

Mental Health Targeted Case Management

Policy Summary: Senate Bill 58 of the 83rd Regular Session carved in targeted case management and mental health rehabilitative services into managed care. As a result, HHSC has drafted two medical policies (one for Targeted Case Management and one for Mental Health Rehabilitative Services) to capture the scope of the benefit, authorization requirements, reimbursement guidelines, documentation requirements and exclusions associated with these benefits. Once the policies are finalized, the section of the TMPPM *Behavioral Health, Rehabilitation and Case Management Services Handbook* that describes these benefits will be updated to reflect any changes or clarifications made during the policy development process.

IMPORTANT:

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in this policy are subject to National Correct Coding Initiative (NCCI) relationships guidelines. According to federal law, Texas Medicaid and the CSHCN Services Program may impose stricter limitations than are imposed by the Centers for Medicare and Medicaid Services (CMS). Additional restrictions made by Texas Medicaid and the CSHCN Services Program may be outlined in the Texas Medicaid and CSHCN Services Program medical policies. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at www.cms.gov/MedicaidNCCICoding/ for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid or CSHCN Services Program medical policy is more restrictive than NCCI MUE guidance, Texas Medicaid or CSHCN Services Program medical policy prevails.

Texas Medicaid managed care organizations (MCOs) must provide all medically necessary, Medicaid-covered services to eligible clients. Administrative procedures such as prior authorization, pre-certification, referrals, and claims/encounter data filing may differ from traditional Medicaid (fee-for-service) and from MCO to MCO. Providers should contact the client's specific MCO for details.

Note: Under the Early Periodic Screening Diagnostic, and Treatment (EPSDT) regulation, Section 1905(r) of the Social Security Act mandates that all Medicaid eligible beneficiaries who are birth through 20 years of age receive medically necessary services to treat, correct and ameliorate illnesses and conditions identified if the service is covered in the state's Medicaid plan or is an optional Medicaid service. It is the responsibility of the state to determine medical necessity on a case specific basis. No arbitrary limitations on services

are allowed (e.g. one pair of eyeglasses or 10 therapy sessions per year) if determined to be medically necessary.

Services not covered under this section include:

- Experimental or investigational treatment;
- Services or items not generally accepted as effective and/or not within the normal course and duration of treatment;
- Services for the caregiver or provider convenience.

All EPSDT requirements must be adhered to for beneficiaries who receive services under managed care arrangements.

Statement of Benefits

- 1 Mental Health Targeted Case Management (MHTCM) services are case management services to individuals within targeted groups. The target population that may receive MHTCM as part of the Texas Medicaid Program are individuals, regardless of age, with a single diagnosis of chronic mental illness or a combination of chronic mental illnesses as defined in the latest edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM), and who have been determined via a uniform assessment process to be in need of MHTCM services.
- 2 Excluded from this benefit are individuals of any age with a single diagnosis of intellectual and developmental disabilities (IDD) and related conditions, or substance use disorder (SUD).
- 3 MHTCM services are services furnished to assist individuals in gaining access to needed medical, social/behavioral, educational and other services and supports.
- 4 MHTCM activities and services include:
 - a) A comprehensive assessment and periodic reassessment, as medically necessary, of individual needs to determine the need for any medical, educational, social/behavioral, or other services.
 - b) The development (and periodic revision, as medically necessary) of a specific care plan that:
 - i. Is based on the information collected through the assessment;
 - ii. Specifies the goals and actions to address the medical, social/behavioral, educational, and other services and supports needed by the individual;
 - iii. Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop these goals; and
 - iv. Identifies a course of action to respond to the assessed needs of the eligible individual.

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- c) Making referrals and performing other related activities, such as scheduling an appointment on behalf of the individual, to help an eligible individual obtain needed services and supports, including activities that help link an individual with:
 - i. Medical, social/behavioral, and educational providers; and
 - ii. Other programs and services that are capable of providing needed services to address identified needs and achieve goals in the care plan.
 - d) Monitoring and performing the necessary follow-up that is necessary to ensure the care plan is implemented and adequately addresses the individual's needs.
- 5 MHTCM activities may be with the individual, family members, legally authorized representative (LAR), providers, or other entities or individuals and conducted as frequently as necessary, and at least once annually, to determine whether the following conditions are met:
 - a) services are being furnished in accordance with the individual's care plan;
 - b) services in the care plan are adequate in amount, scope and duration to meet the needs of the individual; and
 - c) the care plan and service arrangements are modified when the individual's needs or status change.
- 6 MHTCM is a benefit for individuals transitioning to a community setting up to 180 consecutive days prior to leaving a nursing facility, however MHTCM services are coordinated with and do not duplicate activities provided as part of institutional services and discharge planning activities that take place at inpatient facilities.
- 7 MHTCM consists of two different types of case management.
 - a) Intensive Case Management: services are predominantly community-based case management activities provided to the LAR on behalf of the child (who may or may not be present) to assist a child/youth and caregiver or LAR in obtaining and coordinating access to necessary care and services appropriate to the individual's needs.
 - b) Routine Case Management: services are primarily office-based case management activities that assist an individual and/or caregiver/LAR in obtaining and coordinating access to necessary care and services appropriate to the individual's needs.
- 8 Clients birth through 20 years of age may benefit from Intensive Case Management or Routine Case Management
- 9 Clients 21 years of age and older may benefit only from Routine Case Management.

Collateral Contacts

- 10 MHTCM may include contacts with non-eligible individuals who are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible

individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

Intensive Case Management

- 11 Intensive Case Management incorporates a wraparound approach to care planning and treatment plan implementation. The wraparound process is a strengths-based course of action involving a child or youth and their family, including any additional people identified by the child or youth, LAR, primary caregiver, and family, that results in a unique set of community services and natural supports that are individualized for the child or youth to achieve a positive set of identified outcomes.
- 12 Intensive case management is primarily community-based, meaning that services are provided in whatever setting is clinically appropriate and client-centered.
- 13 A case manager assigned to a child or youth who is authorized to receive intensive case management services must have completed training in the National Wraparound Implementation Center's Wraparound Practice model and must incorporate wraparound process planning or other approved models in developing a plan that addresses the child's or youth's unmet needs across life domains
- 14 The case manager must develop an intensive case management treatment plan based on the child's or youth's needs that may include information across life domains from relevant sources.
- 15 The case manager must meet face-to-face with the child or youth and the LAR or primary caregiver:
 - a) within seven days after the case manager is assigned to the child or youth;
 - b) within seven days after discharge from an inpatient psychiatric setting, whichever is later; or
 - c) document the reasons the meeting did not occur and meet at the soonest available opportunity.
- 16 The case manager must identify the child or youth's strengths, service needs, and assistance that will be required to address the identified needs in the plan.
- 17 The case manager must take steps that are necessary to assist the child or youth in gaining access to the needed services and service providers, including:
 - a) making referrals to potential service providers;
 - b) initiating contact with potential service providers;
 - c) arranging, and if necessary to facilitate linkage, accompanying the child or youth to initial meetings and non-routine appointments;
 - d) arranging transportation to ensure the child's or youth's attendance;
 - e) advocating with service providers;
 - f) providing relevant information to service providers; and,
 - g) monitoring the child's or youth's progress toward the goals set forth in the plan.

Authorization Requirements

- 18 Fee for service providers (LMHAs) obtain authorization from their internal utilization management department, while providers contracting with MCOs for delivery of services must submit prior authorization requests to the client's MCO.
- 19 Eligibility determinations occur at the facility providing targeted case management services using the Clinical Management of Behavioral Health Services (CMBHS) software system.
- 20 Criteria used to make these service determinations are from the recommended Level of Care (LOC) of the individual as derived from the Uniform Assessment (UA), the needs of the individual, and the Texas Resilience and Recovery Utilization Management Guidelines.
- 21 In determining service, the Qualified Mental Health Professional - Community Services (QMHP-CS) or Licensed Practitioner of the Healing Arts (LPHA) performs a screening for eligibility utilizing the UA. The LPHA gives a diagnosis and determines if the services are medically necessary.
- 22 The LPHA determination of diagnosis shall include an interview with the individual conducted either in-person or via telemedicine or telehealth (see Telemedicine and Telehealth policies in the Telecommunication Services Handbook in the Texas Medicaid Provider Procedures Manual for further information).
- 23 A facility that provides MHTCM must ensure that at minimum a QMHP-CS administers the uniform assessment to the individual at specified intervals (every 3 months for children/youth and every 6 months for adults), and obtains a recommended Level of Care (LOC) for the individual.
- 24 The facility must evaluate the clinical needs of the individual to determine if the amount of MHTCM services associated with the recommended LOC described in the utilization management guidelines is sufficient to meet those needs and ensure that an LPHA reviews the recommended LOC and verifies whether the services are medically necessary.
- 25 If the facility determines that the type of MHTCM services associated with the recommended LOC is sufficient to meet the individual's needs, the facility must submit a request for service authorization according to the recommended LOC.
- 26 If the facility determines that a LOC other than the recommended LOC is more appropriate for the individual, the provider must submit a deviation request that includes:
 - a) a request for an authorization of an LOC that is higher or lower than initially recommended; and
 - b) the clinical justification for the request.
- 27 The clinical justification must include the specific reason(s) why the individual requires interventions outside the recommended LOC. Client refusal of recommended LOC may be noted as part of the justification.
- 28 All plans of care are subject to retrospective review by the state.

Eligibility and Service Determinations for Clients birth through 20 years of age

- 29 MHTCM is available to children under 21 years of age with a diagnosis of mental illness (excluding a single diagnosis of IDD and related disorders, or SUD) or serious emotional disturbance and who:
- Have a serious functional impairment; or
 - Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
 - Are enrolled in a school system's special education program because of serious emotional disturbance.
- 30 The initial assessment is the clinical process of obtaining and evaluating historical, social/behavioral, functional, psychiatric, developmental or other information from the individual seeking services in order to determine specific treatment and support needs.
- 31 Functioning is assessed using a standardized assessment tool, the Child and Adolescent Needs and Strengths Assessment (CANS).
- 32 Services and supports to be provided to the client, birth through 20 years of age, are determined jointly by the client, family, and the provider.
- 33 Children and Youth MHTCM services authorized for care by the provider through a clinical override are eligible for the duration of the authorization.
- 34 Youth receiving children's mental health services who are approaching their 21st birthday and continue to need mental health services shall either be transferred to adult mental health services on their 21st birthday or referred to another community provider, dependent upon the individual's needs.
- 35 Clients who are 21 years of age or older and have previously received children's mental health services must be reassessed for adult mental health services.

Continued Eligibility for Services

- 36 Continued eligibility for MHTCM services is based on a reassessment every 3 months by the provider and reauthorization of services by the facility.
- 37 Assignment of diagnosis in the CMBHS is required at any time the DSM diagnosis changes and at least annually from the last diagnosis entered into CMBHS.

Eligibility and Service Determinations for clients 21 years of age and older

- 38 MHTCM is available to adults 21 years of age or older who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, post-traumatic stress disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.
- 39 Adults with schizophrenia and bipolar disorder are automatically eligible for services while adults with any other mental health diagnoses require evidence of significant

difficulty functioning across one or more domains such as work or school to be eligible for services.

- 40 Functioning is assessed using a standardized assessment tool called the Adult Needs and Strengths Assessment (ANSA).

Continued Eligibility for Services

- 41 Adults are reassessed every six months for continued need for services.
- 42 Assignment of diagnosis in the CMBHS is required at any time the DSM diagnosis changes and at least annually from the last diagnosis entered into CMBHS.
- 43 Adults with a diagnosis of schizophrenia or bipolar disorder are automatically eligible for continued services.
- 44 An individual with major depressive disorder whose level of functioning qualified them initially is also automatically eligible for continued services, regardless of whether their level of functioning has improved or not.
- 45 Individuals with any other mental health diagnoses are eligible should their level of functioning continue to be significantly impaired, as evidenced by the results of a standardized assessment tool.

Reimbursement/Billing Guidelines

- 46 A MHTCM reimbursable session is the provision of a case management activity by an authorized case manager during a face-to-face meeting with an individual who is authorized to receive that specific type of case management. A billable unit of MHTCM is 15 continuous minutes of contact.
- 47 MHTCM is payable for individuals transitioning to a community setting up to 180 consecutive days prior to leaving a nursing facility.

Table A: Procedure Code and Limitations for Mental Health Targeted Case Management

Service	Procedure Code	Limitations
Routine TCM (client over 21)	T1017	32 units (8 hours) per calendar day for individuals who are 21 years of age and older
Routine TCM (client birth through 20)	T1017	32 units (8 hours) per calendar day for individuals who are 20 years of age and younger

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Intensive TCM (client birth through 20)	T1017	32 units (8 hours) per calendar day for individuals who are 20 years of age and younger
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Table B: Modifiers with Descriptions

Modifier	Description
TF	Routine Case Management
TG	Intensive Case Management
HZ	Court ordered services
HA	Services for children birth through 20

48 Reimbursement for procedure code T1017 is limited to the following diagnosis codes:

Table C: Diagnosis Codes for Mental Health Targeted Case Management

F060	F061	F062	F0630	F0631	F0632	F0633	F0634
F064	F068	F070	F0789	F09	F200	F201	F202
F203	F205	F2081	F2089	F209	F21	F22	F23
F24	F250	F251	F258	F259	F28	F29	F3010
F3011	F3012	F3013	F302	F303	F304	F309	F310
F3110	F3111	F3112	F3113	F312	F3130	F3131	F3132
F314	F315	F3160	F3161	F3162	F3163	F3164	F3170
F3171	F3172	F3173	F3174	F3175	F3176	F3177	F3178
F3181	F3189	F319	F320	F321	F322	F323	F324
F325	F328	F329	F330	F331	F332	F333	F3340
F3341	F3342	F338	F339	F340	F341	F348	F349
F39	F4000	F4001	F4002	F4010	F4011	F40210	F40218
F40220	F40228	F40230	F40231	F40232	F40233	F40240	F40241
F40242	F40243	F40248	F40290	F40291	F40298	F408	F409
F410	F411	F413	F418	F419	F42	F430	F4310
F4311	F4312	F4320	F4321	F4322	F4323	F4324	F4325
F4329	F438	F439	F440	F441	F442	F444	F445
F446	F447	F4481	F4489	F449	F450	F451	F4520
F4521	F4522	F4529	F4541	F4542	F458	F459	F481
F482	F488	F489	F5000	F5001	F5002	F502	F508
F509	F5101	F5102	F5103	F5104	F5105	F5109	F5111
F5112	F5113	F5119	F513	F514	F515	F518	F519
F53	F54	F600	F601	F602	F603	F604	F605
F606	F607	F6081	F6089	F609	F630	F631	F632
F633	F6381	F6389	F639	F641	F642	F648	F649

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F6810	F6811	F6812	F6813	F69	F900	F901	F902
F908	F909	F910	F911	F912	F913	F918	F919
F930	F938	F939	F940	F941	F942	F948	F949
F980	F981	F9821	F9829	F983	F984	F985	F988
F989	F99	O906	T7402XA	T7402XD	T7402XS	T7412XA	T7412XD
T7412XS	T7422XA	T7422XD	T7422XS	T7602XA	T7602XD	T7602XS	T7612XA
T7612XD	T7612XS	T7622XA	T7622XD	T7622XS			

- 49 The following activities are included in the MH Targeted Case Management rate and therefore payment will not be made separately for the following activities:
- Documenting the provision of MH Case management services.
 - On-going administration of the Uniform Assessment to determine amount, duration, and type of MH Case Management.
 - Travel time required to provide MH case management services at a location not owned, operated or under arrangement with the provider.
- 50 Intensive case management and routine case management are not payable on the same day.
- 51 Texas Medicaid must *not* be billed for MHTCM services provided before the establishment of a diagnosis of mental illness and the authorization of services.

Provider Credentials for Facilities Rendering Mental Health Targeted Case Management

- 52 The credentialing requirements for QMHP-CS and Community Services Specialist (CSSPs) are outlined below. These providers are eligible to deliver Mental Health Targeted Case Management as outlined in this policy.
- 53 A case manager performing MHTCM must:
- Be certified as a QMHP-CS or a CSSP;
 - Be an employee of the facility where the case management is delivered; and
 - Be competent in the provision of MHTCM.

Provider Credentials

Qualified Mental Health Professional - Community Services (QMHP-CS)

- 54 The credentialing requirement minimums for a QMHP-CS are as follows:
- Completion of a standardized training curriculum,
 - Demonstrated competency in the work to be performed, and
 - Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or

- d) An RN.
- 55 Staff administering the assessment instruments must have documentation of current certification in the CANS or ANSA. Certification must be updated annually through an approved entity.
- 56 An individual who possesses any of the following licenses is considered an LPHA automatically certified as a QMHP-CS:
 - a) Licensed Physician
 - b) Physician Assistant
 - c) Advanced Practice Registered Nurse
 - d) Licensed Psychologist
 - e) Licensed Clinical Social Worker (LCSW)
 - f) Licensed Marriage and Family Therapist (LMFT)
 - g) Licensed Professional Counselor (LPC)
- 57 A QMHP-CS must be clinically supervised by at least another QMHP-CS. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by a LPHA.

Community Services Specialist (CSSP)

- 58 The credentialing requirement minimums for a CSSP are as follows:
 - a) High school diploma or high school equivalency,
 - b) Three continuous years of documented full-time experience in the provision of mental health rehabilitative services prior to August 30, 2004, and
 - c) Demonstrated competency in the provision and documentation of mental health rehabilitative services.

Documentation Requirements

- 59 A comprehensive diagnosis must be included in the client record, including documentation of applicable diagnostic criteria according to the latest edition of the DSM, as well as the specific justification of need for services.
- 60 MHTCM services, including attempts to provide MHTCM services, must be documented in the individual's medical record.
- 61 For routine case management, the case manager must document the client's strengths, service needs, and assistance required to address the service needs as well as the steps that are necessary to accomplish the goals required to meet the client's service needs.
- 62 For intensive case management, the assigned case manager must include the intensive case management treatment plan in the client's medical record, and the assigned case manager must document steps taken to meet the client's goals and needs in the client's progress notes.

- 63 As a result of the face-to-face meetings, assessments, and reassessments conducted, the case manager must document the individual's identified strengths, service needs, and assistance given to address the identified need, and specific goals and actions to be accomplished.
- 64 The case manager must document the following for all services provided:
- a) the event or behavior that occurs while providing the MH case management service or the reason for the specific case management encounter;
 - b) the person, persons, or entity, including other case managers, with whom the encounter or contact occurred;
 - c) collateral contacts such as contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the client access services and managing the client's care, including coordination with other case managers;
 - d) the recovery plan goal(s) that was the focus of the service, including the progress or lack of progress in achieving recovery plan goal(s);
 - e) the timeline for obtaining the needed services;
 - f) the specific intervention that is being provided;
 - g) the date the MH case management service was provided;
 - h) the start and end time of the MH case management service;
 - i) the location where the MH case management service was provided and whether it was a face-to-face or telephone contact;
 - j) the name of the provider agency and the signature of the employee providing the MH case management service, including their credentials; and
 - k) the timeline for reevaluating the needed services.
- 65 If the individual refuses MH case management services, the case manager must document the reason for the refusal in the progress notes of the individual's medical record and request that the individual sign a waiver of MH case management services that is filed in the individual's medical record.
- 66 The provider must retain documentation in compliance with applicable records retention requirements in federal and state laws, rules, and regulations.

Crisis service documentation

- 67 A crisis is a situation in which an individual presents an immediate danger to self or others; the individual's mental or physical health is at risk of serious deterioration; or an individual believes that he or she presents an immediate danger to self or others, or that his or her mental or physical health is at risk of serious deterioration.
- 68 In addition to the general documentation requirements described above, a provider must document the following for crisis intervention services:
- a) the date the service was provided;
 - b) the beginning and end time of the crisis contact;
 - c) the name and any other identifying information of the individual to whom the service was provided (if given);
 - d) the location where the service was provided;
 - e) the behavioral description of the presenting problem;

- f) lethality (e.g., suicide, violence);
- g) substance use or abuse;
- h) trauma, abuse, or neglect;
- i) the outcome of the crisis (e.g., individual in hospital, individual with friend and scheduled to see doctor at 9:00 a.m. the following day);
- j) the names and titles of staff members involved;
- k) all actions (including rehabilitative interventions and referrals to other agencies) used by the provider to address the problems presented;
- l) the response of the individual, and if appropriate, the response of the LAR and family members;
- m) the signature of the staff member providing the service and a notation as to whether the staff member is an LPHA or a QMHP-CS;
- n) any pertinent event or behavior relating to the individual's treatment which occurs during the provision of the service;
- o) follow up activities, which may include referral to another provider; and
- p) the outcome of the individual's crisis.

Exclusions

- 69 Excluded from this benefit are individuals of any age with a single diagnosis of intellectual and developmental disabilities (IDD) and related conditions, or substance use disorder (SUD).
- 70 The following services are not covered by MHTCM:
 - a) Case management activities that are an integral component of another covered Medicaid service;
 - b) The provision of a medical, educational, social/behavioral, or other service to which an individual has been referred, including for foster care programs, services such as, but not limited to, the following:
 - i. Research gathering and completion of documentation required by the foster care program.
 - ii. Assessing adoption placements.
 - iii. Recruiting or interviewing potential foster care parents.
 - iv. Serving legal papers.
 - v. Home investigations.
 - vi. Providing transportation, including transporting the client to his/her LAR/primary caregiver.
 - vii. Administering foster care subsidies.
 - viii. Making placement arrangements.
 - c) Performing an activity that does not directly assist an individual in gaining or coordinating access to needed services
 - d) Providing medical or nursing services
 - e) Performing pre-admission or intake activities
 - f) Monitoring the individual's general health status

- g) Performing outreach activities
- h) Performing quality oversight of a service provider
- i) Conducting utilization review or utilization management activities
- j) Conducting quality assurance activities
- k) Authorizing services or authorizing the provision of services
- l) Services to individuals over 21 and under 65 years of age residing in institutions for mental disease
- m) Services to inmates of public institutions

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