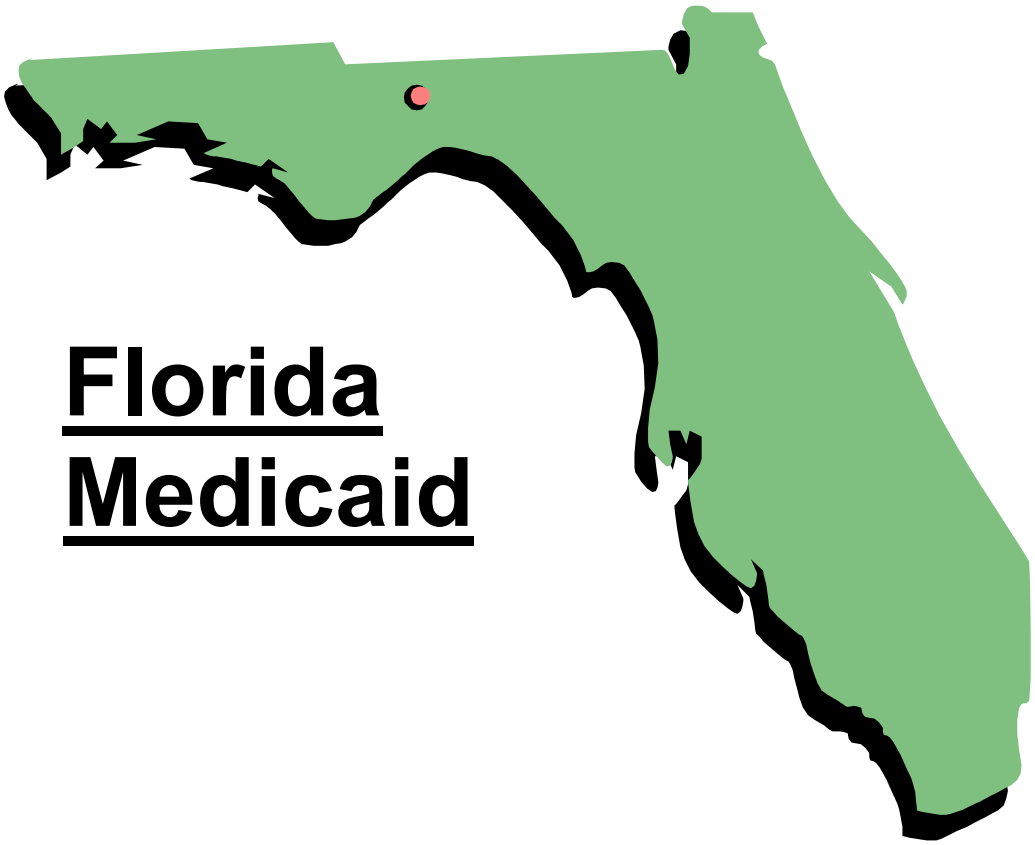

Florida Medicaid

Targeted Case Management Services Coverage Policy

Agency for Health Care Administration

Incorporated by reference in Rule 59G-4.199, F.A.C.

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1.0 Introduction

Florida Medicaid targeted case management (TCM) services provide assistance to recipients who meet the eligibility requirements for targeted populations specified in the Florida Medicaid State Plan, and who reside in, or are transitioning to, a community setting.

Targeted case management services are activities performed by a provider to assist a recipient in gaining access to necessary services, including medical, social, educational, and other services.

Florida Medicaid covers TCM services, as follows:

- Mental Health TCM, for children and adults who meet qualifying mental health-related criteria
- Child Health Services TCM, for children receiving services from the Florida Department of Health's (DOH) Early Steps program
- Juvenile Reentry TCM for children and adults preparing for release and those recently released from a carceral setting who meet incarceration and age qualifying criteria

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render TCM services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.4), and any applicable service-specific or claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) website at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Florida Medicaid TCM services are authorized by the following:

- Title XIX, section 1915(g)(1)(2) of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), sections 440.169 and 441.18 (42 CFR 440.169 and 441.18)
- Section 409.906, Florida Statutes (F.S.)
- Section 5121 of the Consolidated Appropriations Act (CAA) 2023

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Definitions Policy.

1.4.1 Carceral Setting

For purposes of this coverage policy, the term means a public institution where an eligible child or adult, post adjudication, may be confined as an inmate, including a state prison, local jail, tribal jail and prison, and any juvenile detention and youth correctional facility.

1.4.2 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C., that provides instructions on how to bill for services.

1.4.3 Coverage and Limitations Handbook or Coverage Policy
A policy document found in Rule Division 59G, F.A.C., that contains coverage information about a Florida Medicaid service.

1.4.4 General Policies
A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C., that contain information applicable to all providers (unless otherwise specified) that render services to recipients.

1.4.5 Incarcerated
For the purposes of this coverage policy, the term means residing as an inmate of a public institution.

1.4.6 Medically Necessary/Medical Necessity
As defined in Rule 59G-1.010, F.A.C.

1.4.7 Provider
The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with a provider agreement.

1.4.8 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

1.4.9 Targeted Case Management (TCM) Services
As defined in 42 CFR 440.169(b).

2.0 Eligible Recipient

2.1 General Criteria
To be eligible for TCM services, a recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility every time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients who meet target population criteria and require TCM services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.2.1 Mental Health TCM
Recipients must receive assistance from a Department of Children and Families (DCF) funded child or adult mental health program or service, and meet all of the following criteria, to be eligible to receive Mental Health TCM services:

- Have a mental health disability that is expected to last more than one year and requires advocacy for, and coordination of, services to maintain or improve level of functioning
- Require services that assist in attaining self-sufficiency in the living, learning, work, or social environments of choice
- Lack a natural support system sufficient to assist accessing needed medical, social, educational, or other services
- Require ongoing assistance to access or maintain needed care consistently within the service delivery system
- Be in an out-of-home mental health placement, or at risk of, out-of-home mental health treatment placement (recipients under the age of 18 years only). If the recipient is at risk, to qualify for Mental Health TCM, there must be medical documentation demonstrating the recipient's risk.

2.2.2 Child Health Services TCM

A recipient must be under the age of three years and receiving services from DOH's Children's Medical Services (CMS) Early Steps program.

2.2.3 Juvenile Reentry TCM

Recipients must be preparing for release or recently released from a carceral setting, where they were held in custody involuntarily post adjudication, as an inmate of a public institution in accordance with 42 C.F.R. § 435.1010, and eligible for Florida Medicaid prior to or during incarceration.

Additionally, recipients must meet one of the following:

- Under 21 years of age
- Under 26 years of age and a former foster care youth

2.3 Coinsurance and Copayments

There is no Florida Medicaid coinsurance or copayment for these services, in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

3.1 General Criteria

Providers must meet the qualifications specified in this policy to be reimbursed for Florida Medicaid TCM services.

3.2 Who Can Provide

Services must be provided by a case management agency that has a system to provide documentation of costs, has established links with the local network of human services providers and other resources in the service area, and employs or contracts with the following practitioners working within the scope of their practice, as applicable:

3.2.1 Mental Health TCM and Juvenile Reentry TCM

In accordance with section 394.4573, F.S., services must be rendered by a TCM supervisor or case manager who has been certified or provisionally certified by an approved credentialing entity, as defined in section 397.311, F.S., as a Certified Case Manager Supervisor (CCMS) or a Certified Case Manager (CCM), respectively.

A CCM must be supervised by a CCMS.

TCM agencies must adhere to the following criteria:

- Ensure all TCM services are provided by CCMSs or CCMs
- Maintain average caseloads of 20 recipients or less, per case manager, for recipients under the age of 18 years
- Maintain average caseloads of 40 recipients or less, per case manager, for recipients aged 18 years and older

TCM agencies must not subcontract with another agency for the delivery of services.

3.2.2 Child Health Services TCM

Services must be provided by an Early Steps local program agency and rendered by a case manager who is contracted with, or employed by, an Early Steps program group provider.

The rendering provider must comply with the DOH's case manager/service coordinator requirements.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined to be medically necessary
- Do not duplicate another service
- Meet the criteria specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following TCM services, which include documentation, follow-up, monitoring, and referrals, in accordance with 42 CFR 440.169, the applicable Florida Medicaid fee schedule, or as specified in this policy. All TCM providers must provide the following services:

- Assessing the recipient's medical, social, and functional status, as well as identifying the recipient's service needs
- Working with the recipient's natural support system to develop a service plan, including reassessment when needed
- Referring, coordinating, or arranging for service delivery from the recipient's chosen provider(s) to ensure access to needed services specified in the care plan
- Monitoring and follow-up activities to determine that services have been received and are effective in meeting the recipient's needs
- Preparing and maintaining case record documentation to include service plans, reports, narratives, and other documents, as appropriate, that relate to access to care

4.2.1 Mental Health TCM Services for Adults and Children

The primary goal of Mental Health TCM 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 be the accurate result of the individual needs, goals, and abilities of each recipient, and must not simply reflect the Florida Medicaid maximum allowable for the service.

Each Mental Health TCM recipient must receive a thorough assessment conducted by the recipient's TCM provider and completed within the first 30 days of receiving TCM services. The assessment must include at least one home visit by the targeted case manager to the location where the recipient resides.

4.2.1.1 30-day Eligibility for Mental Health TCM

The following Medicaid recipients may receive Mental Health TCM 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 of a Florida Medicaid managed care plan after a denied admission to, or discharge from, an inpatient psychiatric unit
- A recipient who has been admitted to an inpatient psychiatric unit
- A recipient who has been identified by Medicaid's contracted utilization management services vendor or a Florida Medicaid managed care plan as high risk

Recipient eligibility for the 30-day presumptive eligibility period must be documented in the assessment, service plan, and case note documentation.

4.2.1.2 Mental Health TCM Services for Children Residing in a Facility

Florida Medicaid covers TCM services for recipients under the age of 18 years residing in a facility in the following two instances:

- In preparation for discharge from behavioral health overlay services (BHOS): TCM coverage is limited to the final 90 days of BHOS services.
- The last 180 days of a stay in a Statewide Inpatient Psychiatric Program (SIPP): the planned discharge date must be documented in the medical record.

For continuity, TCM services must be provided by a TCM provider agency located in the same district as the recipient's aftercare placement.

4.2.1.3 Intensive Mental Health TCM Team Services for Adults

Intensive TCM case management team services are provided to recipients over the age of 17 years with serious and persistent mental illness, to assist the recipient to remain in the community and avoid institutional care.

Recipient eligibility for intensive team services must be documented in the assessment, service plan, and case note documentation.

Intensive team case managers coordinate needs assessment and services planning, and provide service oversight.

Florida Medicaid does not cover intensive team case managers for providing services that are medical or clinical in nature, or services that provide direct care (i.e., psychotherapy or skills training services).

The maximum average caseload size for a team with four or more case managers shall be 15 recipients, per each team case manager.

The maximum average caseload size for a team with three case managers shall be 7 recipients, per each team case manager.

The maximum average caseload size for a team with less than three case managers shall be 6 recipients, per each team case manager.

4.2.2 Child Health TCM Services

Child Health TCM services assist a recipient receiving services from DOH's Early Steps program gain access to services in all areas of medical, social, educational, and other services, as identified. In addition to providing the core TCM services identified in section 4.2, providers must explain the importance of following prescribed treatment to the parent, guardian, or legal custodian, and help all of them understand and manage the recipient's medical condition(s).

Each recipient must receive an assessment, service plan, referrals and related activities, and monitoring and follow-up.

4.2.3 Juvenile Reentry TCM

TCM services are provided for 30 days pre-release and 30 days post-release from a carceral setting. TCM services include referrals to appropriate care and services available in the assigned Florida Medicaid region of the recipient's residence.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Activities that are not necessary or required to assist the recipient in gaining access to needed services
- Activities that do not relate directly to the identification, access, or management of the recipient's needs or care
- Administrative activities or tasks, including assistance with Florida Medicaid eligibility determinations and redeterminations, or completing documents for reimbursement purposes
- Direct therapeutic medical, clinical or foster care services
- Discharge planning services when discharge planning is covered by a residential facility's per diem
- Incomplete assessments or service plans
- Observation
- Services provided by staff who are not employed or under contract with a Florida Medicaid enrolled TCM agency
- Services provided by more than one case manager to the same recipient on the same day
- Services rendered by unpaid interns or volunteers
- Services rendered to a resident of an institution for mental diseases unless the resident is participating in the Statewide Inpatient Psychiatric Program (SIPP)
- Services rendered to Florida Assertive Community Treatment (FACT) Services' recipients
- Services rendered to recipients enrolled in a home and community-based services waiver
- Services rendered to recipients residing in a nursing facility or an intermediate care facility for individuals with intellectual disabilities
- Supervision of a TCM manager by a TCM supervisor
- Transportation
- Travel, including time traveling to and from a recipient's place of service
- Time spent trying to reach the recipient, family member, caregiver, or service provider without making contact

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Requirements Policy.

6.2 Specific Criteria

Providers must maintain documentation that accurately reflects the recipient's need for TCM services, intervention goals, services to address those needs and goals, and the recipient's progress toward the need-related goals. Providers must also maintain documentation that demonstrates compliance with Florida Medicaid rules.

6.2.1 Assessment

The assessment must use evidence-based tools to assess and report the following components:

- Adherence to mental health and/or substance use disorder and treatment
- Identification of the recipient's needs and functioning abilities
- Recipient's current and potential strengths
- Family support and family education
- Social network and support
- Caregiver's history and current patterns of behavior
- Education, vocational, job training, and volunteer activities
- Housing, food, clothing, and transportation
- Medical and dental services
- Legal assistance
- Development of environmental support groups
- Assistance with establishing financial resources
- Service-specific criteria as indicated in section 2.2

The TCM supervisor must sign and date assessments prior to the completion of the service plan.

Assessments must be completed within 30 days of the date the recipient first presented for services then updated annually.

6.2.2 Service Plan

Service plans must be developed in partnership with the recipient and their parent or legal guardian, address needs identified in the assessment, and contain all of the following components:

- Recipient's service needs, activities, and long-term desired outcomes
- Measurable goals and objectives based on the assessment that identify how to assist the recipient in achieving desired long-term outcomes
- Time frames for achieving goals
- The agency (or agencies) responsible for providing services

Service plans must be signed and dated within 45 days of the initiation of service by the recipient (and, if the recipient is under 18 years of age, by the recipient's parent, guardian, or legal custodian), the recipient's targeted case manager, and the targeted case manager's supervisor.

The service plan must be reviewed and updated at least once every six months. The recipient's eligibility for continued TCM services must be re-evaluated during the service plan review and documented in the updated service plan.

6.2.3 Case Notes

Case notes must provide the following information:

- Services provided
- How the TCM services are linked to the goals in the service plan
- The identification of needs that may require additional services
- Recipient's progress
- Findings of a mental status exam and/or suicide risk screening if conducted
- Circumstances that require a substitute targeted case manager (if applicable)
- Actual time spent providing service

Case notes must be signed and dated with the location and time of service delivery.

6.2.4 Supervision Log

A case manager supervisor must keep a log that contains the amount of supervision, starting and ending times of the supervision, the case manager's name, and the signature of the case manager supervisor.

6.2.5 Service Continuation

The following documents must be completed every 30 days:

- Current Recipient Status Summary: This must include functional issues, behavior problems, or developmental concerns; and, information gathered from service providers, teachers, family members, or caregivers.
- Comprehensive Summary Statement: This must address the recipient's stability within the identified living environment and depict the recipient's progress toward achieving established goals and objectives.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria

There are no specific authorization criteria for this service.

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Specific Criteria

Mental Health and Child Health TCM services are reimbursed in 15-minute units. TCM for Children at Risk of Abuse or Neglect claims are reimbursed for comprehensive services delivered throughout the month.

8.2.1 Mental Health TCM

The TCM agency is the billing provider, and the enrolled TCM supervisor is the rendering provider.

8.2.2 Child Health Services TCM

The TCM agency is the billing provider, and the enrolled TCM case manager is the rendering provider.

8.3 Claim Type

Professional (837P/CMS-1500)

Claims must be filed under the provider numbers of case manager supervisors who are employed with the TCM agency.

8.4 Billing Code, Modifier, and Billing Unit

For each service rendered, providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) as set forth in the applicable fee schedule, incorporated by reference in Rule 59G-4.002, F.A.C.

8.4.1 Mental Health TCM and Child Health Services TCM

Mental Health and Child Health Services TCM services are reimbursed in time increments. Each time increment is a 15-minute unit of service.

- If multiple units are provided on the same date of service, the actual time spent during the day must be calculated in total minutes of service and then rounded to the nearest 15-minute increment. The provider must not round each service episode to the nearest 15-minute increment prior to summing the total minutes of service.
- If the total minutes of service ends in 7 or less, the provider must round down to the nearest 15-minute increment. If the total ends in 8 or more, the provider must round up to the nearest 15-minute increment. For example, 37 minutes of service

is rounded down and submitted as two units of service on the claim form; 38 minutes is rounded up and submitted as three units of service on the claim form.

8.5 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for the service.

8.6 Rate

For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA website at http://ahca.myflorida.com/Medicaid/review/index.shtml.