating the delivery of services to the member, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well-child health exams and follow-up (see the EPSDT Services provider manual);

f) Contacting non-eligible or non-targeted individuals when the purpose of the contact is directly related to the management of the member's care. For example, family members may be able to help identify needs and supports, assist the member to obtain services, provide case managers with useful feedback and alert them to changes in the member's status or needs;

g) Instructing the member or caretaker, as appropriate, in independently accessing needed services;

h) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the targeted case management service plan is effectively implemented and adequately addresses the needs of the member, and is updated to meet the member's needs and reflect progress. The targeted case manager is responsible for making necessary adjustments in the case management service plan and service arrangements with any necessary providers; and

i) Monitoring the member's progress and continued need for targeted case management and other services.

2. Covered TCM services provided to Medicaid members transitioning to a community setting will be made available for up to 30 consecutive days of a covered stay in a medical institution.

2-2 Non-covered services

The following services and activities are not considered Targeted Case Management (TCM) and may not be reported as targeted case management services:

1. Documenting TCM services is not reimbursable with the exception of the time spent developing the written needs assessment, service plan, and 180-day service plan review (See Record Keeping);

2. Teaching, tutoring, training, instructing, or educating the member or others, except in so far as the activity is specifically designed to assist the member, parent, or caretaker to independently obtain the services needed for the member.

   For example, assisting the member to complete a homework assignment, creating chore or behavioral charts and other similar materials for members or families, or instructing a member or family member on nutrition, budgeting, cooking, parenting skills or other skills development;

3. Directly assisting with personal care or activities of daily living (bathing, hair or skin care, eating, etc.) or instrumental activities of daily living (assisting with budgeting, cooking, shopping, laundry, home repairs, apartment hunting, moving residences, or acting as a protective payee;

4. Performing routine services including courier services. For example, running errands or picking up and delivering food stamps or entitlement checks;

5. Direct delivery of an underlying medical, educational, social or other service to which the member has been referred, or provision of a Medicaid-covered service.

For example, providing medical and psycho-social evaluations, treatment, therapy and counseling that are otherwise reportable under other categories of service (e.g., services described in the *Behavioral Health Services* provider manual);

6. Direct delivery of foster care services, including but not limited to research gathering and completion of documentation required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster care placements, serving legal papers, home investigations, providing transportation, administering foster care subsidies or making foster care placement arrangements;

7. Time spent traveling to the member's home or other location where a covered case management service will occur is not reimbursable, nor is time spent transporting a member or a member's family members;

8. Providing services for or on behalf of other family members that do not directly assist the member to access needed services. For example, counseling the member's sibling or helping the member's parent obtain a mental health service;

9. Recruitment activities in which the case manager attempts to contact potential members of service;

10. Time spent assisting members to gather evidence for a hearing with DIH or participating in a hearing as a witness;

11. Time spent coordinating between case management team members for a member is a non-reportable activity;

12. When there is a failed face-to-face or telephone contact, time spent leaving a note or message noting the failed attempt ; and

13. Time spent by two or more treatment providers arranging or coordinating their treatment services, and indirect activities of the entity (i.e., supervision of

treatment providers, and interdisciplinary team conferences for the development of rehabilitative treatment plans).

2-3 Limitations

1. The agency may report the covered services and activities only if:
    a) The services and activities are identified in the targeted case management service plan;

    b) The time spent in the service or activity involves a face-to-face encounter, telephone or written communication with the member, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring the member obtains the necessary services documented in the targeted case management service plan;

    c) There are no other third parties liable to pay for such services, including reimbursement under a medical, social, education, or other program;

    d) Activities are not an integral and inseparable component of another covered Medicaid service; and

    e) Activities do not constitute the direct delivery of underlying medical, education, social, or other services to which an eligible individual has been referred including foster care programs.

2. The agency may not report the covered services if no payment liability is incurred. Reimbursement is not available if services are provided free of charge to non-Medicaid members.

3. Payment for targeted case management services may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

4. Team case management are targeted case management services provided to a member by more than one targeted case manager employed by or under contract with the same entity are reimbursable only under the following conditions:

a) All targeted case managers on the team meet the qualifications described in this manual;

b) All targeted case managers on the team coordinate with one another to ensure only necessary, appropriate, and unduplicated case management services are delivered by all team members;

c) Time spent by two or more targeted case managers on the team in the same targeted case management activity may be reported by one case manager team member only; and

d) The member is informed of and understands the roles of the team members.

2-4 Substance use disorder (SUD) treatment in licensed SUD residential treatment programs and mental health treatment in licensed mental health residential treatment programs

When SUD and mental health residential treatment programs are reimbursed on a per diem bundled payment basis in accordance with the corresponding *Behavioral Health Services provider* manual sections, targeted case management services are included in the per diem bundled payment and cannot be reported separately.

3 Record keeping

The Targeted Case Management (TCM) services record must be maintained on file in accordance with any federal or state law or state administrative rules, and made available for state or federal review, upon request.

The following documents must be contained in each member's case file:

1. A written individualized needs assessment which documents the member's need for TCM services;

2. A written, individualized TCM service plan that identifies the services (i.e., medical, social educational, and other services) the member is to receive, who will provide them, and a general description of the TCM activities needed to help the member obtain or maintain these services; and

3. A written review of the service plan, at a minimum every 180 days, summarizing the members' progress toward TCM service plan objectives. The service plan review must be completed within the month due, or more frequently as required by the member's condition. If changes are required in the written service plan, a revised service plan must also be developed.

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

Record:
For each date of service, documentation must include:

1. Date, start and stop time, and duration of each service;
2. Setting in which the service was rendered (when via telehealth, the provider setting and notation that the service was provided via telehealth);
3. At the end of the day, total number of minutes of TCM services based on the rules specified in the 'Unit' section below;
4. At a minimum, one note summarizing all of the TCM activities performed during the day, or a separate note summarizing each TCM activity. Notes must document how the activities relate to the TCM service plan and be sufficient to support the number of units reported; and
5. Signature and licensure or credentials of the individual who rendered the TCM service(s).

4 Coding and billing

Procedure code	Service and units	Limits per patient
T1017	Targeted Case Management – per 15 minutes	Available for up to 30 consecutive days of a covered stay in a medical institution
H0006	Targeted Case Management – alcohol and/or drug services; case management - per 15 minutes	

When reporting these procedure codes, follow the rules specified below for converting the total duration of Targeted Case Management (TCM) services provided in a day to the specified unit.

1. The number of 15-minute units of service reported cannot exceed four units in an hour and cannot exceed total billings in a day, the number of hours the case manager worked (e.g., 8-hour workday).

2. If the duration of targeted case management activities provided in a day totals less than 15 minutes, there must be a minimum of 8 minutes to report one 15-minute unit.

3. If the duration of targeted case management activities provided in a day totals in excess of 60 minutes, divide the total number by 15 to determine the number of 15-minute units that can be reported. If there are minutes left over, apply the following rules:

   1-7 minutes equal 0 units; and
   8-15 minutes equals one 15-minute unit.

   For example, the targeted case manager performed five separate TCM activities for the member during the day for a total duration of 70 minutes. If divided by 15 this would result in 5 units of service.

   Codes must be billed separately for each date of service. A range of dates should not be reported on a single line of a claim (e.g., listing a from and through date of 01/01/2024 - 01/15/2024 with 15 units).