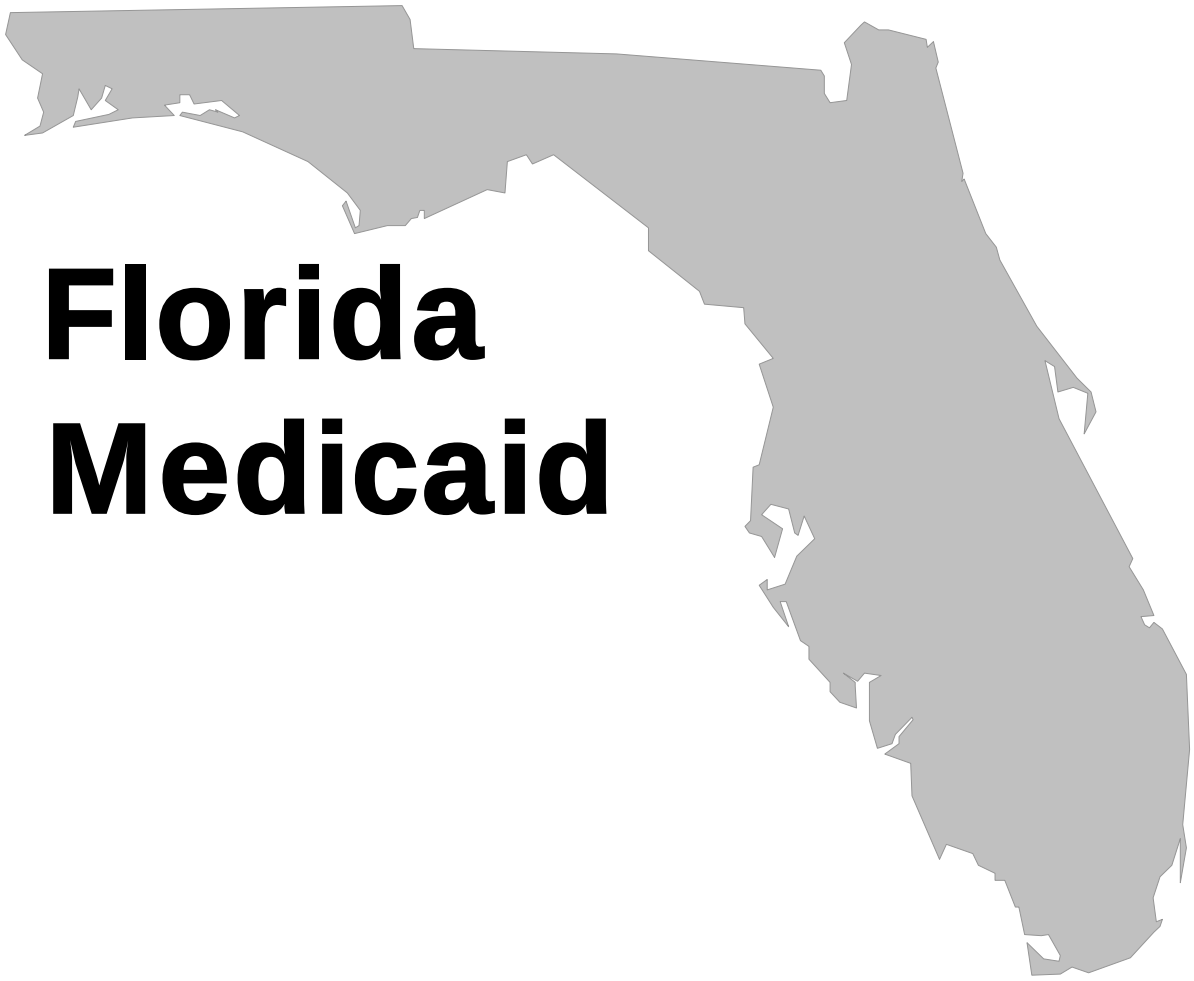

Florida Medicaid

Mental Health Targeted Case Management Handbook

Agency for Health Care Administration

ACS

FLORIDA MEDICAID

FLORIDA MEDICAID

CHARLIE CRIST
GOVERNOR

ANDREW C. AGWUNOBI, M.D.
SECRETARY

December 19, 2007

Dear Medicaid Mental Health Targeted Case Management Provider:

The Florida Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook was updated effective June 2007. The handbook was revised to remove the enrollment requirement for all Medicaid Mental Health Targeted Case Management providers to have an active contract with the Substance Abuse and Mental Health (SAMH) district or regional office for the location in which the agency will provide services. We have revised the update to include the policy that targeted case management providers who deliver case management services only under contract with managed care organizations are not required to enroll in Medicaid as a mental health targeted case management provider. Any targeted case management provider who will be submitting claims to Medicaid under a fee-for-service mechanism must be enrolled in Medicaid to seek reimbursement. The revised update also includes revised certification forms that reflect the new policies.

The following pages were updated to remove this requirement from the handbook:

Updated Pages
Update Log
Chapter 1, pages 1-3 to 1-5
Appendices B through K

Please contact your area Medicaid office if you have any questions. The area Medicaid offices' phone numbers and addresses are available on the Agency's website at http://ahca.myflorida.com. Click on Medicaid, and then on Area Offices. They are also listed in Appendix C of the Florida Medicaid Provider General Handbook. All the Medicaid handbooks are available on the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. Click on Provider Support, and then on Handbooks.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder
Chief, Bureau of Medicaid Services

UPDATE LOG
MENTAL HEALTH TARGETED CASE MANAGMENT COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages.

It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

The provider can use the update log to determine if all the updates to the handbook have been received.

Update No. is the month and year that the update was issued.
Effective Date is the date that the update is effective.

Instructions

1. Make the pen and ink changes and file new or replacement pages.
2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in Appendix C of the Medicaid Provider General Handbook.

UPDATE NO.	EFFECTIVE DATE
New Handbook	October 1998
99-1 — Revised Handbook	July 1999
Apr02 — Revised Handbook	April 2002
June 02 — Pen and Ink Changes	April 2002
Jul2006 — Revised Handbook	July 2006
Jun2007 — Replacement Pages	June 2007

MENTAL HEALTH TARGETED CASE MANAGEMENT COVERAGE AND LIMITATIONS HANDBOOK

Table of Contents

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

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

Background

There are three types of Florida Medicaid handbooks:

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

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

Legal Authority

The following federal and state laws govern Florida Medicaid:

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

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

In This Chapter

This chapter contains:

Handbook Use and Format

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

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.
Note	Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a topic roster on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an “Update No.” and the “Effective Date”.

Handbook Updates, continued

How Changes Are Updated

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.

Numbering Update Pages

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

Effective Date of New Material

The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

Identifying New Information

New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

New Label and New Information Block

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

New Material in an Existing Information Block

New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.

New or Changed Paragraph

A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

Paragraph with new material.

CHAPTER 1
MENTAL HEALTH TARGETED CASE MANAGEMENT PROVIDER QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

This chapter describes the Medicaid mental health targeted case management program, legal authority for the program, its purpose and characteristics, and provider participation requirements.

Legal Authority

Targeted case management services are authorized under Section 1915(g) of the Social Security Act. The Florida Medicaid targeted case management program was implemented through Chapter 409, Florida Statutes and Chapter 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

Purpose, Description and Definitions

Introduction

The purpose of mental health targeted case management services is to assist individuals (recipients) in gaining access to needed medical, social, educational, and other services.

The primary goal of mental health targeted case management is to optimize the functioning of recipients who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner. Services and service frequency should accurately reflect the individual needs, goals, and abilities of each recipient and must not simply reflect the Medicaid maximum allowable for the service.

Purpose, Description and Definitions, continued

Medicaid Provider Handbooks	This handbook is intended for use by mental health targeted case management providers who are enrolled in the Medicaid program. It must be used in conjunction with the Florida Medicaid Reimbursement Handbook, Non-Institutional 081, which specifies procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which contains general information about the Florida Medicaid program.
Mental Health Targeted Case Management Target Groups	To receive mental health targeted case management services, a recipient must be in one of the specific target groups described below: • Children's mental health targeted case management for recipients' birth through 17 years. • Adult mental health targeted case management for recipients age 18 years and older. • Intensive case management team services for recipients age 18 years and older. Note: See Chapter 2 in this handbook for additional information on recipient eligibility for mental health targeted case management services.
Area Medicaid Office	The Agency for Health Care Administration (AHCA) has eleven area Medicaid offices that serve as the local liaisons to providers and recipients. The area offices are responsible for claims resolution, provider relations, and training. Note: See Appendix C in the Florida Medicaid Provider General Handbook for the area Medicaid offices' phone numbers and addresses.
District or Regional SAMH Office	The district or regional Substance Abuse and Mental Health (SAMH) program office is the local mental health and substance abuse authority within the Department of Children and Families (DCF). Note: See the Department of Children and Families website at http://www.state.fl.us/cf_web for the district and regional offices' phone numbers and addresses.

Provider Enrollment

General Enrollment Requirements	Providers must meet the general Medicaid provider enrollment requirements contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, providers must follow the specific enrollment requirements listed in this section.
Provider Type	Mental health targeted case management agency providers are enrolled as Provider Type 91, Case Management Agency. Mental health targeted case management supervisors are enrolled as Provider Type 32, Social Worker/Case Manager.
Group Provider	A mental health targeted case management agency must enroll as a Medicaid group provider. The group must consist of at least one case management supervisor.
Specific Target Group	A mental health targeted case management agency must enroll as a Medicaid provider in order to provide services to one or more of the specific target groups.
Enrollment Process for Fee-for-Service Providers	To enroll as a mental health targeted case management fee-for-service provider, the mental health targeted case management agency must submit the following documents to the Medicaid fiscal agent: • Completed Medicaid enrollment application package(s) for the provider agency and its case management supervisor(s). • Certification forms signed by the area Medicaid office for the provider agency. Targeted case management providers who deliver case management services only under contract with managed care organizations are not required to enroll in Medicaid as a mental health targeted case management provider. Any targeted case management provider who will be submitting claims to Medicaid under a fee-for-service mechanism must be enrolled in Medicaid to seek reimbursement. Note: Medicaid enrollment application packages are obtained from the Medicaid fiscal agent. Enrollment forms are also available on the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. Click on Provider Support. Medicaid enrollment application forms are incorporated by reference in 59G-5.010, F.A.C.

Provider Enrollment, continued

Enrollment Period	The effective date of enrollment is the date the provider application is received by the Medicaid fiscal agent. Medicaid does not enroll providers retroactively. A provider should not bill until it receives confirmation from Medicaid that it is enrolled in Medicaid, has received its Medicaid provider number, and confirmation of the effective date of the enrollment. Providers cannot bill for dates of service prior to the effective date of enrollment.
District or Regional SAMH Office Responsibilities	The district or regional SAMH program office may participate in the process of training targeted case managers. The term district or regional SAMH program office is recognized to mean regional SAMH program office in certain areas of the state.
Department of Children and Families Mental Health Program Office Responsibilities	The Department of the Children and Families (DCF), Mental Health Program Office is responsible for approving policy for the mental health targeted case management program in conjunction with Medicaid.
Medicaid Headquarters Responsibilities	Medicaid Headquarters is responsible for the following: • Establishing policy for the mental health targeted case management program. • Developing the mental health case management training requirements in conjunction with DCF.
Area Medicaid Office Responsibilities	Area Medicaid offices are responsible for the following: • Certifying the agency for the specific target group(s) that it will serve. • Participating in the process of training targeted case managers. • Approving certifications for 30-day Medicaid certification (Appendix L).

Provider Enrollment, continued

Medicaid Fiscal Agent Responsibilities	The Medicaid fiscal agent is responsible for enrolling each fee-for-service provider agency and case management supervisor for which it receives a completed enrollment package.

Provider Agency Qualifications and Certification

Provider Agency Qualifications	To enroll as a Medicaid mental health targeted case management provider, the agency must be certified by its area Medicaid office for the specific target group(s) that the agency will serve. A targeted case management provider agency may not subcontract with another agency for service provision.
Provider Agency Certification	The AHCA Medicaid Headquarters determines the targeted case management certification criteria. The area Medicaid office must certify the mental health targeted case management agency for the specific target group that the agency will serve. The agency certification criteria are listed on the next page. A copy of the agency's certification must be signed by the area Medicaid office and submitted with the provider agency's enrollment application. Note: See Appendices B through D in this handbook for copies of the certification forms.

Provider Agency Qualifications and Certification, continued

Administrative Provider Agency Certification Criteria for Mental Health Targeted Case Management

To be certified as a mental health targeted case management agency, the agency must meet the following administrative certification criteria:

1. Be knowledgeable of and agree to comply with the statutes, rules and policies that affect the target population.
2. Have the ability to administer case management services to the target population.
3. Have established linkages with the local network of mental health treatment providers and other resources in the service area.
4. Have a quality improvement program with written policies and procedures.
5. Provide mental health targeted case managers with supervision as outlined later in this chapter.
6. Cooperate with and participate in monitoring conducted by AHCA, the area Medicaid office or other staff designated by AHCA.
7. Have the capacity to manage utilization of mental health targeted case management services and to conduct utilization review of these services on a regular basis.
8. Have the financial management capacity and system to provide documentation of costs.
9. Have the ability to maintain and produce documentation that verifies mental health targeted case managers have participated in case management training as required by the Mental Health Central Office.
10. Have the capacity to provide or procure targeted case management training approved by AHCA.

Programmatic Provider Agency Certification Criteria for Mental Health Targeted Case Management

To be certified as a mental health targeted case management agency, the agency must meet the following programmatic certification criteria:

1. Have all Medicaid mental health targeted case management services provided by certified case managers.
2. Provide mental health targeted case management for recipients who ask or are referred for service and who meet eligibility requirements.
3. Maintain average caseloads of 20 or fewer for recipients birth through 17 years per mental health targeted case manager.
4. Maintain average caseloads of 40 or fewer recipients age 18 and older per mental health targeted case manager.
5. Maintain records that include clearly identified mental health targeted case management certifications for eligibility, assessments, service plans, and service documentation.

Provider Agency Qualifications and Certification, continued

Provider Agency Certification Criteria for Intensive Case Management Team Services	To be certified as an adult mental health intensive team case management services agency, the agency must meet the following criteria: 1. Be certified to provide adult mental health targeted case management services. 2. Serve recipients who meet the eligibility requirements for intensive case management team services as specified in Chapter 2 of this handbook. 3. Certify individuals who receive intensive case management team services. 4. Respond 24 hours a day, seven days a week to the needs of recipients served by the team. 5. The maximum average caseload size for a team with four or more case managers shall be 15 persons per each team case manager. The maximum average caseload size for a team with three case managers shall be seven persons per each team case manager. The maximum average caseload size for a team with less than three case managers shall be six persons per each team case manager. 6. Transfer an individual from an intensive case management team to an individual case manager when the recipient and the team agree that intensive case management team services are no longer needed or when the individual refuses intensive case management team services.
Compliance of Quality of Care Reviews	AHCA or its authorized representative periodically reviews a provider's compliance with service eligibility determination procedures, service authorization policy, staffing requirements, and service documentation requirements. Providers in violation of these requirements will be referred to Medicaid Program Integrity for a potential fraud or abuse investigation. Note: See Chapter 5 in the Florida Medicaid Provider General Handbook for information on Medicaid fraud and abuse.

Targeted Case Management Supervisor Qualifications and Certification

Targeted Case Management Supervisor Enrollment	To be eligible to enroll as a mental health targeted case management supervisor, an individual must be employed by or under contract with a Medicaid-enrolled mental health targeted case management provider agency.

Targeted Case Management Supervisor Qualifications and Certification, continued

Individual Mental Health Targeted Case Managers

Individual mental health targeted case managers are not enrolled as Medicaid providers. Services are billed using the agency's Medicaid provider number as the payee provider number, and the name and Medicaid provider number of the mental health targeted case management supervisor who authorizes the services as a Medicaid-enrolled case manager (provider type 32).

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, for detailed information on completing the claim.

Certification

The provider agency administrator must certify case management supervisors upon initial enrollment for the target group that the supervisor will serve. The provider agency must maintain the case management supervisor's certification forms on file.

Note: See Appendices E and F in this handbook for copies of the certification forms.

Supervisor Certification Criteria

Mental health targeted case management supervisors must meet the following certification requirements:

- A master's degree from an accredited university or college with a major in counseling, social work, psychology, criminal justice, nursing, rehabilitation, special education, health education, or a related human services field and three years of full time or equivalent professional experience serving the target population; or
- A bachelor's degree from an accredited university or college and five years of full time or equivalent case management experience serving the target population; and
- Bring to the position a previous mental health targeted case management certification or have at least three years experience with mental health case management.

Each supervisor must complete AHCA-approved mental health targeted case management training within three months of initially supervising case managers. If the training is not completed within three months, the provider agency must request that the Medicaid fiscal agent disenroll the supervisor. The provider agency cannot continue to bill Medicaid for services rendered by the case management supervisor or by case managers under the supervisor's supervision.

Note: See Targeted Case Management Training Requirements in this chapter for additional information.

Documentation Requirements

Each supervisor must keep an ongoing log documenting his supervision of each mental health case manager. The log must contain at a minimum the amount of supervision and length of time that the supervision took and the case manager's name and the specific target population he serves.

Individual Targeted Case Manager Certification

Introduction

The mental health targeted case management provider agency must certify individual targeted case managers for the specific target group that the case manager will serve. The provider agency must maintain the individual case managers' certification forms on file.

Medicaid will only reimburse for services provided by certified mental health targeted case managers under the supervision of a Medicaid-enrolled mental health targeted case management supervisor.

Individual Children's Mental Health Targeted Case Manager Certification

To be certified as a mental health targeted case manager for the children's mental health target group, an individual must meet the following criteria:

1. Have a bachelor's degree from an accredited university or college with a major in counseling, social work, psychology, criminal justice, nursing, rehabilitation, special education, health education, or a related human services field (a related human services field is one in which major course work includes the study of human behavior and development) and have a minimum of one year of full time or equivalent experience working with children with serious emotional disturbances; or

   Have a bachelor's degree from an accredited university or college and three years full time or equivalent experience working with children with serious emotional disturbances.

2. Has completed or agrees to complete AHCA-approved mental health targeted case management training within three months of initially providing Medicaid services. If the training is not completed within three months, the provider agency cannot continue to bill Medicaid for services rendered by the case manager under the supervisor's Medicaid provider number.
3. Have knowledge of available resources in the service area for children with serious emotional disturbances.
4. Is knowledgeable of and comply with state and federal statutes, rules and policies that affect the target population.

Note: See Mental Health Targeted Case Management Training Requirements in this chapter for additional information.

Note: See Appendix G in this handbook for a copy of the Case Manager Certification for Children's Mental Health Targeted Case Management.

Individual Targeted Case Manager Certification, continued

Individual Adult Mental Health Targeted Case Manager Certification

To be certified as a mental health targeted case manager for the adult mental health target group, an individual must meet the following criteria:

1. Have a bachelor's degree from an accredited university or college with a major in counseling, social work, psychology, criminal justice, nursing, rehabilitation, special education, health education, or a related human services field (a related human services field is one in which major course work includes the study of human behavior and development) and have a minimum of one year of full time or equivalent experience working with adults experiencing serious mental illness; or

   Have a bachelor's degree from an accredited university or college and three years full time or equivalent experience working with adults experiencing serious mental illness.

   Case managers who were certified prior to July 1, 2006, who do not meet the above requirements may provide Medicaid services if they meet all other requirements.

2. Has completed or agrees to complete AHCA-approved mental health targeted case management training within three months of initially providing Medicaid services. If the training is not completed within three months, the provider agency cannot continue to bill Medicaid for services rendered by the case manager under the supervisor's Medicaid provider number.
3. Have knowledge of available resources in the service area for adults with serious mental illness.
4. Is knowledgeable of and comply with state and federal statutes, rules and policies that effect the target population.

Note: See Targeted Case Management Training Requirements in this chapter for additional information.

Note: See Appendix H in this handbook for a copy of the Case Manager Certification for Adult Mental Health Targeted Case Management.

Targeted Case Management Training Requirements

Required Training Components

Each mental health targeted case management supervisor and individual targeted case manager must complete training that promotes the knowledge, skills, and competency of the mental health targeted case manager. The training must include the following information:

1) The core elements of case management:

Assessment;
Person-centered service plan development;
Linking and coordination of services;
Reassessment and follow-up;
Wrap around and non-traditional services; and
Monitoring of services.

2) Relevant topic areas:

Community resources with emphasis on the development of natural support systems;
Benefits and entitlement programs;
Use and purpose of clinical and functional assessment tools;
How to work with families;
Human growth and development;
Identification and treatment of serious mental disorders and co-occurring substance abuse related disorders;
Psychotropic medications including side effects and access to medications;
Confidentiality;
Information regarding the ramifications of abuse and neglect;
Issues identified by the provider's quality improvement program;
Principles of recovery and empowerment including self-directed care options;
Eliminating barriers and stigma reduction;
Available community resources for adults (e.g., supported employment, drop-in/self-help centers, supported housing/housing resources in the community, and Florida Assertive Community treatment (FACT));
Supplemental security income (SSI) program application and renewal process;
Available community resources for children (e.g., child care options, community based care agencies, therapeutic foster care, specialized therapeutic foster care (STFC), statewide inpatient psychiatric program (SIPP), behavioral health overlay services (BHOS), therapeutic group care, schools, child's natural support systems, and children's medical services (CMS);
Principles of resiliency in children;
Evidence-based practices;
Development of Service Plans;
Time management; and
Advocacy and communication skills.

Provider Responsibilities	
General Requirements	In addition to the general provider requirements and responsibilities that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook, providers are also responsible for complying with the provisions contained in this section.
HIPAA Responsibilities	Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. The Coverage and Limitations Handbooks contain information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA. Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook. Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081. Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the fiscal agent EDI help desk at 800-829-0218.

Provider Responsibilities, continued

Provider Agency Responsibilities

The mental health targeted case management provider agency is responsible for the following:

- Certifying mental health case management supervisors.
- Certifying individual mental health targeted case managers.
- Informing the Medicaid fiscal agent when it wishes to add a mental health targeted case management supervisor to the provider agency's group.
- Informing the Medicaid fiscal agent when a mental health targeted case management supervisor is no longer employed by or no longer functions as a mental health targeted case management supervisor for their agency. This information must include the exact date that the mental health targeted case management supervisor ends employment or ceases to function as a mental health targeted case management supervisor.
- An agency cannot continue to bill Medicaid using the provider number of the targeted case manager supervisor who has left its employment.
- Not billing Medicaid for mental health targeted case management services rendered by individual targeted case managers who fail to complete the training requirement within three months.
- Requesting that the Medicaid fiscal agent disenroll a targeted case management supervisor who has not met the training requirements within three months.

Restrictions on Who May Provide Services

Medicaid will not reimburse mental health targeted case management services that are:

- Provided by anyone other than a certified mental health targeted case manager (e.g., aides, clerks) working under a Medicaid-enrolled targeted case management supervisor;
- Provided by staff who are not employed by or under contract to the Medicaid-enrolled targeted case management agency; or
- Provided by unpaid interns or other individuals not compensated monetarily by the provider.

CHAPTER 2
MENTAL HEALTH TARGETED CASE MANAGEMENT COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes recipient eligibility and certification requirements. It also describes the services, reimbursement restrictions, and documentation requirements covered under the mental health targeted case management program.

Topic Roster

This chapter contains:

General Recipient Eligibility and Certification Requirements

Introduction

To receive mental health targeted case management services, the recipient must be Medicaid eligible on the date of service and must be certified as meeting the eligibility criteria for a specific target group.

Exceptions to Recipient Eligibility Requirements

The following Medicaid recipients may receive mental health targeted case management for up to a maximum of 30 days without meeting the eligibility criteria for a specific target group:

- A recipient who has been referred by Medicaid's contracted utilization management services vendor after a denied admission to or discharge from an inpatient psychiatric unit;
- A recipient who has been admitted to an inpatient psychiatric unit; or
- A recipient who has been identified by Medicaid's contracted utilization management services vendor as high risk.

Note: See Medicaid 30-Day Certification in this chapter for additional information.

Eligibility for Children's Mental Health Targeted Case Management

Introduction

In order to receive children's mental health targeted case management services, a child must be certified as requiring the service by the mental health targeted case manager and that case manager's supervisor.

To initially certify any child, the provider must complete a Children's Certification, Children's Mental Health Targeted Case Management form within 30 days of the initial date of service. The certification form must be signed and dated by the mental health targeted case manager and that case manager's supervisor.

Note: See Appendix I in this handbook for a copy of the Children's Certification, Children's Mental Health Targeted Case Management form.

Eligibility for Children's Mental Health Targeted Case Management, continued

Ongoing Eligibility for Children's Mental Health Targeted Case Management

The provider is responsible for ensuring ongoing eligibility. Justification of eligibility must be documented in the recipient's case record. If circumstances change and the recipient no longer meets eligibility criteria, Medicaid will no longer reimburse for mental health targeted case management services.

Certification Criteria for Children's Mental Health Targeted Case Management

In order to be certified to receive children's mental health targeted case management services, documentation must be provided in the child's case record indicating that the child meets all of the following criteria:

1. Is enrolled in a Department of Children and Families (DCF) children's mental health target population (birth through 17 years);
2. Has a mental health disability (i.e., serious emotional disturbance) that requires advocacy for and coordination of services to maintain or improve level of functioning;
3. Requires services to assist in attaining self sufficiency and satisfaction in the living, learning, work, and social environments of choice;
4. Lacks a natural support system for accessing needed medical, social, educational, and other services;
5. Requires ongoing assistance to access or maintain needed care consistently within the service delivery system;
6. Has a mental health disability (i.e., serious emotional disturbance) that, based upon professional judgment, will last for a minimum of one year;
7. Is in out-of-home mental health placement or at documented risk of out-of-home mental health treatment placement; and
8. Is not receiving duplicate case management services from another provider.

If the recipient has relocated from a DCF district or region where he was receiving mental health targeted case management services, the recipient does not need to meet the above criteria. This must be documented in the recipient's case record.

Eligibility for Adult Mental Health Targeted Case Management

Introduction

In order to receive adult mental health targeted case management services, a recipient must be certified as requiring the service by the mental health targeted case manager and that case manager's supervisor.

To initially certify any recipient, the provider must complete an Adult Certification, Adult Mental Health Targeted Case Management form within 30 days of the initial date of service. The certification form must be signed and dated by the mental health targeted case manager and that case manager's supervisor.

Note: See Appendix J in this chapter for a copy of the Adult Certification, Adult Mental Health Targeted Case Management form.

Ongoing Eligibility for Adult Mental Health Targeted Case Management

The provider is responsible for ensuring ongoing eligibility. Justification of eligibility must be documented in the recipient's case record. If circumstances change and the recipient no longer meets eligibility criteria, Medicaid will no longer reimburse for mental health targeted case management services.

Certification Criteria for Adult Mental Health Targeted Case Management

In order to be certified to receive adult mental health targeted case management services, documentation must be provided in the recipient's case record indicating that the recipient:

1. Is enrolled in a DCF adult mental health target population (18 years and older);
2. Has a mental health disability (i.e., severe and persistent mental illness) that requires advocacy for and coordination of services to maintain or improve level of functioning;
3. Requires services to assist in attaining self sufficiency and satisfaction in the living, learning, work, and social environments of choice;
4. Lacks a natural support system for accessing needed medical, social, educational, and other services;
5. Requires ongoing assistance to access or maintain needed care consistently within the service delivery system;
6. Has a mental health disability (i.e., severe and persistent mental illness) that, based upon professional judgment, will last for a minimum of one year;
7. Is not receiving duplicate case management services from another provider; and

Eligibility for Adult Mental Health Targeted Case Management, continued

Certification Criteria for Adult Mental Health Targeted Case Management, continued

8. Meets at least one of the following requirements:
   a. Is awaiting admission to or has been discharged from a state mental health treatment facility;
   b. Has been discharged from a mental health residential treatment facility;
   c. Has had more than one admission to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities within the past 12 months;
   d. Is at risk of institutionalization for mental health reasons; or
   e. Is experiencing long-term or acute episodes of mental impairment that may put him at risk of requiring more intensive services.

If the recipient has relocated from a DCF district or region where he was receiving mental health targeted case management services, the recipient does not need to meet the above criteria. This must be documented in the recipient's case record.

Eligibility for Mental Health Intensive Case Management Team Services

Introduction

In order to receive intensive case management team services, a recipient must be certified as requiring the service by the mental health case manager and the case manager's supervisor.

To initially certify any recipient, the provider must complete an Adult Certification, Intensive Case Management Team Services, Adult Mental Health Targeted Case Management form for approval within 30 days of the initial date of service. The certification form must be signed and dated by the mental health targeted case manager and the case manager's supervisor.

Note: See Appendix K in this chapter for a copy of the Adult Certification, Intensive Case Management Team Services, Adult Mental Health Targeted Case Management form.

Ongoing Eligibility for Intensive Case Management Team Services

The provider is responsible for ensuring ongoing eligibility. Justification of eligibility must be documented in the recipient's case record. If circumstances change and the recipient no longer meets eligibility criteria, Medicaid will no longer reimburse for intensive mental health case management services.

Eligibility for Mental Health Intensive Case Management Team Services, continued

Certification Criteria for Recipients Receiving Intensive Case Management Team Services

In order to be certified to receive intensive case management team services, documentation must be provided in the recipient's case record, indicating that the recipient:

1. Is enrolled in a DCF adult mental health target population (18 years and older); and
2. Meets at least one of the following requirements:
   a. Has resided in a state mental health treatment facility for at least six months in the past 36 months;
   b. Resides in the community and has had two or more admissions to a state mental health treatment facility in the past 36 months;
   c. Resides in the community and has had three or more admissions to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities within the past 12 months; or
   d. Resides in the community and, due to a mental illness, exhibits behavior or symptoms that could result in long-term hospitalization if frequent interventions for an extended period of time were not provided.

If the recipient has relocated from a DCF district or region where he was receiving mental health targeted case management services, the recipient does not need to meet the above criteria. This must be documented in the recipient's case record.

Eligibility for Medicaid 30-Day Certification

Introduction

The following Medicaid recipients may receive mental health targeted case management for up to a maximum of 30 days without meeting the eligibility criteria for a specific target group:

- A recipient who has been referred by Medicaid's contracted utilization management services vendor after a denied admission to or discharge from an inpatient psychiatric unit;
- A recipient who has been admitted to an inpatient psychiatric unit; or
- Has been identified by Medicaid's contracted utilization management services vendor as high risk.

Note: See Appendix L in this chapter for a copy of the Medicaid 30-Day Certification for Children or Adult Mental Health Targeted Case Management form.

Medicaid 30-Day Certification, continued

Certification Criteria for Recipients	The area Medicaid office must certify that the Medicaid recipient meets one of the three criteria listed on the preceding page.
Services Beyond 30 Days	If it is determined that the recipient requires mental health targeted case management beyond 30 days, the recipient must be certified for a specific target group and must receive services in accordance with policy. Medicaid will not reimburse for mental health targeted case management services beyond the 30-day period unless the recipient is certified for one of the three target groups. Note: See the Eligibility for Children's Mental Health, Adult Mental Health, or Intensive Case Management Team Targeted Case Management Services in this chapter for the certification criteria for each specific target group.

General Service Requirements

Adult and Children's Mental Health Targeted Case Management	Adult and children's mental health targeted case management services assist recipients in gaining access to needed financial and insurance benefits, employment, medical, social, education, assessment of functional abilities and needs, and other services. These supportive services include working with the recipient and the recipient's natural support system to develop and implement the recipient's service plan. They also include follow-up to determine the status of the recipient's services, and the effectiveness of activities related to the successful implementation of the service plan toward enhancing the recipient's inclusion in the community.
Who Must Provide	Medicaid mental health targeted case management services must be provided by case managers who are employed by an enrolled mental health targeted case management agency and certified to provide services to a specific target group. The case manager must be certified and supervised by a certified, Medicaid-enrolled case management supervisor.
Single Case Manager per Recipient	A recipient in the children's mental health or adult mental health target group may have only one targeted case manager at a time, except in the situations described below.

General Service Requirements, continued

Exceptions to a Single Targeted Case Manager per Recipient	A recipient may have more than one case manager when one of the following circumstances apply: • The recipient is referred by Medicaid's contracted utilization management service vendor for Medicaid 30-day certification and the area Medicaid office assigns a different case manager for the purpose of consultation, peer review, and provision of service planning. • The recipient's regular case manager is unavailable. The reason for the substitution must be documented in the record. • The recipient has been certified for and is receiving adult intensive case management team services. • The recipient is a transitional youth age 18-22.

Restrictions

Introduction	The restrictions listed in this section apply to all mental health targeted case management services.
Services Provided by More Than One Case Manager	Medicaid will not reimburse mental health targeted case management services provided by more than one case manager to the same recipient on the same date of service except in those cases described under "exceptions to a single targeted case manager per recipient."
Direct Service Provision	Medicaid will not reimburse mental health targeted case management services for the provision of direct therapeutic medical or clinical services (e.g., checking blood pressure, measuring height and weight, or providing psychotherapy).
Administrative Functions	Medicaid will not reimburse mental health targeted case management services for administrative functions (e.g., checking recipient eligibility or clerical duties).

Restrictions, continued

Ineligible Recipients	Medicaid will not reimburse mental health targeted case management services for recipients who are not Medicaid eligible on the date of service, who have not been certified as meeting the eligibility criteria, or who no longer meet the eligibility criteria for mental health targeted case management.
Recipients Receiving FACT Services	Medicaid recipients enrolled in the Florida Assertive Community Treatment (FACT) program funded through Medicaid administrative matching may not receive any fee-for-service Medicaid mental health targeted case management services. This would constitute a duplication of payment.
Home and Community-Based Waiver Recipients	Except for the Model Waiver, Medicaid will not reimburse mental health targeted case management services for recipients who are enrolled in a home and community-based services waiver program. Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for information on home and community-based services waiver programs.
Institutionalized Recipients	Medicaid will not reimburse mental health targeted case management services for recipients who are in nursing facilities, state mental health treatment facilities, county jails, prisons, detention centers, other secure residential correction facilities, or intermediate care facilities for the developmentally disabled.
Institutions for Mental Diseases	Medicaid does not reimburse for mental health targeted case management services rendered to a resident of an institution for mental diseases (IMD), unless the resident is participating in the Statewide Inpatient Psychiatric Program Waiver. Per Title 42, Code of Federal Regulations, Part 441.13, an institution for mental disease is defined as a hospital or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care to persons with behavioral diseases. Note: The Code of Federal Regulations is available on the Internet at www.gpoaccess.gov/cfr/index.html.
Discharge Planning	Medicaid will not reimburse mental health targeted case management for discharge planning services when discharge planning is covered by a residential facility's per diem. Medicaid will reimburse for discharge planning for a recipient coming out of a state mental health treatment facility 60 days prior to discharge.

Restrictions, continued

Statewide Inpatient Psychiatric Program (SIPP) Recipients	Medicaid will reimburse targeted case management services for children in a Statewide Inpatient Psychiatric Program (SIPP) for the last 180 days prior to a planned discharge date that is documented in the medical record. For continuity, targeted case management services must be provided by a targeted case management provider agency located in the same district as the child's aftercare placement. If a case manager is assigned prior to or at the time of placement, the case manager must: • Provide relevant information to the SIPP staff relating to the child's strengths as well as problems and symptoms that have resulted in the need for placement. • Inform the SIPP of previous mental health interventions and services, the child's response to these services, and of significant individuals involved with the child. Targeted case management services provided to a SIPP recipient must include the following: • Meeting the child, parent or guardian, and contacting other people (guardian ad litem, child welfare, community-based care, and other agencies) to explain the role of targeted case manager for a child in a SIPP placement. • Attending at least one treatment team meeting monthly and determine if treatment plan goals address the problems and symptoms that resulted in the need for the child's restricted placement and the child's strengths and assets. For children who are placed out of district, attendance may occur by phone if justified in the record. • Having face-to-face contact with the child and the child's therapist monthly, and contact with the family or guardian to support the family's involvement in treatment and to further the treatment and discharge planning goals. If the case manager is unable to visit the child, the case manager must call the child at least once every 14 days. • Assisting the parent or guardian in coordinating aftercare services in the home, school, and community environments to assess and assist the youth's transition and adjustment to discharge placement. • Recommending and implementing any changes or revisions to the aftercare services array, as needed. • After discharge, collecting outcome data to include a two-month follow-up and reporting the information to the SIPP. Services are limited to eight hours monthly. This limit may be increased to 12 hours monthly during the last month of a child's SIPP placement to facilitate implementation of the aftercare plan.

Restrictions, continued

Supervision	Medicaid will not reimburse for internal supervision between the mental health targeted case management supervisor and the mental health targeted case manager.
Behavioral Health Overlay Services Recipients	Medicaid will not reimburse mental health targeted case management services for children who are receiving behavioral health overlay services under the Medicaid Community Behavioral Health Services Program, except for case management activities clearly done in preparation for the child's discharge from behavioral health overlay services (last 90 days).
Incomplete Assessment or Service Plan	Medicaid will not reimburse mental health targeted case management services provided to a recipient who does not have a written assessment and current service plan developed in accordance with the requirements in this chapter. Note: See Assessment and Service Plan in this chapter for the requirements.
No Recipient Contact	Medicaid will not reimburse for mental health targeted case management services for unsuccessful attempts to contact the recipient, e.g., a home visit when the recipient is not at home, a phone call when the recipient does not answer, or leaving a message on voice mail, e-mail, or an answering machine.
Duplication of Services	Medicaid will not reimburse mental health targeted case management services: • If the Medicaid reimbursement for mental health targeted case management would duplicate payments for the same services through another funding source. • If the services overlap with or are duplicative of mental health targeted case management services provided to the recipient by the same agency or by any other agency. All Medicaid case managers associated with a recipient must coordinate with each other to ensure non-duplication of services. • For a targeted case manager simply being present during a face-to-face therapeutic activity.

Restrictions, continued

Transportation	Medicaid will not reimburse mental health targeted case management provider agencies for transporting recipients. The Medicaid transportation program provides transportation for Medicaid recipients to medically-necessary, Medicaid-compensable services. Medicaid contracts with a vendor, who arranges for non-emergency transportation services for Medicaid recipients.
Travel	Reimbursement for travel time is incorporated into the unit rate and may not be billed separately.

Assessment

Assessment	Each mental health targeted case management recipient must receive a thorough assessment, which will serve as the basis for the development of the recipient's service plan. The assessment is a holistic review of the recipient's emotional, social, behavioral, and developmental functioning within the home, school, work, and community. The assessment must be updated annually.
Who Must Provide	The recipient's mental health targeted case manager is required to conduct the assessment.
Time Frame for Development of the Assessment	The case management assessment must be completed within the first 30 days that the recipient receives mental health targeted case management services, and prior to the development of the service plan.
Home Visit Requirement	The mental health targeted case manager must make at least one home visit prior to completion of the assessment to evaluate the safety and well being of the recipient. The home visit should be conducted in the setting in which the recipient resides. If the mental health targeted case manager is unable to make a home visit, he must conduct a face-to-face interview in another setting. Written justification must be provided in the recipient's case record explaining why the home visit could not be made. The mental health targeted case manager and his supervisor must sign the written justification.

Assessment, continued

Information Sources for the Assessment

The assessment must include information from the following sources:

- The recipient;
- The agency or individual who referred the recipient for mental health targeted case management services;
- The recipient's family and friends (with appropriate consent);
- Other agencies that are providing services to the recipient;
- The school district (for recipients under the age of 18 or who are still attending school); and
- Previous treating providers, including inpatient and outpatient treatment. (If collateral information cannot be obtained, the mental health targeted case manager must provide written justification in the recipient's case record.)

Assessment Components

The assessment must include all of the following components:

- Presenting problem(s) and history, including the recipient's, legal representative's and family's assessment of his situation (with appropriate consent);
- Psychiatric and medical history including medications and side effects;
- Recipient's current and potential strengths;
- Resources that are available to the recipient through his natural support system;
- Recipient's school placement, adjustment and progress (if applicable);
- Recipient's relationship with his family and significant others;
- Identification and effectiveness of services currently being provided; and
- Assessment of the recipient's needs and functioning abilities in the following areas:
  - Mental health maintenance and abstinence from substance abuse or use;
  - Family support and family education;
  - Education, vocational, or job training;
  - Housing, food, clothing, and transportation;
  - Medical and dental services;
  - Legal assistance;
  - Development of environmental supports through support groups, peer groups, activities, community services, friends, landlords, employers; and
  - Assistance with establishing financial resources.

Assessment, continued

Assessment Documentation Requirements

The following assessment documentation requirements must be met:

- The assessment must be an identifiable document in the recipient's case record. Supporting documentation (e.g., copies of findings, evaluations and discharge summaries) gathered to complete the assessment must be filed in the recipient's case record.
- The assessment must include documentation that the mental health targeted case manager made a home visit prior to the completion of the assessment or written documentation by the case manager with sign-off by the case manager's supervisor, explaining why this requirement could not be met.
- The assessment must be reviewed, signed, and dated by the case manager's supervisor prior to the completion of the service plan, which is described below.

Service Plan

Service Plan	Each recipient must have an individualized service plan written within 30 days of initiation of services by his mental health targeted case manager or case management team. The service plan must include measurable short and long-term goals for the recipient and must outline the comprehensive strategy for assisting the recipient in achieving these goals.
Service Plan Requirements	The service plan must: • Be an identifiable document; • Be developed in partnership with the recipient and the recipient's parent, guardian, or legal custodian (if applicable); • Describe the recipient's service needs and the activities that the mental health targeted case manager will undertake in partnership with the recipient; • Contain measurable goals and objectives derived from the recipient's assessment; • Have identified time frames for achievement of goals; • Include the name of the individual or agency responsible for providing the specific assistance or services; • Be consistent with the recipient's treatment plan(s); • Be signed and dated by the recipient, the recipient's parent, guardian or legal custodian (if the recipient is under 18 years of age), the recipient's mental health targeted case manager (must include title), and the mental health targeted case manager's supervisor (must include title); and • Be retained in the recipient's case record.
Exception to the Requirement for the Recipient's Signature	If the recipient's age precludes the recipient's participation in the development and signing of the service plan, the recipient's parent, guardian or legal custodian must sign the service plan, unless an exception listed on the next page is met.
Copies of the Service Plan	Copies of the service plan must be provided to the recipient or the recipient's guardian if the recipient is under age 18, and with the recipient's consent, to other service providers involved in the development or implementation of the service plan. This information must be documented in the recipient's case record.

Service Plan, continued

Exceptions to the Requirement for Signature of Parent, Guardian, or Legal Custodian

There are exceptions to the requirement for a signature by the recipient's parent, guardian, or legal custodian if the recipient is under age 18. Written documentation and justification of the exception must be provided in the recipient's case record. The following are the exceptions:

- Recipients in the custody of the Department of Juvenile Justice that have been court ordered into treatment or require emergency treatment such that delay in providing treatment would endanger the mental or physical well being of the recipient. The signature of the parent, guardian, or legal custodian must be obtained as soon as possible after emergency treatment is administered.
- For recipients in the care and custody of the DCF (foster care or shelter status), the child's caseworker must sign the service plan if it is not possible to obtain the parent's signature. The caseworker and foster parent must participate in the service planning. In cases in which the DCF is working toward reunification, the parent or designated or identified future caregiver must be involved and should sign the service plan.

Service Plan Review

The service plan review is a process conducted to ensure that services, goals, and objectives continue to be appropriate to the recipient's needs and to assess the recipient's progress and continued need for mental health targeted case management services. The recipient's eligibility for continued mental health targeted case management services must be re-evaluated during the service plan review. The activities, discussion, and review process must be clearly documented. The recipient, the mental health targeted case manager, and the mental health targeted case manager's supervisor must sign and date the service plan review.

Frequency of the Service Plan Review

The service plan must be reviewed and revised as significant changes occur in the recipient's condition, situation, or circumstances, but no less frequently than every six months. Documentation of the service plan review must be recorded in the recipient's case record.

Covered Services

Covered Services for All Target Groups

The following services are covered for all mental health target groups:

- Conducting the assessment in accordance with the criteria outlined in this chapter.
- Developing the recipient's service plan in accordance with the criteria outlined in this chapter.
- Working with the recipient and the recipient's family to address issues related to implementation of the service plan. Services where the family is involved must clearly be directed to meeting the identified needs of the recipient.
- Assessing the effectiveness of the service plan in meeting the identified needs of the recipient.
- Linking and facilitating the recipient with appropriate services and resources identified in the service plan through referrals to reach desired goals.
- Advocating for the acquisition of services and resources necessary to implement the service plan by representing or defending recipients through direct intervention.
- Coordinating the delivery of services as specified in the service plan with the help of the recipient, the recipient's family, and the recipient's natural support system.
- Monitoring service delivery to evaluate the recipient's progress.
- Documenting mental health targeted case management activities in accordance with the documentation requirements in this chapter.
- Crisis Intervention/Support by assisting recipients in crisis in getting access to the necessary resources in order to cope with the situation.
- Case management services may be billed in conjunction with any Medicaid reimbursable service for the purpose of providing and communicating critical information that would assist the recipient (not to exceed two units per event).
- Arranging for and coordinating after care services upon discharge from a residential or inpatient facility when discharge planning is not covered by the facility's per diem.
- Participating in the recipient's individualized treatment plan development or individualized services plan review under the Medicaid community behavioral health services program (Time billed must be clearly justified as time dedicated to the recipient).
- Providing mental health targeted case management services in preparation for a child's discharge (last 90 days) from Behavioral Health Overlay Services (BHOS).
- Conducting a clinical care Medicaid recipient staffing, in which the case manager is meeting with either the recipient's treatment team or one-on-one with one of the following individuals: psychiatrist, psychiatric ARNP, physician, therapist, teacher, attorney, guardian ad litem, or any other professional who is directly serving the recipient.

Covered Services, continued

Case Load Limitations	Maximum average caseloads are as follows: • Children's mental health targeted case management – 20 recipients per each targeted case manager. • Adult mental health targeted case management – 40 recipients per each targeted case manager. If a mental health targeted case manager has a combined caseload, a child counts as two. The mental health targeted case manager must be certified to serve both target groups.

Intensive Case Management Team Services

Introduction	Intensive case management team services provide team case management to adults with serious and persistent mental illness to assist the recipient to remain in the community and avoid institutional care. Intensive team case managers coordinate needs assessment, services planning, and provide service oversight.
Service Exclusions	Medicaid does not reimburse team case managers for providing: • Services that are medical or clinical in nature or services that provide direct care (i.e., psychotherapy and skills training services); or • Services that are duplicative of those provided by other mental health targeted case managers.
Case Load Limitations	The maximum average caseload size for a team is 15 recipients per each team case manager.
Documentation for Intensive Case Management Team Services	Documentation for intensive case management team services must reflect that services are coordinated with, but separate and distinct from, the other team case managers' services.

Medicaid 30-Day Certification

Covered Services	Medicaid reimburses the same mental health targeted case management services for recipients in the 30-day period as for recipients in the children's mental health and adult mental health target groups. Note: See this chapter for covered services.
Reimbursement	Services rendered during the 30-day certification period are reimbursed using the policies and procedure codes for either children's or adult mental health targeted case management services, depending upon the age of the recipient.
Documentation During the 30-Day Certification Period	The recipient's case record must include complete case notes of all contacts and written justification for continuing or discontinuing services after 30 days or if a child turns 18 during the 30-day period.

Documentation Requirements

Introduction

In addition to the general Medicaid record keeping requirements and the specific documentation requirements listed for each target group, the documentation requirements described in this section apply to all mental health targeted case management services.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for general Medicaid record keeping requirements.

Recipient Case Record

The recipient's case record must contain the recipient's certification form, assessment, service plan, service plan review(s), documentation of the home visit, and the service documentation described below.

Documentation Requirements for Case Notes

The case manager's case notes must include the following information for each mental health targeted case management activity:

- Case manager's name, signature, title, and date. Photocopied signatures, stamped signatures, or signatures of anyone other than the person rendering the service are not acceptable;
- Recipient's name;
- Service provided;
- Date of the service;
- Services beginning and ending time on the clock (e.g., 2:00 p.m. to 3:25 p.m.);
- Location of the service;
- Updates when the recipient changes residence, enters or is discharged from an inpatient hospital or state mental hospital, experiences a significant change in mental status, experiences a significant change that impacts his life and support system, changes custody, changes educational placement, or changes employment; and
- Detailed case notes that:
    1. Clearly reflect how the case manager's efforts are linked to the services and goals in the recipient's service plan;
    2. Describe the recipient's progress or lack of progress relative to the service plan; and
    3. If a substitute case manager provided the service, explain the circumstances requiring the provision of services by a substitute case manager.

If more than one contact to a recipient is made in a day, all contacts should be summarized in one case note.

Documentation Requirements, continued

Documentation Reviews	The provider must submit files for retrospective reviews upon request to the area Medicaid office, AHCA, or staff designated by Medicaid.

CHAPTER 3
MENTAL HEALTH TARGETED CASE MANAGEMENT PROCEDURE CODES AND FEE SCHEDULE

Overview

Introduction

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

In This Chapter

This chapter contains:

Reimbursement Information

Procedural Code Origination

The procedure codes listed in this handbook are Level II Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the standard code set described in HCPCS Level II Expert code book. Please refer to the HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert code book is copyright 2005 by Ingenix, Inc. All rights reserved.

Effective October 1, 2003, in compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation.

All previously used “local codes” can no longer be processed by the Florida Medicaid claims processing system for Medicaid payment for dates of service after October 1, 2003.

Reimbursement Information, continued

Units of Service

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

If multiple units are provided on the same day, the actual time spent must be totaled and rounded to the nearest unit. If the minutes total ends in a 7 or less, round down to the nearest 15-minute increment. If the minutes total ends in 8 or more, round up to the nearest 15-minute increment. For example, 37 minutes is billed as two units of service; 38 minutes is billed as three units of services.

One Claim Submission per Date of Service

To receive reimbursement, the mental health targeted case management agency must total the amount of time that a mental health targeted case manager (children's or adult) provided mental health targeted case management services and submit one claim for the appropriate number of units of service per day.

Entering Providers Numbers on the Claim Form

The targeted case management agency must enter its group provider number as the pay-to provider and the case management supervisor's provider number in the field titled treating provider on the claim form. Under no circumstances may the mental health targeted case management supervisor's Medicaid number be entered as the pay-to provider number.

Note: See Chapter 1 in the Medicaid Provider Reimbursement Handbook, Non-Institutional 081, for additional information on entering provider numbers on the claim form.

Reimbursement Limitations

Medicaid will reimburse:

- Up to 344 units of children's mental health or adult mental health targeted case management per month, per recipient.
- Up to 48 units of intensive case management team services per recipient, per day, per case management team.

Exceptions to Service Limits

Requests to exceed service limits for recipients under age 21 must be made through Medicaid's prior authorization process.

Procedure Code Table

Each procedure code on the Procedure Codes and Fee Schedule, Appendix A, corresponds to a specific target group. The maximum fee shows the maximum amount that Medicaid will reimburse for the procedure code, per unit of service, and the maximum units shows the maximum number of units that Medicaid reimburses per recipient, per date of service.

Procedure Code Modifiers

Definition of Modifier

For certain types of services, a two-digit modifier must be entered on the Non-Institutional 081, claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.

The modifiers are entered in the field next to the procedure code field in item 33, under Modifier.

Targeted case management providers must use the modifiers with the procedure codes listed on Appendix A, Procedure Codes and Fee Schedule, when billing for the specific services in the procedure code descriptions. The modifiers listed in Appendix A can only be used with the procedure codes listed. Use of modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, for additional information on entering modifiers on the claim form.

APPENDIX A
PROCEDURE CODES AND FEE SCHEDULE

Procedure Code	Modifier	Description of Service	Maximum Fee	Maximum Units
Children's Mental Health Target Group				
T1017	HA	Targeted Case Management for Children (birth through age 17)	$12.00 per unit	344 per month
Adult Mental Health Target Group				
T1017		Targeted Case Management for Adults (18 years or older)	$12.00 per unit	344 per month
T1017	HK	Intensive Team Targeted Case Management for Adults (18 years or older)	$12.00 per unit	48 per day

APPENDIX B
AGENCY CERTIFICATION
CHILDREN'S MENTAL HEALTH TARGETED CASE MANAGEMENT

Agency Name _____

Agency Address _____

_____

Phone Number (___)_____Medicaid Provider # _____

Is hereby certified to provide targeted case management services and meets the following criteria:

Administrative:
1. Is knowledgeable of and agrees to comply with the statutes, rules and policies that affect the target population.
2. Has the ability to administer case management services to the target population.
3. Has established linkages within the local network of mental health treatment providers and other resources in the service area.
4. Has a quality improvement program with written policies and procedures.
5. Will ensure that case managers are certified within three months from their date of hire
6. Will provide mental health targeted case managers with supervision (as described in the Mental Health Targeted Case Management Coverage and Limitations Handbook).
7. Will cooperate with and participate in monitoring conducted by the Agency for Health Care Administration and the Department of Children and Families, Mental Health Program Office and the district or regional Substance Abuse and Mental Health program office.
8. Has the capacity to manage utilization of mental health targeted case management services and to conduct utilization review of these services on a regular basis.
9. Has the financial management capacity and system to provide documentation of costs.
10. Has the ability to maintain and produce documentation that verifies that mental health targeted case managers have participated in case management training as required and approved by AHCA.

Programmatic:
1. Ensures that all mental health targeted case management services are provided by certified case managers.
2. Provides mental health targeted case management for recipients who ask or are referred for service and who meet eligibility requirements.
3. Maintains average caseloads of 20 or fewer recipients per mental health targeted case manager.
4. Maintains programmatic records that include clearly identified mental health targeted case management certifications for eligibility, assessments, service plans and service documentation.

_____ _____
Provider Administrator Date

_____ _____
Area Medicaid Office Designated Representative Date

All fee-for-service providers must have a fully executed certification form on file and all managed care organizations must ensure all certification criteria are met.

AHCA-Med Serv Form 022, June 2007 (incorporated by reference in 59G-4.199)