sunshine health™

# T1017: Targeted Case Management (TCM)

# Topics to Be Covered:

- TCM 101
  - What is TCM?
  - Eligible providers
  - Caseload limitations
- Recipient eligibility and certification
  - Appendix I & J
  - Exceptions (appendix L)
- Assessments

Rule 59G-4.199: Mental Health Targeted Case Management (Effective 1/2/2008)

- Service plans
- Covered services
- Statewide inpatient psychiatric program (SIPP)
- Restrictions / non-covered services
- Documentation requirements
- Reimbursement information
- Example authorization

# TCM 101

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| **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. |

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| **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. |

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| **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:<br>• 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.<br>• The recipient's regular case manager is unavailable. The reason for the substitution must be documented in the record.<br>• The recipient has been certified for and is receiving adult intensive case management team services.<br>• The recipient is a transitional youth age 18-22. |

- Targeted case management must be provided by a certified behavioral health case manager (CBHCM) credentialed through the Florida Certification Board (FCB) or other credentialing authority
- Case managers must be supervised by a certified behavioral health case manager supervisor (CBHCMS) credentialed through the Florida Certification Board (FCB) or other credentialing authority

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| **Case Load Limitations** | Maximum average caseloads are as follows:<br>• Children's mental health targeted case management – 20 recipients per each targeted case manager.<br>• Adult mental health targeted case management – 40 recipients per each targeted case manager.<br>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. |

# Recipient Eligibility and Certification

Certification (appendix I or J, as appropriate) must be signed and dated by **BOTH** the CBHCM and CBHCMS within 30 days of the initial date of service

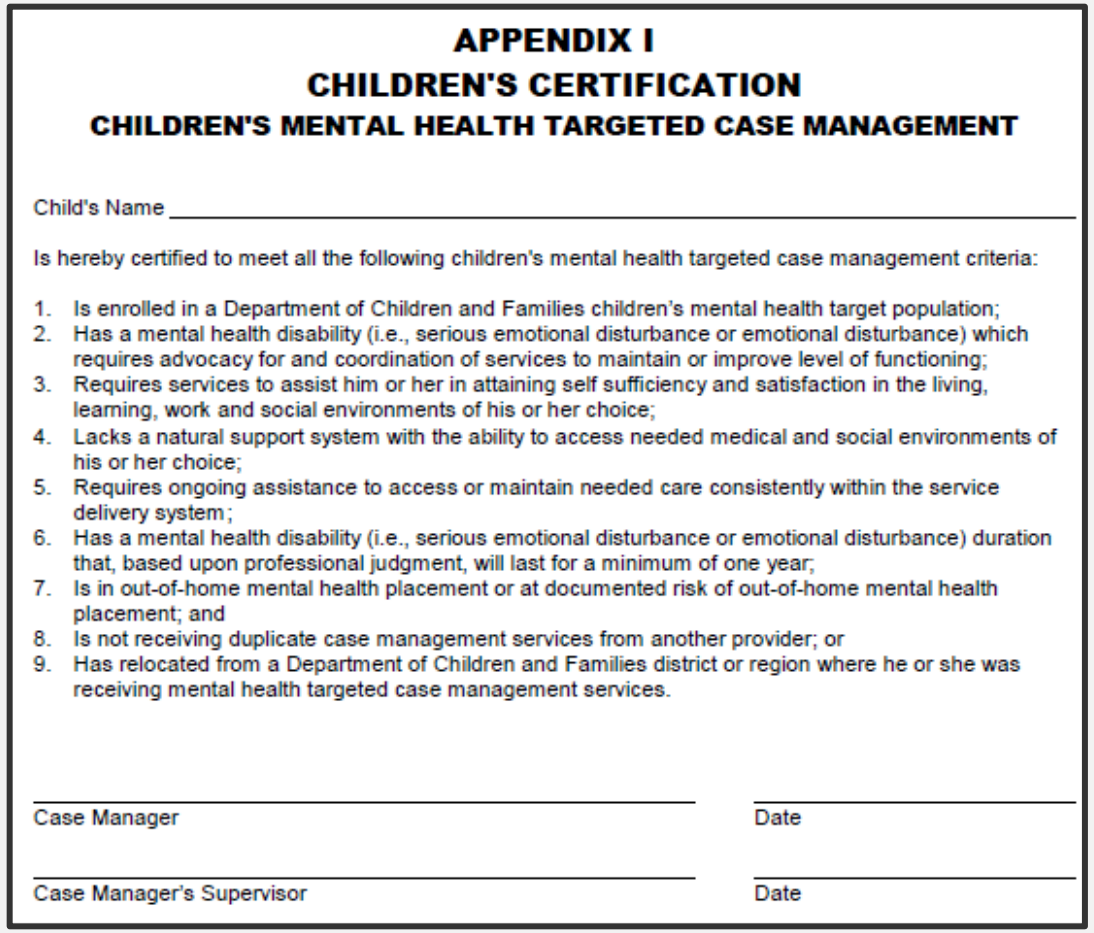
Must be updated at least every 6 months

Justification of eligibility must be documented in the case record

The provider is responsible for ensuring ongoing eligibility

If circumstances change and the recipient no longer meets eligibility criteria, Medicaid will no longer reimburse for TCM

# Appendix I – Child TCM



**APPENDIX I**
**CHILDREN'S CERTIFICATION**
**CHILDREN'S MENTAL HEALTH TARGETED CASE MANAGEMENT**

Child's Name _____

Is hereby certified to meet all the following children's mental health targeted case management criteria:

1. Is enrolled in a Department of Children and Families children's mental health target population;
2. Has a mental health disability (i.e., serious emotional disturbance or emotional disturbance) which requires advocacy for and coordination of services to maintain or improve level of functioning;
3. Requires services to assist him or her in attaining self sufficiency and satisfaction in the living, learning, work and social environments of his or her choice;
4. Lacks a natural support system with the ability to access needed medical and social environments of his or her choice;
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 or emotional disturbance) duration 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 placement; and
8. Is not receiving duplicate case management services from another provider; or
9. Has relocated from a Department of Children and Families district or region where he or she was receiving mental health targeted case management services.

_____ _____
Case Manager Date

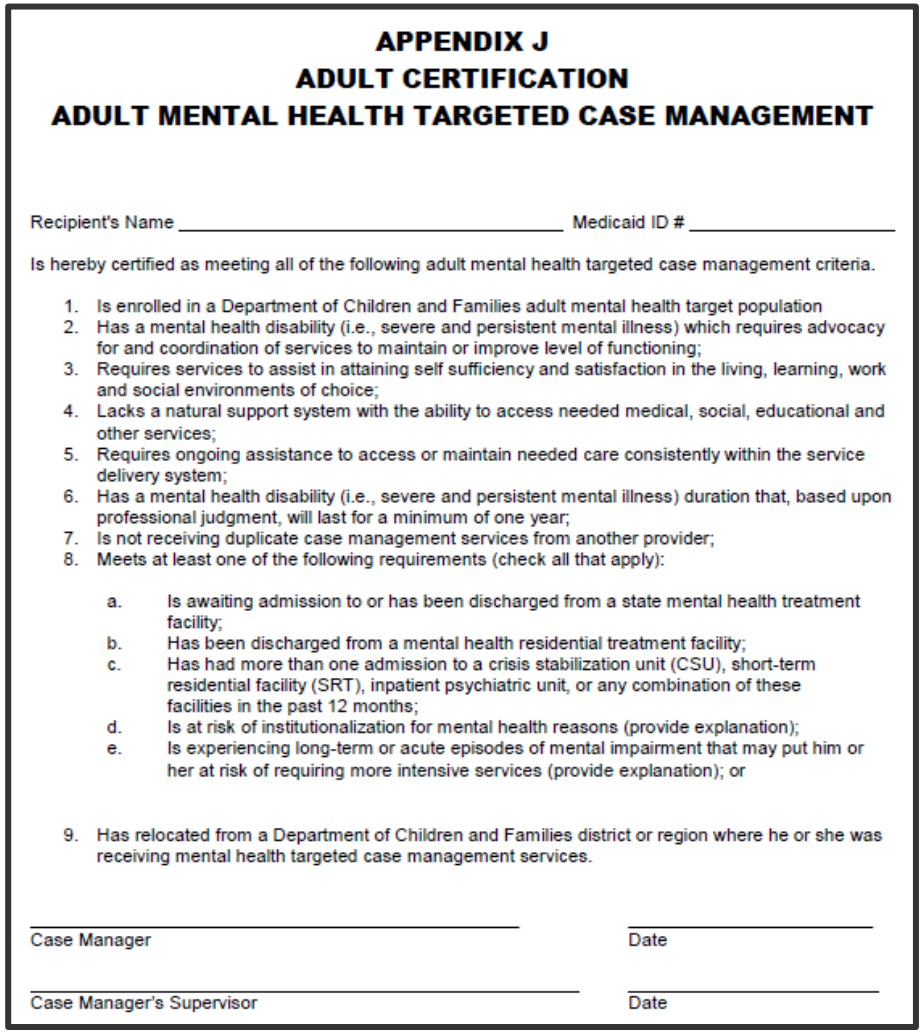
_____ _____
Case Manager's Supervisor Date

- Out-of-home MH placement
  - CSU
  - BH RTC
  - SIPP
- Duplicate CM services
  - Any CM program (not just TCM)
- Relocation
  - Only applicable for initial certification

# Appendix I – Child TCM

- Child = birth to 17
- At time of admission to TCM, they must have a qualifying mental health diagnosis
  - › *Note: Adjustment disorder, ASD, SUD, and personality disorders are ineligible as primary diagnosis*
- They must ALSO require advocacy and coordination of care as it relates to the qualifying diagnosis
- If they are already linked to appropriate services, they do NOT meet criteria
  - › Unless substantial barriers prevent them from attending or benefitting from treatment
  - › Ex: require advocacy due to frequent no shows and/or UTR
- If they have adequate support to access services, they do NOT meet criteria

# Appendix J – Adult TCM



**APPENDIX J**
**ADULT CERTIFICATION**
**ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT**

Recipient's Name _____ Medicaid ID # _____

Is hereby certified as meeting all of the following adult mental health targeted case management criteria.

1. Is enrolled in a Department of Children and Families adult mental health target population
2. Has a mental health disability (i.e., severe and persistent mental illness) which 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 with the ability to access 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) duration that, based upon professional judgment, will last for a minimum of one year;
7. Is not receiving duplicate case management services from another provider;
8. Meets at least one of the following requirements (check all that apply):

    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 in the past 12 months;
    d. Is at risk of institutionalization for mental health reasons (provide explanation);
    e. Is experiencing long-term or acute episodes of mental impairment that may put him or her at risk of requiring more intensive services (provide explanation); or

9. Has relocated from a Department of Children and Families district or region where he or she was receiving mental health targeted case management services.

_____ _____
Case Manager Date

_____ _____
Case Manager's Supervisor Date

- Adult = 18+
- Most criteria are the same as appendix I (child TCM)
- State mental health treatment facility
    - Florida State Hospital (FSH)
    - Northeast Florida State Hospital (NEFSH)
    - North Florida Evaluation and Treatment Center (NFETC)
- Discharge from a state or residential MH treatment facility must have occurred within 6 months immediately prior to certification

# Eligibility Exceptions

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| **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:<br>• 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;<br>• A recipient who has been admitted to an inpatient psychiatric unit; or<br>• A recipient who has been identified by Medicaid's contracted utilization management services vendor as high risk. |

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| **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. |

- Must complete appendix L.

**APPENDIX L**
**MEDICAID 30-DAY CERTIFICATION**
**FOR CHILDREN'S OR ADULT**
**MENTAL HEALTH TARGETED CASE MANAGEMENT**

Recipient's Name: _____

DOB: _____ Medicaid ID #: _____

Is hereby certified as meeting the following criteria:

____ The recipient has been referred by Medicaid's utilization management service after a denied admission to or discharge from an inpatient psychiatric unit; or

____ The recipient has been admitted to an inpatient psychiatric unit and has been identified by AHCA's utilization management service as high risk.

This certification is effective for 30 days. To receive Medicaid reimbursement for services beyond 30 days, the recipient must be determined eligible for children's or adult mental health targeted case management and must receive services in accordance with policy.

_____ _____
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.

# Assessments

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| **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. |

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| **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.<br><br>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. |

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| **Assessment Documentation Requirements** | The following assessment documentation requirements must be met:<br><br>• 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.<br>• 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.<br>• 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. |

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| **Information Sources for the Assessment** | The assessment must include information from the following sources:<br><br>• The recipient;<br>• The agency or individual who referred the recipient for mental health targeted case management services;<br>• The recipient's family and friends (with appropriate consent);<br>• Other agencies that are providing services to the recipient;<br>• The school district (for recipients under the age of 18 or who are still attending school); and<br>• 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:<br><br>• Presenting problem(s) and history, including the recipient's, legal representative's and family's assessment of his situation (with appropriate consent);<br>• Psychiatric and medical history including medications and side effects;<br>• Recipient's current and potential strengths;<br>• Resources that are available to the recipient through his natural support system;<br>• Recipient's school placement, adjustment and progress (if applicable);<br>• Recipient's relationship with his family and significant others;<br>• Identification and effectiveness of services currently being provided; and<br>• Assessment of the recipient's needs and functioning abilities in the following areas:<br>  ➢ Mental health maintenance and abstinence from substance abuse or use;<br>  ➢ Family support and family education;<br>  ➢ Education, vocational, or job training;<br>  ➢ Housing, food, clothing, and transportation;<br>  ➢ Medical and dental services;<br>  ➢ Legal assistance;<br>  ➢ Development of environmental supports through support groups, peer groups, activities, community services, friends, landlords, employers; and<br>  ➢ Assistance with establishing financial resources. |

# Service Plans

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| **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.<br><br>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:<br>• Be an identifiable document;<br>• Be developed in partnership with the recipient and the recipient's parent, guardian, or legal custodian (if applicable);<br>• Describe the recipient's service needs and the activities that the mental health targeted case manager will undertake in partnership with the recipient;<br>• Contain measurable goals and objectives derived from the recipient's assessment;<br>• Have identified time frames for achievement of goals;<br>• Include the name of the individual or agency responsible for providing the specific assistance or services;<br>• Be consistent with the recipient's treatment plan(s);<br>• 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<br>• Be retained in the recipient's case record. |

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| **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. |

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| **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:<br>• 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.<br>• 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. |

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| **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. |

# Covered Services

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.

- Services involving the family must clearly be directed to meeting the recipient's needs
- Monitoring service delivery via record/chart reviews requires an evaluation of progress toward service plan goals/objectives
- Overlapping services must clearly document why TCM's presence was necessary
  - Not to exceed 30 minutes (2 units) per overlapping service

# Statewide Inpatient Psychiatric Program

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.

Key points:

- Document planned discharge date from SIPP
  - Must be less than 180 days
- Services are limited to 8 hours (32 units) per month
- Attend monthly treatment team meetings
- Maintain regular contact with the child, their therapist, and the parent/guardian
- Provide 2-month follow up data to the SIPP post-discharge

# Restricted / Non-Covered Services

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| **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). |

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| **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. |

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| **Transportation** | Medicaid will not reimburse mental health targeted case management provider agencies for transporting recipients.<br><br>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. |

- Sunshine Health provides round trip transportation
  - No visit limits for medical appts, healthcare facilities, or pharmacies
- Members 18+ can schedule 3 non-medical trips per month
  - Shopping, social events, etc.

**More information:**
SunshineHealth.com/transportation

# Restricted / Non-Covered Services

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| **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). |

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| **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. |

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| **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. |

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| **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.<br><br>Medicaid will reimburse for discharge planning for a recipient coming out of a state mental health treatment facility 60 days prior to discharge. |

- Administrative functions vs. documenting TCM activities
- Restricted / non-covered
  - Completing consent forms
  - Drafting a letter to provide to the client or their family
- Covered services
  - Documented service must meet all documentation requirements
    - › Ex: Documenting home visit after returning to the office

# Documentation Requirements

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| **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:<br>• 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;<br>• Recipient's name;<br>• Service provided;<br>• Date of the service;<br>• Services beginning and ending time on the clock (e.g., 2:00 p.m. to 3:25 p.m.);<br>• Location of the service;<br>• 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<br>• Detailed case notes that:<br>1. Clearly reflect how the case manager's efforts are linked to the services and goals in the recipient's service plan;<br>2. Describe the recipient's progress or lack of progress relative to the service plan; and<br>3. If a substitute case manager provided the service, explain the circumstances requiring the provision of services by a substitute case manager. |

- If services occur in the community, specify the community location

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

- This note refers to processing claims on the back end, NOT documenting contacts
  - Start/end times must be exact
    - No rounding to the nearest hour or nearest quarter hour

# Documentation Requirements

(1) This rule applies to providers rendering Florida Medicaid services to recipients.
(2) Documentation Requirements.
(a) All Florida Medicaid providers must:
1. Ensure medical records establish the medical necessity for and the extent of services provided.
2. Sign and date each medical record within two business days from the date and time of service, or otherwise authenticate the record by signature, written initials, or computer entry. Electronic signatures are permissible as defined in Chapter 668, Part I, F.S.
3. Initial rubber stamped signatures.
(b) Unless otherwise specified in Florida Medicaid coverage policies, providers must document the following information for each service visit or encounter with a Florida Medicaid recipient:
1. Chief complaint of the visit.
2. Date(s) of service.
3. Description of services rendered (as applicable).
4. Diagnosis.
5. Diagnostic tests and results (as applicable).
6. History and physical assessment (as applicable).
7. Prescribed or provided medications and supplies (as applicable).
8. Progress reports.
9. Referrals to other services (as applicable).
10. Scheduling frequency for follow-up or other services (as applicable).
11. Treatment plan (as applicable).
(3) Electronic Records.
(a) Providers that create or maintain electronic records must develop and implement an electronic records policy to comply with the applicable state and federal laws, rules, and regulations to ensure the validity and security of electronic records. Electronic record policies must address the technical safeguards required by Title 45, Code of Federal Regulations, section 164.312, where applicable.
(b) Providers that maintain electronic records must have the ability to produce electronic records in a paper format within a reasonable time, upon AHCA's request.
(4) Recordkeeping Requirements. Providers must retain all business records, medical-related records, and medical records, as defined in Rule 59G-1.010, F.A.C., according to the requirements specified below, as applicable:
(a) Providers may maintain records on paper, magnetic material, film, or other media including electronic storage, except as otherwise required by law or Florida Medicaid requirements. All records must be accessible, legible, and comprehensible.
(b) Providers must retain all records related to services rendered to Florida Medicaid recipients for a period of at least five years from the date of service. Medicare crossover-only providers must retain health care service records for six years.

Rule 59G-1.054: Recordkeeping and Documentation Requirements (effective 5/8/2017)

# Reimbursement Information

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| **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.<br><br>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. |

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| **Reimbursement Limitations** | Medicaid will reimburse:<br><br>• Up to 344 units of children's mental health or adult mental health targeted case management per month, per recipient. |

| Procedure Code | Modifier | Description of Service |
|---|---|---|
| *Children's Mental Health Target Group* | | |
| T1017 | HA | Targeted Case Management for Children (birth through age 17) |
| *Adult Mental Health Target Group* | | |
| T1017 | | Targeted Case Management for Adults (18 years or older) |

- Sunshine Health requires prior authorization for TCM
- Initial authorization requests should include referral and/or evaluation information and be individualized based on recipient's anticipated needs
  - Bio-psychosocial and/or psychiatric evaluations are great sources of information
  - Additional units can be requested as needed / justified by continued medical necessity

# Example Authorization

- Member (39) has been diagnosed with bipolar, schizophrenia, and anxiety. She recently moved in with her dad but is in need of her own place. She needs housing, employment, PCP provider, OB/GYN provider, a new therapist, and a new psychiatrist.
- She has a final appointment scheduled with her previous psychiatrist to get a monthly injection and refills.
- She receives SSI disability.
    - Authorization is unlikely to be approved in full.
        - While several examples of service needs were identified, there is no explanation of **why** the member requires TCM to meet these needs.
            - Member appears to have natural support from her dad.
            - Member appears compliant with medication.
            - No evidence to support behavioral health symptoms impacting functioning.
            - No evidence that housing or finances are unstable or posing barriers.

# Example Authorization (cont.)

- Information that would make approval more likely:
  - Member's dad is only able to provide housing temporarily because he is elderly and plans to move into assisted living within the next 6 months.
  - Member requires additional support and advocacy to link to new behavioral and physical health providers because her anxiety impacts her ability to follow through with referrals independently. She also has a history of canceling or no showing appointments due to anxiety and paranoia until trust is established.
  - While member has been compliant with medications, she has a history of psychiatric hospitalization when medications lapse.

# Questions?