To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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1.0 Description of the Procedure, Product, or Service

Intellectual and Developmental Disabilities Targeted Case Management (I/DD TCM) is a service for children ages six through eighteen who have Intellectual and Developmental Disabilities.

Case management (I/DD TCM) is an activity that assists recipients with gaining access to necessary care: medical, behavioral, social, educational, and other services appropriate to their needs. Case management is individualized, person centered, empowering, comprehensive, strengths-based, and outcome-focused. The functions of case management include:

a. Case Management Assessment;
b. Person Centered Planning;
c. Referral/linkage; and
d. Monitoring/follow-up.

1.1 Case Management Assessment

A comprehensive and culturally appropriate case management assessment documents a recipient's service needs, strengths, resources, preferences, and goals to develop a Person-Centered Plan. The case manager gathers information regarding all aspects of the recipient, including medical, physical/functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, and vocational/educational areas. The case management assessment integrates all current assessments including the comprehensive clinical assessment, psychological assessments, and medical assessments, including assessments and information from Community Care of North Carolina (CCNC) and the primary care physician.

The case management assessment includes early identification of conditions and needs for prevention and amelioration. The case management assessment involves consultation with other natural and paid supports such as family members, medical and behavioral health providers, and educators to form a complete assessment. The case management assessment includes periodic reassessment to determine whether a recipient's needs or preferences have changed. Reassessment occurs at least annually as part of the Person-Centered Planning process.

1.2 Person Centered Planning

Person centered planning promotes recipient self-direction and self-management. The case manager uses the information gathered during the case management assessment and ensures the active participation of the recipient and his or her caregivers in the person-centered planning process. The person-centered planning process involves information exchange between the recipient and his or her supports in order to help the recipient make informed decisions.

Person centered planning is an ongoing process that drives the development and periodic revision of a specific service plan based on the information collected from the person, family, other personal supports, and assessments or reassessments. The Person-Centered Plan is comprehensive and addresses the recipient's identified needs, strengths, resources, and preferences as identified in the case management assessment. The Person Centered

Plan specifies the recipient's goals and the actions necessary to address the medical, behavioral, social, educational and other service needs of the recipient. The goal of person-centered planning is to develop an appropriate and fiscally responsible service plan that enhances quality and achieves individual's outcomes. A recipient's Person-Centered Plan is revised as his or her abilities, needs, preferences, and goals change.

The primary reference documents for person centered planning and Person-Centered Plans are the DMH/DD/SAS *Person Centered Planning Instruction Manual* and the *Records Management and Documentation Manual*. These can be downloaded from the DMH/DD/SAS web site at: https://www.ncdhhs.gov/divisions/mhddsas. Person Centered Thinking will be done per DMH/DD/SAS's curriculum.

1.3 Referral/Linkage

Referral and linkage activities connect a recipient with medical, behavioral, social and other programs, services, and supports to address identified needs and achieve goals specified in the Person-Centered Plan. Referral and linkage activities include but are not limited to:

a. Coordinating the delivery of services to reduce fragmentation of services and supports and maximize mutually agreed upon outcomes;
b. Facilitating access to and connecting recipients to services and supports identified in the Person-Centered Plan;
c. Making referrals to providers for needed services and scheduling appointments with the recipient;
d. Assisting the recipient as he or she transitions through levels of care;
e. Facilitating communication and collaboration among all service providers and the recipient; and
f. Assisting the recipient in establishing and maintaining a medical home with a Community Care of North Carolina (CCNC) physician.

1.4 Monitoring/Follow-up

Monitoring and follow up includes activities and contacts that are necessary to ensure that the Person-Centered Plan is effectively implemented and adequately addresses the needs of the recipient. Monitoring activities may involve the recipient, his or her supports, providers, and others involved in service/support delivery. Monitoring activities helps determine whether:

a. Services are being provided in accordance with the recipient's Person-Centered Plan;
b. Services in the Person-Centered Plan are adequate and effective;
c. There are changes in the needs or status of the recipient; and
d. The recipient is making progress toward his or her goals.

1.5 Expected Outcomes

a. The recipient has a single, unified Person-Centered Plan that addresses all service and support needs.
b. The recipient is connected to all services and supports necessary to meet the goals in the Person-Centered Plan.
c. The recipient or his or her family has become increasingly independent in managing the services and support needs of the recipient.

Case Managers may deliver services in various environments, such as homes, office settings, schools, court, homeless shelters, libraries, street locations, and other community settings.

***Note:** For all services, NCHC will deny payment for services delivered to inmates of public correctional institutions or secure juvenile detention centers.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

A comprehensive clinical assessment that documents medical necessity shall be completed prior to provision of this service. If a substantially equivalent assessment is available and reflects the current level of functioning and contains all the required elements as outlined below, as well as in all applicable federal and state requirements, it may be used as part of the current comprehensive clinical assessment.

The format of a comprehensive clinical assessment is determined by the individual provider based on the clinical presentation. Although a comprehensive clinical assessment does not have a designated format, the assessment (or collective assessments) used must include the following elements:

a. a chronological general health and behavioral health history (including mental health and substance abuse) of the consumer's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;
b. biological, psychological, familial, social, developmental and environmental dimensions which identifies strengths, weaknesses, risks, and protective factors in each area;
c. a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;
d. a strengths/protective factors/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment (MH/SA), and treatment and recovery history (MH/SA);
e. a strengths-based assessment that identifies the consumer/family functional strengths including natural and informal supports, preferences, needs, and cultural diversity issues;

f. evidence of the recipient's or legal guardian's participation in the assessment;
g. an analysis and interpretation of the assessment information with an appropriate case formulation;
h. diagnoses on all five (5) axes of DSM-IV; and
i. recommendations for additional assessments, services, support, or treatment based on the results of the comprehensive clinical assessment.

In addition, a completed LME Consumer Admission and Discharge Form shall be submitted to the LME.

2.2 Eligibility Criteria

This policy applies to a NCHC recipient who is 6 through 18 years of age and meets the coverage criteria in this policy. A recipient is eligible for this service when:

a. Children, ages six through eighteen, who are diagnosed with a developmental delay/disability or diagnosed with mental retardation or who have mental or physical impairments similar to developmental disabilities as the result of a traumatic brain injury.

AND

b. The recipient requires coordination between two or more agencies, including medical or non-medical providers and there are no natural supports that can provide this coordination.

AND

c. The recipient has at least three unmet basic needs, such as safe and adequate housing, food, legal, educational, vocational, financial, health care, or transportation for necessary services.

2.3 Continued Service Criteria

The recipient is making measurable progress toward meeting the goals that require case management functions and there is documentation that supports that continuation of this service will be effective in assisting the recipient in meeting those goals identified in the Person-Centered Plan.

AND

Eligibility criteria listed above continue to be met with the exception that:

a. The recipient requires coordination with **one** (or more) agency (ies), including medical or non-medical providers, and there are no natural supports that can provide this coordination;

AND

b. The recipient has at least **one** basic need identified in the initial assessment for services that continues to be unmet;

OR

c. The recipient has at least three unmet basic needs that have been identified through additional assessments during the course of service.

2.4 Discharge Criteria

a. The recipient has met the goals in the goals outlined in the Person-Centered Plan that require case management functions;

OR

b. Recipient no longer meets Continued Service Criteria;

OR

c. Recipient or legal guardian no longer wishes to receive Case Management Services.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**

c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

All NCHC services are based upon a finding of medical necessity, which is determined by generally accepted North Carolina community practice standards as verified by independent NCHC Utilization Review. There must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the individual.

a. **Preventive** means to anticipate the development of a disease or condition and preclude its occurrence.

b. **Diagnostic** means to examine specific symptoms and facts to understand or explain a condition.

c. **Therapeutic** means to treat and cure disease or disorders; it may also serve to preserve health.

d. **Rehabilitative** means to restore that which one has lost, to a normal or optimum state of health.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**

b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**

c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or

d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

The following are not covered under this service:

a. Transportation time

b. Transportation services

c. Any treatment interventions (for example, habilitation or rehabilitation activities)

d. Any direct service provision (i.e. cooking, laundry, etc.)

e. Any social or recreational activities (or the supervision thereof)

f. Running errands (i.e. grocery shopping)

g. Escorting individuals to and/or attending medical appointments

h. Clinical and administrative supervision of staff, including agency staff meetings

i. Time spent with supervisor receiving supervision/guidance

j. Writing/Typing assessment reports and Person Centered Plans (though the actual assessment and planning are billable activities)

k. Writing/Typing service notes

l. Case management agency service record reviews

5.0 Requirements for and Limitations on Coverage

Case management billing is limited to 1 unit per calendar week (Sunday-Saturday); however, the expectation is that service will be provided and documented according to the needs of the recipient.

In order to bill for case management services, the provider must have documentation in the service record to reflect at least 15 minutes of weekly activity within any of the four case management functions (assessment, person centered planning, linking, monitoring). Case management activities include indirect service activities such as referral to needed service, and coordination among providers. A minimum quarterly face-to-face contact with the recipient is required, with an at home visit at least once every other quarter. It is expected that face-to-face contact will occur more often as needed, based on the needs of the individual recipient.

Case Management services cannot be provided during the same authorization period as the following services: Intensive In-Home Services, Multi-systemic Therapy, Child and Adolescent Day Treatment or Substance Abuse Intensive Outpatient Program. Case management is a component of these services.

NCHC recipients receiving I/DD case management cannot receive other case management services during the same period, including, but not limited to the following:

a. Community Alternatives Program (CAP), including CAP-MR/DD, CAP-DA, CAP-C or CAP Choice.
b. At-Risk Case Management for Adults and Children At Risk for Abuse, Neglect, or Exploitation
c. Child Service Coordination
d. Maternal Care Coordination
e. Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM)

NCHC payments for targeted case management shall not duplicate payments under other program authorities (such as child welfare and foster care services).

Case-management services will be made available for up to 60 consecutive days of a covered stay in a medical institution for discharge planning. These case management services may not be billed by the medical institution in which the recipient is residing.

Case management may not be provided to an individual by an agency that is providing any other service to the individual.

Case management may not be provided to an individual by a member of the individual's family (biological, adoptive, foster, or by marriage/partnership).

NC Medicaid may impose unit limits as approved by the Physician Advisory Group (PAG) according to Session Law 2003, Section 284 10.19.(bb).

5.1 Prior Approval

Prior approval is required for Intellectual and Developmental Disabilities Targeted Case Management.

5.2 Prior Approval Requirements

Prior authorization is required on the first day of this service. Reauthorization occurs annually thereafter.

Services, based upon a finding of medical necessity, shall be directly related to the recipient's diagnostic and clinical needs, and are expected to achieve the goals specified in the individual's Person-Centered Plan. Medical necessity is determined by NCHC policy; North Carolina community practice standards are verified by independent NCHC Utilization Review consultants.

Medically necessary services are authorized in the most cost-efficient mode, as long as the treatment that is made available is similarly efficacious to services requested by the recipient's physician, therapist, or other licensed practitioner. Typically, a medically necessary service shall be generally recognized as an accepted method of medical practice or treatment.

5.3 Other Requirements or Limitations

5.3.1 Service Orders

The dated signature of the appropriate professional in the designated service order section of the Person-Centered Plan (PCP) (Section A) for the services outlined in the PCP becomes the service order. Therefore, there is no requirement for a separate form to be used to order this service. The signature shall be in place prior to or on the day that the service is initially provided in order to bill for the service. The service order shall be based on a comprehensive clinical assessment of the recipient's needs. The Qualified Professional signing the order for TCM must also address, in Section B of the PCP signature page, that medical necessity for the TCM services requested is present. For NCHC-funded I/DD Targeted Case Management, the Qualified Professional is the appropriate professional.

NCHC-funded services ordered via signature on a PCP must be reordered at the time of the annual re-write of the PCP.

5.3.2 Documentation Requirements

The service record documents the nature and course of an individual's progress in treatment. In order to bill NCHC, providers must ensure that their documentation is consistent with the requirements contained in this policy and the *DMH/DD/SAS Records Management and Documentation Manual*. Required documents include at a minimum:

a. A comprehensive clinical assessment;
b. A Person-Centered Plan, signed by all required parties, based on the clinical assessment, which is developed in coordination with recipient and or representative/guardian, and updated annually or whenever there are major changes; and
c. Service notes are in compliance with requirements in **Subsection 5.3.2** below.

5.3.2.1 Responsibility for Documentation

The case manager who provides the service is responsible for accurately documenting the services billed to and reimbursed by NCHC. The case manager must sign the written entry. The signature must include credentials.

5.3.2.2 Contents of a Service Note

Refer to the *DMH/DD/SAS Records Management and Documentation Manual* for a complete listing of documentation requirements.

For this service, one of the documentation requirements is a full service note for each contact, or a full service note for each date of service, written and signed by the person(s) who provided the service that includes all of the following:

a. Recipient's name
b. NCHC identification number
c. Service Record Number

d. Service provided (for example, case management/referral activities)
e. Date of service
f. Place of service
g. Type of contact (face-to-face, telephone call, collateral)
h. Purpose of the contact
i. Description of the case management activity [i.e., assessing, arranging, informing, assisting, monitoring, etc.], which relates to a goal/activity in the Person-Centered Plan
j. Amount of time spent performing the intervention
k. Description of the results or outcome of the case management activity, any progress noted, and next steps, when applicable
l. Signature and credentials of the staff member(s) providing the service

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

a. meet NCHC qualifications for participation;
b. be currently enrolled with NCHC; **AND**
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. The provider organization shall be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Provider Agreement, Medicaid Bulletins, and service implementation standards.

6.1 Provider Requirements

I/DD TCM shall be delivered by practitioners employed by I/DD provider organizations that:

a. meet the provider qualification policies, procedures, and standards established by NC Medicaid; and
b. meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS); and
c. fulfill the requirements of 10A NCAC 27G.

Upon direct enrollment, each provider must ensure that each case manager has 20 hours of training relating to case management functions within the first 90 days of hire. Case managers who were employed prior to August 1, 2010, when direct enrollment was required will have 90 days from the implementation date of this policy to complete the required 20 hours of training. Local Management Entities (LMEs) will monitor the providers of Targeted Case Management Services per Administrative Rule. Each provider will be assigned a level of confidence, and that level will determine the frequency and extent of monitoring by the LMEs, with providers with high confidence based upon a statewide automated tool being monitored less frequently than providers

who score low confidence. Services will be monitored by DHHS audit and monitoring staff to assure compliance with all federal and state requirements.

6.2 Staffing Requirements

Case managers shall meet *one* of the following qualifications regarding degree held:

a. A Licensed clinical social worker; or
b. A Licensed psychologist; or
c. A Master's prepared individual with a degree in a human service area* with one year of experience working with individuals with intellectual and developmentally disabilities; a Master's prepared individual with a degree in a human service field, employed by the agency at the time of enrollment, but who does not have one year of experience in working with individuals with intellectual and developmentally disabilities must meet this experience criteria within one year; or
d. A Bachelor's prepared individual with degree in a human service area with two years of experience working with individuals with intellectual and developmentally disabilities; a college prepared individual with a Baccalaureate degree in a human service area that includes the above disciplines, employed by the agency at the time of enrollment, but does not have two years experience with working with individuals with intellectual and developmentally disabilities must meet this experience criteria within two years; or a Bachelor's prepared individual with a degree in an area other than a human service field who has 4 years of experience in working with individuals with a intellectual and developmentally disabilities.
e. A registered nurse currently licensed by the North Carolina Board of Nursing at the time of enrollment with two years experience with public sector case management.

*Degrees in a human service field include but are not limited to, the following degrees: psychology, social work, mental health counseling, rehabilitation counseling, addictions, psychiatric nursing, special education, and therapeutic recreation.

It is recommended that the case manager-to-recipient ratio shall not exceed 1:40 for each case manager.

6.3 Staff Training

All staff providing Case Management services shall complete a minimum of 20 hours of training within the first 90 days of each staff member's date of hire to provide this service as follows:

a. training specific to the required functions of the case management service definition (5 hours)
b. Person Centered Thinking (12 hours)
c. PCP Instructional Elements (3 hours)

Case managers who were employed prior to August 1, 2010, when direct enrollment was required will have 90 days from the implementation date of this policy to complete the required 20 hours of training.

Please note that the portability of training is a business decision made by the provider agency who is acquiring new hires based on policies, procedures and consideration of liability.

6.4 Staff Competencies

Case Management Assessment

Knowledge of:

a. Available formal and informal assessment resources in the state
b. The population/disability/culture of the recipient being served

Skills and Abilities to:

a. Apply interviewing skills such as active listening, supportive responses, open-and closed-ended questions, summarizing, and giving options
b. Collect all recent and relevant clinical and medical assessment and evaluation reports, integrating the findings, results and recommendations to form the basis of the recipient's individualized plan of care; engage recipients and families to elicit and gather, and integrate other pertinent information
c. Recognize indicators of risk (health, safety, mental health/substance abuse)
d. Gather and review information through a holistic approach, giving balanced attention to individual, family, community, educational, work, leisure, cultural, contextual factors, and recipient preferences
e. Consult other professionals and formal and natural supports in the assessment process
f. Discuss findings and recommendations with the recipient in a clear and understandable manner

Person Centered Planning

Knowledge of:

a. The values that underlie a person-centered approach to providing service to improve recipient functioning within the context of the recipient's culture and community
b. Biopsychosocial approaches to serving and supporting individuals, and evidenced-based standards of care
c. Processes used to promote recipient and family involvement in case planning and decision-making
d. Approaches to Person-Centered Planning such as Essential Lifestyle Planning, Circles, MAPS (Making Action Plans), Personal Futures Planning, Individual Service Design, and Lifestyle Planning

Skills and Abilities to:

a. Identity and evaluate a recipient's existing and accessible resources and support systems
b. Develop an individualized Service plan with a recipient and his or her supports based on assessment findings that includes measurable goals and outcomes

Linkage/Referral

Knowledge of:

a. Community resources such as medical and behavioral health programs, formal and informal supports, and social service, educational, employment, and housing resources
b. Current laws, regulations, policies surrounding medical and behavioral healthcare

Skills and Abilities to:

a. Research, develop, maintain, and share information on community and other resources relevant to the needs of recipients

b. Maintain consistent, collaborative contact with other health care providers and community resources
c. Facilitate the recipient's transition into services in the care plan in order to achieve the outcomes derived for the consumer's goals
d. Assist the recipient in accessing a variety of community resources

Monitoring & Follow-Up

Knowledge of:

a. Outcome monitoring and quality management
b. Community consumer-advocacy and peer support groups

Skills and Abilities to:

a. Collect, compile and evaluate data from multiple sources
b. Modify care plans as needed with the input of recipients, professionals, and natural supports
c. Discuss quality-of-care and treatment concerns with the recipient, professionals, formal and natural supports
d. Monitor the motivation and engagement of the recipient and his or her supports
e. Encourage and assist a recipient to be a self-advocate for quality care

Professional Responsibility

Knowledge of:

a. Importance of ethical behavior, the potential impact of unethical behavior on the recipient, and the potential consequences of violating ethical expectations
b. Quality assurance practices and standards
c. Confidentiality regulations
d. Consumer Rights
e. Required performance standards and case management best practices
f. Definitions and fundamental concepts of culture and diversity
g. Origins and tenets of one's personal value system, cultural background, and beliefs; understands how this may influence actions and decisions in practice
h. Differences in culture and ethnicity of recipients served

Skills and Abilities to:

a. Use critical thinking skills and consultation with other professionals to make ethical decisions and conduct ethical case management
b. Form constructive, collaborative relationships with recipients of various cultures and use effective strategies for conducting culturally-competent case management
c. Discern with whom protected health information can be shared
d. Communicate clearly, both verbally and in writing
e. Discern when the severity of family problems are beyond the case manager's skill, or responsibility, and when referrals to other professionals are necessary
f. Identify areas for self improvement, pursue necessary education and training, and seek appropriate supervision

7.0 Additional Requirements

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

7.2 Audits and Compliance Reviews

DMH/DD/SAS and NC Medicaid (DHHS team) jointly conduct annual audits of a sample of NCHC-funded mental health, developmental disabilities, and substance abuse services. The purpose of the audit is to ensure that these services are provided to NCHC recipients in accordance with federal and state regulations and that the documentation and billing practices of directly enrolled providers demonstrate accuracy and integrity. It is a quality control process used to ensure that medical necessity has been determined and to monitor the quality of the documentation of services provided (in accordance with the authorities listed in **Section 1.0** of this policy). The LME may also conduct compliance reviews and monitor provider organizations under the authority of NC Medicaid.

Any deficiencies identified in an audit are forwarded to NC Medicaid's Program Integrity Section, with the following information:

a. A report of findings that summarizes the issues identified, time period covered by the review, and type of sampling; and
b. Copies of supporting documentation, showing the specific billing errors identified in the audit and including the recipient's name, NCHC identification number, date(s) of service, procedure code, number of units billed in error, and reason for the error.

Refunds or requests for withholdings from future payments should be sent to

Office of Controller
NC Medicaid Accounts Receivable
2022 Mail Service Center
Raleigh, N.C. 27699-2022

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES
3/1/12	Throughout	NC Health Choice Program Clinical Coverage Policy implemented to be equivalent to NC Medicaid Program Clinical Coverage Policy 8N pursuant to SL2011-145, Section 10.41(b).
10/01/2015	Attachment A: C	"Providers must bill the ICD-9-CM diagnosis codes(s) …" changed to "Providers must bill the ICD-10-CM diagnosis codes(s) …" to comply with federally mandated 10/1/2015 implementation.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/12/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/12/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. Diagnosis Codes

Providers must bill the ICD-10-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

Providers must use code T1017 when billing for Targeted Case Management -IDD.

D. Modifiers

Providers must bill using modifier HE.

E. Billing Units

One (1) unit = at least 15 minutes of service to bill for the weekly case rate.

F. Place of Service

Various environments, such as homes, office settings, schools, court, homeless shelters, libraries, street locations, and other community settings

G. Co-payments

Co-payments vary by the specific service rendered. Refer to *NCTracks Provider Claims and Billing Assistance Guide*:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

Health Choice recipient Identification cards also list all applicable co-payment amounts by service type.

H. Reimbursement

Providers must bill their usual and customary charges.