

Guide for Medicaid Reimbursable Targeted Case Management

Does your school district have students with many health needs, requiring multiple appointments away from school? Do you employ a specific person who works with these students to assist them in accessing all medical, social, educational and other services appropriate to the student's needs? Did you know that your school district could be reimbursed for these services?

Step I: Assess the need for service:

Becoming a provider of target case management allows your school district to recoup money for these services being offered. In order to assess the need for this service in your district, the LEA Supervisor must determine how much time is being spent on these [*targeted case management*](#) services. If this service isn't currently offered, then implementation of this service may need to be considered to benefit certain students with many health, educational requirements. Expect more work for the person responsible for billing Medicaid (more claims to be submitted).

Step II: Who is eligible to provide this service?

From the Targeted Case Management Medicaid Manual (section 201.100)

Providers of targeted case management services for recipients under the age of twenty-one who are recipients participating in the Child Health Services/EPSTD Program and are not eligible to receive service from the Division of Developmental Disabilities Services must:

- A. Have a Master of Social Work degree or
- B. Be licensed in the State of Arkansas as a registered nurse or
- C. Be licensed in the State of Arkansas as a licensed practical nurse or
- D. Be licensed in the State of Arkansas as a licensed social worker or
- E. Be licensed in the State of Arkansas as a licensed psychiatric technician nurse or
- F. Be certified on the basis of a Master's degree of higher by the Arkansas Board of Education as a school guidance counselor, school psychology specialist or special education supervisor.

A copy of the applicant's license or certification must accompany the provider application and Medicaid contract. Subsequent licensure and/or certification renewals must be provided for continuous enrollment.

Step III: Speak with your superintendent:

The school district superintendent will determine if the district will get enrolled with Medicaid or not. When presenting this idea to him/her, have a district-wide implementation plan ready, if/when possible.

Step IV: Apply for a Medicaid provider number:

If the district is planning on billing Medicaid for this service, then the district will need a provider number for targeted case management. The school district will have to complete an [application](#) regardless of the other Medicaid numbers currently used by the district (OT, SBMH, SLP). Please be sure to have the responsible party sign (usually the superintendent) the contract and the W-9 and submit it (with original signature) to [Provider Enrollment at Medicaid](#). The individual who will be providing the service will also need to complete an application for Medicaid. The two applications should be submitted at the same time. It will take about four to six weeks in order to receive your provider number from Medicaid.

Step V: Organization:

Meet with the staff that will be involved with implementing this service (case manager, billing clerk, others). This is a good time to discuss the specific responsibilities that will be attributed to specific positions. Procedures should be put in place for [required documentation](#), billing, and other tasks.

Step VI: Prior Authorization:

Medicaid requires prior authorization for targeted case management services. The [Arkansas Foundation for Medical Care](#) (AFMC) must approve all requests for prior authorization for targeted case management services for Medicaid eligible recipients under the age of 21. The following must be included when submitting the prior authorization to AFMC:

- A. Request for Targeted Case Management Prior Authorization for Recipients Under Age 21 form [DMS-601](#).
- B. Prescription or Arkansas Medicaid Primary Care Physician Managed Care Program Referral Form ([DMS-2610](#)) signed by the recipient's Primary Care Physician and written within the last sixty days.
- C. Service Plan.
- D. For Child Health Services (EPSDT) recipients under age 21, medical documentation substantiating the diagnosis, must accompany the DMS-601, the prescription and the service plan.

Step VII: Description of service:

Per Targeted Case Management Medicaid Manual (section 218.000)

The following targeted case management services must be provided by a targeted case management provider and billed on a per unit basis.

A. Assessment/Service Plan Updating

1. Face to face contact with the recipient and contact with other professionals, caregivers or other parties on behalf of the recipient. Assessment is performed for the purpose of collecting information about the recipient's situation and functioning and to determine and identify the recipient's problems and needs.
2. Updating includes reexamining the recipient's needs, identifying changes that have occurred since the previous assessment and altering the service plan, as the recipient's needs change. Updating includes measuring the recipient's progress toward service plan goals.

B. Service Management

Functions and processes that include the initial development of a service plan, identification of the types of services to address the recipient's needs identified in the assessment, contacting service providers selected by the recipient and negotiation for the delivery of services identified in the service plan. Contacts with the recipient and/or professionals, caregivers or other parties on behalf of the recipient may be a part of service management.

C. Service Monitoring

Verifying through regular contacts with service providers that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contact with the recipient that the recipient continues to participate in the service plan and is satisfied with services.

Step VIII: Billing:

Billing for targeted case management services is similar to billing for any other service. Targeted case management must be billed on a per unit basis. One unit equals 15 minutes. Providers may accumulatively bill for a single day of service, but may not accumulatively bill for spanning dates of service. The following procedure codes must be used to bill for targeted case management services:

T1017	Assessment/ Service Plan Updating
T1017 modifier U4	Service Management
T1017 modifier U1	Service Monitoring