North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

Please visit our website at www.dhhs.state.nc.us/dma

July **Revised 10/27/05** **2005**

Attention:

Targeted Case Management for Mentally Retarded/Developmentally Disabled (MR/DD) Individuals

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Introduction

Effective, September 1, 2005, Medicaid is requiring targeted case management provider agencies to direct enroll to provide Medicaid reimbursable targeted case management services to the Mentally Retarded/Developmentally Disabled (MR/DD) individuals who meet the eligibility requirements. Targeted Case Management for MR/DD individuals, or individuals who are at risk for developmental disabilities or delays manifested before age 22, is a service available statewide that assists recipients in gaining access to needed services described in the North Carolina State Medicaid Plan, as well as needed medical, social, educational, and other services.

ELIGIBLE PROVIDERS

Enrollment is open to all provider agencies that receive endorsement from the Local Management Entities (LMEs) and meet the qualifications specified below. For children in the Infant-Toddler Program, enrollment is limited to CDSA staff and other state or local agencies approved by the Division of Public Health in accordance with the Early Intervention Reorganization Plan approved by the General Assembly.

All case management providers or provider agencies must sign a provider agreement with the Division of Medical Assistance (DMA) and meet all applicable state and federal laws governing the participation of providers in the Medicaid program.

- **Provider Qualifications**

  Providers are to utilize qualified case managers. Case manager qualifications are:

  1. **For children less than 3 years of age**, a master's degree in a human service area and currently licensed by the appropriate North Carolina licensure board as a clinical social worker, psychologist or registered nurse currently licensed by the North Carolina Board of Nursing or hold a degree in sociology or special education/child development (for children 0-3 years of age) or certification by the Division of Public Health (DPH) as meeting the requirements for the Qualified Early Intervention Professional (North Carolina Infant Toddler Program Procedures for Personnel Certification), or **for children over the age of 3 and adults, a master's degree in a human service field and one year of experience with the MR/DD population; or**

  2. A baccalaureate degree in a human service area that includes the above disciplines or certification by DPH as meeting the requirements for the Qualified Early Intervention Professional (North Carolina Infant Toddler Program Procedures for Personnel Certification) and two years experience working with children/adults with MR/DD and their families; **or**

  3. A registered nursing license by the North Carolina Board of Nursing and two years experience working with children/adults with MR/DD and their families or certification by DPH as meeting the requirements of the Qualified Early Intervention Professional (North Carolina Infant Toddler Program Procedures for Personnel Certification), **or**

  4. A master's degree in a human services field, employed by the agency at the time of enrollment, but does not have one year of experience working with children/adults with MR/DD and their families, will be enrolled under a sunset clause until July 31, 2006; **or**

5. A baccalaureate degree in a human service field that includes the above disciplines employed by the agency at the time of enrollment, but does not have two years of experience working with children/adults with MR/DD and their families, will be enrolled under a sunset clause until July 31, 2006; **or**

6. A registered nurse currently licensed by the North Carolina Board of Nursing that is employed by the agency at the time of enrollment, but does not have two years of experience working with children/adults with MR/DD and their families, will be enrolled under a sunset clause until July 31, 2006.

Note: The Division of Medical Assistance will allow enrollment under a "sunset clause" for Practitioners who meet the following qualifications

Master's prepared case manager who does not possess one year of experience with the public sector in case management or

Baccalaureate degree in a human service field who does not possess two years of experience with the public sector in case management or

Registered Nurse who does not possess two years of experience with the public sector in case management

Under the clause all case managers will be required to have completed the experience requirements on or before July 31, 2006. Documentation and proof of experience shall be maintained by the Case Management Agency billing Medicaid. Failure to meet or maintain documentation may result in possible recoupment of Medicaid payments to non qualified practitioners or dis-enrollment of the Case Management Agency billing for Medicaid services.

ELIGIBLE RECIPIENTS

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service. Individuals with developmental disabilities or delays, mental retardation or who are at risk for developmental disabilities or delays manifested prior to age 22 are eligible for Targeted Case Management Services.

COVERED SERVICES

Medicaid covers Targeted Case Management Services for MR/DD when:

1. the service is medically necessary.
2. the 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.
3. the service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
4. the service may be provided to CAP MR/DD waiver recipients.

Targeted Case Management Services for adults and children with MR/DD include the following service components:

- **Assessment**

  This component includes activities that focus on needs identification. Activities include assessment of the recipient to determine the need for any medical, educational, social, and other services. Specific assessment activities include: taking recipient history, identifying the needs of the recipient, and completing related documentation. It also includes gathering information from other sources such as family members, medical providers and educators, if necessary, to form a complete assessment of the recipient.

- **Care Planning**

  This component builds on the information collected through the assessment phase and includes activities such as ensuring the active participation of the recipient or the recipient's representative and working with him/her and others to develop goals and identify and document a course of action to respond to the assessed needs of the recipient. The goals and actions in the PCP or IFSP should address medical, social, educational, and other services needed by the recipient.

- **Referral and Linkage**

  This component includes activities that help link recipients to the medical, social, educational providers, and /or other programs and services identified in the PCP or IFSP that will provide needed services. For example, making referrals to providers for needed services and scheduling appointments may be considered Targeted Case Management. Referral or arrangements for medical treatment, physical or psychological examination or evaluation are billable case management activities. Coordination of care between Targeted Case Management providers for MR/DD and Mental Health/Substance Abuse professionals is critical when there is a co-occurring disorder present.

- **Monitoring/Follow-up**

  This component includes activities and contacts that are necessary to ensure the PCP or IFSP is effectively implemented and adequately addressing the needs of the recipient. The activities and contacts may be with the recipient, family members, providers, or other entities. These may be as frequent as necessary to help determine such things as (i) whether services are being furnished in accordance with the recipient's PCP or IFSP, (ii) the adequacy of the services identified in the PCP or IFSP, and (iii) changes in the needs or status of the recipient. This function, with the consent of the recipient and/or representative, includes making necessary adjustments in the PCP or IFSP and service arrangements with providers.

REQUIREMENTS FOR AND LIMITATIONS ON COVERAGE

- **Service Limitations**

  Provision of targeted case management services to children over the age of three in the Infant-Toddler program is limited to the time period when the recipient is in the process of being transitioned to Part B Preschool Services and should not continue indefinitely.

  A recipient is not required to accept targeted case management services for which he/she might be qualified to receive.

Electing to receive targeted case management services does not restrict a recipient's access to other Medicaid services for which he/she may qualify and/or choice of providers for other Medicaid services.

For recipients with mental retardation, developmental disabilities, or at risk for developmental delays or disabilities manifested prior to age 22, providers are limited to the most qualified to ensure that the case management agency is capable of providing the full range of needed services to the target recipients.

If a child has been referred to a state foster care program, any activities performed by the foster care case worker that relate directly to the provision of foster care services cannot be covered as Targeted Case Management Services for MR/DD.

Services are not covered when the services provided are not outlined in the Individualized Family Service Plan (IFSP) or the Person Centered Plan (PCP).

Targeted Case Management services do not include payment for the provision of direct services (medical, educational, or social) to which the Medicaid recipient has been referred. For example, if a Medicaid recipient is referred for counseling, the provider is responsible for billing Medicaid for the service.

- **Referral Requirements**

Coverage for children less than three years of age begins at the time of referral to the Infant-Toddler Program. Once eligibility for the Infant-Toddler Program has been determined and the recipient has been enrolled in the program, all services must be provided as outlined in the IFSP. For children less than three years of age who have been referred to the Infant-Toddler Program, case management services must be provided to assist the family with the referral, assessment/evaluation and eligibility process.

Children over three years old and adults who are diagnosed with a developmental disability or a developmental delay prior to age 22 or mental retardation are eligible for Targeted Case Management Services for MR/DD. Children within 3 or 4 months short of their third birthday, referred by a primary referral source to the Infant-Toddler program, are entitled to the full range of Infant-Toddler Program services including eligibility determination, IFSP development and service delivery. Three and four year olds referred by a primary referral source must meet Infant-Toddler eligibility determination process to be eligible for the Preschool Program and receive Targeted Case Management. Transition into the public school will be the major focus on the IFSP. Children 5 and older and adults are referred for Targeted Case Management for MR/DD when it is determined through assessment to be a needed service and is noted on the Person Centered Plan.

- **Prior Approval Requirements**

Prior approval for Targeted Case Management for MR/DD is not required for children enrolled in or referred to the Infant/Toddler programs.

Prior approval by the LME will be required.

Prior approval is required for Piedmont Health Care enrollees.

- **Place of Service**

  Services can be provided in any setting except public correctional or detention facilities and institutions. Targeted Case Management for MR/DD individuals can also be provided to home and community-based waiver participants.

- **Documentation requirements**

  The case management provider must maintain case records for a minimum of five years, and the records must describe all contacts with and on behalf of the recipient. The case record, at a minimum, must also contain documentation of the following:

  1. the recipient's full name and birth date on each page of the record.
  2. the name of the provider agency and the credentials and name of the person providing direct services to the recipient.
  3. the place of service delivery.
  4. the date of service.
  5. the nature, extent, and the duration/length of the case management services in minutes or units.
  6. the records of referrals to providers and programs.
  7. a copy of the completed prior approval form with the prior approval authorization number, when appropriate.
  8. a copy of the physician's order for treatment services.

     Note: The signed order date must precede the treatment dates.
  9. a copy of each test performed or a summary listing all test results and the written evaluation report.
  10. a copy of the PCP or IFSP with clearly defined goals and measurable baselines.
  11. progress notes signed by the case manager (including professional credentials) that describe:
      (i) achievements or measurable progress toward goals identified in the PCP or IFSP,
      (ii) description of services performed, and
      (iii) service monitoring evaluations.
  12. claims for reimbursement.

Completing a Claim for DD Targeted Case Management

Completing a Claim for DD Targeted Case Management

Refer to the following information for completing a CMS-1500 claim form for DD targeted case management.

Block #/Description	Instruction
1.	Place an **X** in the MEDICAID block.
1a. Insured's ID Number	Enter the recipient's Medicaid ID number (nine digits and the alpha suffix) from the recipient's Medicaid ID card.
2. Recipient's Name	Enter the recipient's last name, first name and middle initial from the Medicaid ID card.
3. Recipient's Birth Date/Sex	Enter eight numbers to show the recipient's date of birth - MMDDYYYY. The birth date is on the Medicaid ID card. ***EXAMPLE:*** *November 14, 1949 is* **11141949***.* Place an **X** in the appropriate block to show the recipient's sex.
4. Insured's Name.	Leave blank
5. Recipient's Address	Enter the recipient's street address, including the city, state and zip code. The information is on the Medicaid ID card. Entering the telephone number is optional.
6. – 8.	Leave blank.
9. Other Insurer's Name	Enter applicable private insurer's name.
9a. – 9d.	Enter applicable insurance information.
10. Is Recipient's Condition…?	Place an **X** in the appropriate block for each question.
11. – 14.	Optional.
15. – 16.	Leave blank.
17., 17a., and 18.	Optional.
19. Reserved for Local Use	Leave blank.
20. Outside Lab…	Leave blank.
21. Diagnosis or Nature of Illness	Enter the ICD-9-CM code(s) to describe the primary diagnosis related to the service. You may also enter related secondary diagnoses. Entering written descriptions is optional.
22. Medicaid Resubmission Code	Leave blank.
23. Prior Authorization Number	Leave blank.

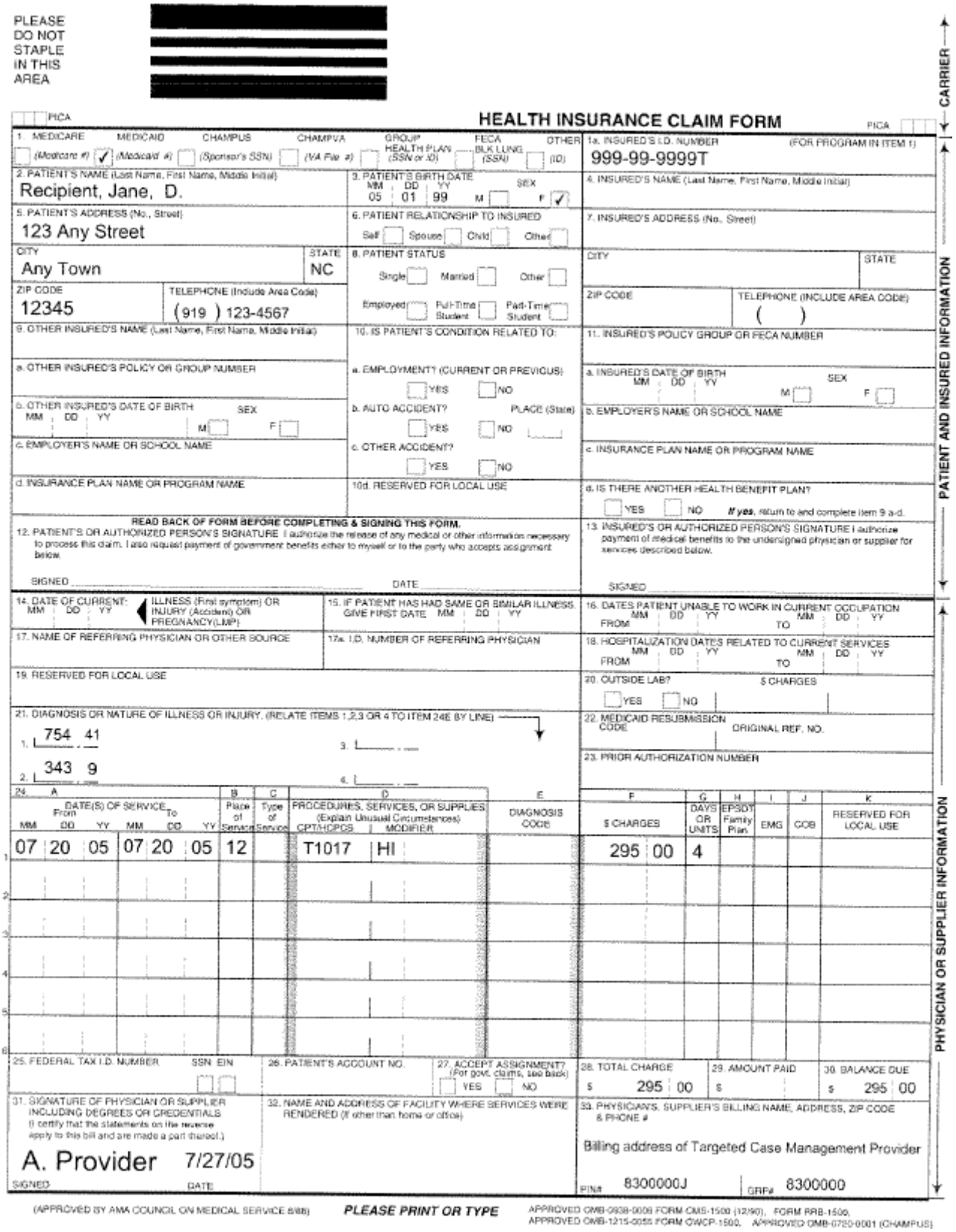
Note: Blocks 24A through 24K are where you provide the details about what you are billing. There are several lines for listing services. Each line is called a "detail." When completing these blocks:

- Use one line for each HCPCS code that you bill on a given date.
- If you provide more than one unit of the same item on one day, include all the items on the same line.
- Include only dates of service for which the recipient is eligible for Medicaid.

Block #/Description	Instruction
24a. Date(s) of Service, From/To	Enter the date of service in the "From" date field and then the same date in the "To" date field.
24b. Place of Service	Enter the appropriate place of service code. (What is the appropriate place of service)
24c. Type of Services	Leave blank.
24d. Procedures, Services…	Enter T1017 as the HCPC code and append the HI modifier
24e. Diagnosis Code	Leave blank.
24f. Charges	Enter the total charge for the items on the line.
24g. Days or Units	Enter the number of units as follows: **1 unit = 15 minutes**.
24h. – 24i.	Leave blank.
24j. – 24k.	Optional.
25. Federal Tax ID Number	Optional
26. Recipient's Account No.	Optional. You may enter your agency's record or account number for the recipient. The entry may be any combination of numbers and letters up to a total of nine characters. If you enter a number, it will appear on your RA. This will assist in reconciling your accounts.
27. Accept Assignment	Leave blank.
28. Total Charge	Enter the sum of the charges listed in Item **24F**.
29. Amount Paid	Enter the total amount received from third party payment sources.
30. Balance Due	Subtract the amount in Item **29** from the amount in Item **28** and enter the result here.
31. Signature of Physician or Supplier…	Leave blank if there is a signature on file with Medicaid. Otherwise, an authorized representative of your agency must sign and date the claim in this block. A written signature stamp is acceptable.

Block #/Description	Instruction
32. Name and Address of Facility...	Optional.
33. Physician's/ Supplier's Billing Name...	Enter your agency's name, address, including ZIP code, and phone number. The name and address must be EXACTLY as shown on your Medicaid participation agreement.
PIN#	Enter your seven-digit Medicaid attending provider number.
GRP#	Enter your seven-digit Medicaid billing provider number.

Example of Claim Form for DD Targeted Case Management



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID ✓ (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999-99-9999T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane, D.

3. PATIENT'S BIRTH DATE MM DD YY: 05 01 99 | SEX: M ☐ F ✓

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Any Town | STATE: NC

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (919) 123-4567

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM _____ TO _____

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM _____ TO _____

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 754.41
2. 343.9
3. _____
4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 20 05	07 20 05	12		T1017	HI		295 00	4				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ 295 00

29. AMOUNT PAID $

30. BALANCE DUE $ 295 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Provider 7/27/05

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Billing address of Targeted Case Management Provider

PIN# 8300000J | GRP# 8300000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Mark T. Benton, Senior Deputy Director
and Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS