

Targeted Case Management

Provider Manual



Iowa Department
of Human Services



Iowa
Department
of Human
Services

Provider

Targeted Case Management

Page

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Date

April 1, 2014

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. ORGANIZATIONS ELIGIBLE TO PARTICIPATE

Targeted case management (TCM) provider organizations are eligible to participate as Iowa Medicaid enrolled providers if they meet the following qualifications:

- ◆ They meet the standards in 441 Iowa Administrative Code (IAC) Chapter 24 (*Division I, "Core Standards for All Providers on MH/ID/DD Services,"* and *Division II, "Standards for Individual Case Management Services"*), and
- ◆ They are:
 - A Mental Health and Disabilities (MHDS) Region, or
 - An agency or provider under subcontract to an MHDS Region, or
 - An agency or provider under subcontract to the Iowa Department of Human Services (DHS).

NOTE: DHS is eligible to be a case management provider organization.

B. COVERAGE OF CASE MANAGEMENT SERVICES

TCM is a service to manage multiple resources effectively for the benefit of Medicaid members. TCM services assist members in gaining access to appropriate and needed medical and interrelated social, educational, housing, transportation, vocational, and other services. The goal of targeted case management is to ensure that:

- ◆ Necessary evaluations are conducted.
- ◆ Individual services and treatment plans are developed, implemented, monitored, and modified as necessary.
- ◆ Reassessment of member needs and service provision occurs on an ongoing and regular basis (*minimum of once a year*).



1. Eligible Members

Payment will be approved for targeted case management services for members of the following populations who are not enrolled in an IA Health Link Managed Care Organization (MCO) or an Integrated Health Home (IHH):

- ◆ Medicaid members who are 18 years of age or over and have a primary diagnosis of:
 - Intellectual disability, or
 - Developmental disabilities, or
 - Chronic mental illness.
- ◆ Medicaid members under 18 years of age receiving:
 - HCBS Intellectual Disability or
 - HCBS Children's Mental Health (CMH) waiver services.

Residents of medical institutions are **not** eligible to receive targeted case management services, except for qualified discharge planning activities provided within 60 days of discharge.

a. Intellectual Disability

"Person with intellectual disability" means a person who meets the following three conditions:

- ◆ The person has significantly subaverage intellectual functioning, meaning an intelligence quotient (IQ) of approximately 70 or below on an individually administered IQ test, or for an infant, a clinical judgment of significantly subaverage intellectual functioning.
- ◆ The person has concurrent deficits or impairments in present adaptive functioning, that is, the person's effectiveness in meeting the standards expected for the person's age and cultural group. The person must have a deficit or impairment in at least two of the following areas:
 - Communication
 - Self care
 - Home living
 - Social and interpersonal skills
 - Use of community resources
 - Self-direction
 - Functional academic skills



- Work
- Leisure
- Health
- Safety

- ◆ The onset of this condition is before age 18.

b. Chronic Mental Illness

A person with chronic mental illness means a person who is 18 years of age or over and has a persistent mental or emotional disorder that seriously impairs the person's functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment.

People with chronic mental illness typically meet at least one of the following criteria:

- ◆ They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).
- ◆ They have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

- ◆ They are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
- ◆ They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
- ◆ They show severe inability to establish or maintain a personal social support system.
- ◆ They require help in basic living skills.
- ◆ They exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness. For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.



c. Developmental Disabilities

A person with developmental disabilities means a person with a severe, chronic disability which:

- ◆ Is attributable to mental or physical impairment, or a combination of mental and physical impairment.
- ◆ Is manifested before the person attains the age of 22.
- ◆ Is likely to continue indefinitely.
- ◆ Results in substantial functional limitation in three or more of the following areas of life activities:
 - Self care
 - Receptive and expressive language
 - Learning
 - Mobility
 - Self-direction
 - Capacity for independent living
 - Economic self-sufficiency
- ◆ Reflects the person's need for a combination and sequence of services which are of lifelong or extended duration.

d. Need for Service

The targeted case manager's documentation must show the initial and ongoing need for service based on evidence presented by the provider, including diagnostic reports, documentation of provision of services, and information supplied by the member and other appropriate sources. The evidence shall demonstrate that all of the following criteria are met:

- ◆ The member has a need for TCM to manage multiple resources pertaining to medical and interrelated social and education services for the benefit of the member.
- ◆ The member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services.
- ◆ The member is not receiving other paid benefits under the Medicaid program or under a Medicaid managed health care plan that serve the same purpose as targeted case management.

For members in the intellectual disability or developmental disability population, the case manager documents the need for service by completing the *TCM Service Authorization Form* in ISIS.



2. Service Provisions

Payment will be made through the IME for targeted case management functions provided to members not enrolled in an MCO or an IHH. TCM services are described in 441 Iowa Administrative Code 90.5(249A) and include:

- ◆ [Assessment](#)
- ◆ [Service plan](#)
- ◆ [Referral and related activities](#)
- ◆ [Monitoring and follow-up](#)
- ◆ [Contacts](#)

a. Assessment

The Core Standardized Assessment (CSA) contractor or case manager will perform a functional assessment and periodic reassessment of the member's individual needs. The CSA contractor will determine whether the contractor or case manager will perform the assessments and reassessments. The contractor will use the CSA tool designated by the Department. The case manager will use form 470-4694, *Targeted Case Management Comprehensive Assessment*.

The assessment will aid the case manager in determining the need for any medical, social, educational, housing, transportation, vocational or other services. The functional assessment shall address all of the member's areas of need, strengths, preferences, and risk factors, considering the member's physical and social environment.

A face-to-face reassessment must be conducted at a minimum annually and more frequently if changes occur in the member's condition. The assessment and reassessment activities include the following:

- ◆ Making annual updates to the member's history (including social history).
- ◆ Identifying the needs of the member and completing related documentation.
- ◆ Gathering information from other sources, such as family members, medical providers, social workers, legally authorized representatives, and others as necessary to form a complete assessment of the member.



b. Service Plan

The targeted case manager shall develop and periodically revise a service plan based on the functional assessment. This shall include a crisis intervention plan based on the risk factors identified in the risk assessment portion of the comprehensive assessment.

The case manager shall ensure the active participation of the member and work with the member or the member's legally authorized representative and other sources to choose providers and develop goals. This service plan shall:

- ◆ Document the parties participating in the development of the plan.
- ◆ Specify the goals and actions to address the medical, social, educational, housing, transportation, vocational or other services needed by the member.
- ◆ Identify a course of action to respond to the member's assessed needs, including identification of all providers, services to be provided, and time frames for services.
- ◆ Document services identified to meet the needs of the member which the member declined to receive.
- ◆ Include an individualized crisis intervention plan that identifies the supports available to the member in an emergency. A crisis intervention plan shall identify:
 - Any health and safety issues applicable to the individual member based on the risk factors identified in the member's comprehensive assessment.
 - An emergency backup support and crisis response system, including emergency backup staff designated by providers, to address problems or issues arising when support services are interrupted or delayed or the member's needs change.
 - After-hours contact information for all persons or resources identified for the member and an alternate contact to be used in the event that an individual provider not employed by an agency is not present to provide services as scheduled; or



- After-hours contact information for an on-call system for the provider of targeted case management to ensure that in the event of an emergency, members have access to a targeted case manager 24 hours per day including weekends and holidays.
- ◆ Include a discharge plan.
- ◆ Be revised at least annually and more frequently if significant changes occur in the member's medical, social, educational, housing, transportation, vocational or other service needs or risk factors.

c. Referral and Related Activities

The targeted case manager shall perform activities to help the member obtain needed services, such as scheduling appointments for the member, and activities that help link the member with medical, social, educational, housing, transportation, vocational or other service providers. The targeted case manager shall also help link the member with programs that are capable of providing services to address identified needs and risk factors and to achieve goals specified in the service plan.

d. Monitoring and Follow-Up

The targeted case manager shall perform activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home when applicable), and all services. Monitoring may also include review of service provider documentation. Monitoring shall be conducted to determine whether:

- ◆ Services are being furnished in accordance with the member's service plan, including the amount of service provided and the member's attendance and participation in the service.
- ◆ The member has declined services in the service plan.
- ◆ Communication is occurring among all providers to ensure coordination of services.



- ◆ Services in the service plan are adequate, including the member's progress toward achieving the goals and actions determined in the service plan.
- ◆ There are changes in the needs or status of the member. Follow-up activities shall include making necessary adjustments in the service plan and service arrangements with providers.

e. Contacts

Targeted case management contacts shall occur as frequently as necessary and shall be conducted and documented as follows:

- ◆ The targeted case manager shall have at least one face-to-face contact with the member every three months.
- ◆ The targeted case manager shall have at least one contact per month with the member, the member's legally authorized representative, the member's family, service providers, or other such entities or individuals.

This contact may be face-to-face or by telephone. The contact may also be by written communication, including letters, email, and fax, when the written communication directly pertains to the needs of the member. A copy of any written communication must be maintained in the case file.

- ◆ The targeted case manager may bill for contacts with non-eligible persons if the contacts are directly related to identifying the member's needs and care as necessary for the purpose of helping the member:
 - Access services,
 - Identify needs and supports to assist the member in obtaining services,
 - Provide targeted case managers with useful feedback, and
 - Alert targeted case managers to changes in the member's needs.
- ◆ When applicable, documentation of targeted case management contacts shall include:
 - The name of the service provider.
 - The need for and occurrences of coordination with other targeted case managers within the same agency or of referral or transition to another targeted case management agency.



3. Exclusions

Payment shall not be made for activities otherwise within the definition of targeted case management when any of the following conditions exist:

- ◆ The activities are an integral component of another covered Medicaid service. This includes care coordination through an IHH.
- ◆ The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include, but are not limited to:
 - Services under parole and probation programs
 - Public guardianship programs
 - Special education programs
 - Child welfare and child protective services
 - Foster care programs
- ◆ The activities are integral to the administration of foster care programs, including but not limited to, the following:
 - Research gathering and completion of documentation required by the foster care program
 - Assessing adoption placements
 - Recruiting or interviewing potential foster care parents
 - Serving legal papers
 - Home investigations
 - Providing transportation
 - Administering foster care subsidies
 - Making placement arrangements

The activities for which a member may be eligible are integral to the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

- ◆ The activities duplicate institutional discharge planning.



C. BASIS OF PAYMENT

For members not enrolled with an MCO or IHH, the basis of payment for targeted case management services is a targeted case management activity of 15 minutes in duration. The following rounding rules apply when billing for services:

- ◆ 1 through 7 minutes of service should be rounded down to zero.
- ◆ 8 through 14 minutes of service should be rounded up to 15 minutes.

Providers shall add the total minutes of service provided for the day and then round once. The rate is established on the basis of cost information submitted to the Iowa Medicaid Enterprise Cost Audit Unit.

Providers are required to submit a projected cost report by July 1 of each year. This form is used to establish a projected rate for the new fiscal year, thus, avoiding underpayment or overpayment. A cost report showing actual costs shall be submitted 90 days after each state fiscal year end. Providers may contact the Iowa Medicaid Enterprise Cost Audit Unit for a copy of the cost report form and instructions for completion.

State and local government entities that enroll in the Medicaid program as case management providers must establish their rates in accordance with the cost principles contained in the Office of Management and Budget Circular No. A-87, "Cost Principles for State and Local Governments." Targeted Case Management agencies include the costs of translation and interpretation services in their cost reports. Translation and interpretation services are not separately billable by Targeted Case Management agencies.

1. Targeted Case Management Billable Activities

Below are listed those activities that are billable case and targeted case management activities when done by a targeted case manager or targeted case management supervisor for members not enrolled in an MCO or IHH. Any activity undertaken by an employee who is not a targeted case manager or targeted case manager supervisor is not a billable activity. This listing is not meant to be all-inclusive.



a. Assessment, Social History, and Reassessment

Legal reference: 441 IAC 90.5(1)"a"

- ◆ Taking member history.
- ◆ Gathering and reviewing information pertaining to the member's history from any source, including obtaining and verifying diagnoses.
- ◆ Completing *Risk Assessments* and the *Targeted Case Management Comprehensive Assessment* if the TCM is designated by the Core Standardized Assessment contractor to complete the functional assessment.
- ◆ Completing program assessments in order to determine service needs.
- ◆ Researching funding sources, including non-Medicaid sources for services needed before the service plan implementation.
- ◆ Dictating, writing, editing, and updating the assessment and social history documents.
- ◆ Dictating, writing, typing, and signing narrative entries to document assessment and social history activities.
- ◆ Contacts to establish or verify initial Title XIX eligibility (e.g., calls to income maintenance workers). Checking eligibility via ISIS or ELVS is not billable as this is not a person-to-person contact.

b. Care Planning

Legal reference: 441 IAC 90.5(1)"b"

- ◆ Reviewing progress on previous goals.
- ◆ Completing activities to request funding, from all sources, for services (including exceptions to policy).
- ◆ Planning for development or revision of the member's comprehensive service plan (e.g., scheduling the meeting with the member, determining who the member wants to attend, etc.).
- ◆ Conducting the comprehensive service plan meeting.
- ◆ Dictating, writing, typing, and signing of the comprehensive service plan document.



- ◆ Dictating, writing, typing, and signing narrative entries to document care planning activities.
- ◆ Completing forms (paper or electronic) that are required to ensure access to, or funding of, needed services. (e.g., entering service plan and specific service information in ISIS).
- ◆ Closing a case and associated activities completed before the date of closing (e.g., writing a discharge summary, identifying other services that will be needed after discharge, making referrals to other agencies or providers).

c. Referrals and Linkage

Legal reference: 441 IAC 90.5(1)"c"

- ◆ Scheduling appointments for members with other providers.
- ◆ Dictating, writing, typing, and signing narrative entries to document referral activities.
- ◆ Researching service options for a member, including coordination with funders and providers, including completion of referral documents and related contacts.
- ◆ Contacts to complete service arrangements (e.g., arranging transportation, etc.).

d. Monitoring and Follow-Up

Legal reference: 441 IAC 90.5(1)"d"

- ◆ Monitoring and follow up, to determine whether services are being furnished in accordance with the member's care plan. This includes time spent reviewing service provider files.
- ◆ Monitoring and follow up, to determine whether the services in the care plan are adequate to meet the needs of the member.
- ◆ Monitoring and follow up, to determine whether there are changes in the needs or status of the member.
- ◆ Making necessary adjustments in the care plan and service arrangements with providers to address changes in needs or status of the member.



- ◆ Dictating, writing, typing, and signing case record entries to document the monitoring activities.
- ◆ Completing forms or reports to ensure the health and safety of the member, including *Incident Report* review, processing, and follow-up.

2. Examples of Non-Billable Activities

- ◆ Travel time
- ◆ Paid time off (vacation, sick leave, etc.)
- ◆ Activities provided by anyone other than a person who meets the qualifications to be a targeted case manager, even if they are working under the supervision of a targeted case manager
- ◆ Unsuccessful attempts to contact the member or collaterals (e.g., a home visit when member is not at home or leaving a voice mail message for the member or collateral)
- ◆ Services provided by more than one targeted case manager to the same member at the same time
- ◆ Staff meetings, trainings, and supervision
- ◆ Time spent in case review for Quality Assurance purposes
- ◆ Contacts with support staff within the agency
- ◆ Scheduling targeted case manager's appointments
- ◆ Bill submission and collection activities
- ◆ Checking Medicaid or service eligibility in ISIS or ELVS
- ◆ Calls to the ISIS helpdesk
- ◆ Preparing and mailing Notice of Decisions (NODs)
- ◆ Filing



D. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Paper claims for targeted case management are billed on form 470-2486, *Claim for Targeted Medical Care*.

Click [here](#) to view a sample of the claim form.

Click [here](#) to view billing instructions for the claim form.

The IME supports the electronic submission of claims. Through electronic submission, submission and processing errors can be reduced. Information regarding electronic submission of claims is located on the Iowa Medicaid website. Click [here](#) to view this information.

Bill the IME for each service rendered to each member using applicable charges or the rate determined by the Division of Medical Services.

Submit claims to the IME on a monthly basis to facilitate payment in a timely manner. To receive payment monthly, submit the claim for the month's service by the tenth of the month following the month of service.

Refer to [Chapter IV. Billing Iowa Medicaid](#) for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
<http://dhs.iowa.gov/sites/default/files/All-IV.pdf>



**APPENDIX I.
Targeted Case Management, Children’s Mental Health, and
Integrated Health Home Overview Chart**

| Program | Member Status | Case Management Provided By | Service Authorization | Billing Submitted To |
|---|------------------------|---|--|-----------------------------|
| Habilitation | Medically Needy | CM as a habilitation services when the member does not qualify for TCM | IME Medical Services Unit (MSU) | IME |
| | Iowa Plan eligible | When the member does not qualify for TCM, CM as a habilitation service and until the member is attributed and enrolled in an IHH | IME Medical Services Unit | IME |
| Habilitation and HCBS Brain Injury or Elderly Waivers | Iowa Plan eligible | Targeted Case Management as a state plan service | IME IME Medical Services Unit (MSU) | IME |
| Habilitation and HCBS AIDS/HIV, Health and Disability or Physical Disability Waivers | Iowa Plan eligible | CM as a habilitation service funded through the IME | IME Medical Services Unit (MSU) | IME |
| Children’s Mental Health Waiver | Medically Needy | Targeted Case Management as a state plan service | IME MSU | IME |
| | Iowa Plan eligible | TCM service funded through the IME until the member is attributed and enrolled in an Integrated Health Home (IHH) * See IHH transition white paper. | IME Medical Services Unit (MSU) | IME |
| HCBS AIDS/HIV, Health and Disability or Physical Disability Waivers | Not Iowa Plan eligible | Service coordination provided by a service worker | Waiver services: IME | Waiver services: IME |