ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

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TO: **Arkansas Medicaid Health Care Providers – Targeted Case Management**

DATE: **March 1, 2008**

SUBJECT: **Provider Manual Update Transmittal # 62**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	10-13-03	201.000	3-1-08
201.100	10-13-03	201.100	3-1-08
201.200	10-13-03	201.200	3-1-08
202.000	10-13-03	202.000	3-1-08
202.100	10-13-03	202.100	3-1-08
203.000	10-13-03	203.000	3-1-08
204.000	10-13-03	204.000	3-1-08
211.000	10-13-03	211.000	3-1-08
212.000	10-13-03	212.000	3-1-08
—	—	212.100	3-1-08
—	—	212.200	3-1-08
—	—	212.300	3-1-08
—	—	212.400	3-1-08
—	—	212.410	3-1-08
213.000	10-13-03	213.000	3-1-08
—	—	213.100	3-1-08
214.000	10-13-03	214.000	3-1-08
215.000	10-13-03	215.000	3-1-08
216.000	10-13-03	216.000	3-1-08
217.000	10-13-03	217.000	3-1-08
217.100	10-13-06	217.100	3-1-08
217.200	10-13-03	—	—
217.300	10-13-03	—	—
218.000	10-13-03	218.000	3-1-08
—	—	218.100	3-1-08
—	—	218.200	3-1-08
—	—	218.300	3-1-08
219.000	10-13-03	219.000	3-1-08
—	—	220.000	3-1-08
241.000	10-13-03	241.000	3-1-08
242.000	10-13-03	242.000	3-1-08

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
242.100	10-13-03	242.100	3-1-08
242.330	10-13-03	242.330	3-1-08
242.340	10-13-03	242.340	3-1-08
250.100	10-13-03	250.100	3-1-08
261.000	10-13-03	261.000	3-1-08
262.000	10-13-03	262.000	3-1-08
262.100	10-13-03	262.100	3-1-08

Explanation of Updates

Section 201.000 has been included to add enrollment qualifications for targeted case management (TCM) providers, with a notation that the Division of Health may enroll as a TCM provider. The department name has been changed to the Department of Health and Human Services (DHHS).

Section 201.100 has been included to change the title of the section. Text changes have been made in the section for clarification of policy.

Section 201.200 has been included to change the title of the section.

Section 202.000 has been included to change the title of the section. Text changes have been made in the section for clarification of policy.

Section 202.100 has been included to change the title of the section. Text changes have been made in the section for clarification of policy.

Section 203.000 has been included to change the title of the section. Text changes have been made in the section for clarification of policy.

Section 204.000 has been included to revise the title of the section. Qualifications for certification of providers by the Division of Aging and Adult Services have been included. Some text previously included in the section has been transferred to the newly developed section 212.410, titled "Regulations for ElderChoices Program Case Management".

Section 211.000 has been revised to change the reference to Medicaid eligible individuals from "recipients" to "beneficiaries". Information has been added regarding temporary situations involving the caseload numbers for targeted case managers. Other language has been added for clarification of information.

Section 212.000 has been included to revise the title of the section. The text of the section has been transferred to the newly developed section 212.200.

Section 212.100 has been created and titled "Beneficiaries Age Twenty-One (21) and Younger Who Are Not Receiving DDS ACS Waiver Services". Information has been added that advises of the characteristics of this target group.

Section 212.200 has been created and titled "Beneficiaries Age Twenty-One (21) and Younger Eligible for Developmental Disabilities ACS Services". The body of the section has been transferred from 212.000.

Section 212.300 has been created and titled "Beneficiaries Age Twenty-Two (22) and Older with a Developmental Disability Who Are Not Receiving DDS ACS Waiver Services". Text in the body of the section has been transferred from section 213.000.

Section 212.400 has been created and titled "Beneficiaries Age Sixty (60) and Older." Text in the body of the section has been transferred from section 214.000.

Section 212.410 has been created and titled “Regulations for ElderChoices Program Case Management”. Information in the section has been transferred from section 204.000 and new requirements have been added.

Section 213.000 has been included to revise the title of the section. The section contains a list of covered TCM services. Previous information in the body of the section has been transferred to section 212.300.

Section 214.000 has been included and is titled “Exclusions”. Information in the section has been transferred from section 215.000 and additional excluded services have been added for clarification of policy. Information formerly in this section has been transferred to section 212.400.

Section 215.000 has been included to revise the title of the section to “Physician’s Role”. Text in the section has been transferred from section 216.000. Terminology has been revised for clarification of information. Information formerly in this section has been transferred to section 214.000.

Section 216.000 has been included to revise the title to “Documentation in Beneficiary Files”. Text from section 217.200 has been transferred to the section, and additional information has been added for clarification.

Section 217.000 has been revised and is titled “Record Keeping Requirements”. The text in the section has been transferred from section 217.300 and additional information has been added for clarification of policy. Old language in the section has been deleted.

Section 217.100 has been revised and is titled “Requirements for Time Records and the Tickler System”. Text that was previously included in the section has been deleted.

Section 217.200 has been deleted and text from the section has been transferred to section 216.000.

Section 217.300 has been deleted and the text in the body of the section has been transferred to 217.000.

Section 218.000 has been included because information has been revised.

Section 218.100 has been developed to include information about assessments and/or service plan development and visits. Maximum units for services for beneficiaries age 21 and over have been capped at twelve (12) units per assessment/service plan.

Section 218.200 has been developed to include information about service management/referral and linkage.

Section 218.300 has been developed to include information about service monitoring and/or service plan updating. Services for beneficiaries age 21 and over have been capped at four (4) units per assessment/service plan.

Section 219.000 has been revised and is titled “Contacts with Non-eligible or Non-Targeted Individuals”. Text in the body of the section has been transferred to section 220.000.

Section 220.000 has been developed and is titled “Benefit Limits”. Information has been added revising the number of units allowed for targeted case management services per year for beneficiaries age 21 and over. Instructions have been included in how to document information about utilization.

Section 241.000 has been included to change the reference to Medicaid eligible individuals from “recipients” to “beneficiaries”.

Sections 242.000 and 242.100 have been included to change the title of the section and to clarify the procedure for applying for prior authorization. References to Medicaid eligible individuals have been changed from “recipients” to “beneficiaries”.

Section 242.330 has been included to change the title of the section, to clarify the procedure for a provider to apply for a reconsideration of a denied prior authorization request and to change the reference to Medicaid eligible individuals from “recipients” to “beneficiaries”.

Section 242.340 has been included to change the title of the section and to change the reference to Medicaid eligible individuals from “recipients” to “beneficiaries”.

Section 250.100 has been included to add information and examples that clarify the method of reimbursement and to change the reference to Medicaid eligible individuals from “recipients” to “beneficiaries”.

Section 261.000 has been included to remove obsolete information and to change the reference to Medicaid eligible individuals from “recipients” to “beneficiaries”.

Section 262.000 has been included to remove obsolete information.

Section 262.100 has been included to add procedure code modifiers for beneficiaries age 21 and over, to revise procedure code descriptions and to remove obsolete information from the section.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 (TDD only).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

TOC required

201.000 Arkansas Medicaid Participation Requirements for Providers of Targeted Case Management 3-1-08

To participate in the Arkansas Medicaid Program, providers must adhere to all applicable professional standards of care and conduct.

Providers of targeted case management (TCM) services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

Targeted case management provider applicants must complete and submit to Provider Enrollment a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (DMS-652), a Medicaid Contract (DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).**

Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

Providers must be licensed or certified to serve their respective target population(s).

NOTE: Individual employees of the Department of Health and Human Services (DHHS) are excluded from enrolling as Medicaid providers for the Targeted Case Management Program; however, the Division of Health may enroll as a TCM provider agency.

201.100 Participation Requirements for Providers of Targeted Case Management for Beneficiaries Under the Age of Twenty-One (21) Who Are Not Receiving Division of Developmental Disabilities Services Alternative Community Services (DDS ACS) Waiver Program Services 3-1-08

Providers of targeted case management services who are restricted to serving beneficiaries under the age of twenty-one (21) who participate in the Child Health Services/EPSDT Program and are not receiving services from the DDS ACS waiver program 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 or higher by the Arkansas State 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 submitted to Provider Enrollment within 30 days of issuance in order for the provider to maintain continuous enrollment.

201.200 Participation Requirements for Group Providers of Targeted Case Management for Beneficiaries Under the Age of Twenty-One (21) Who Are Not Receiving DDS ACS Waiver Services 3-1-08

In situations where the case manager is a member of a group of case managers, each individual case manager and the group must both enroll according to the following criteria:

A. Each individual case manager in the group must enroll following the criteria established in section 201.000

B. The group must complete and submit to Provider Enrollment a provider application and Medicaid contract as an Arkansas Medicaid provider of targeted case management services. **View or print a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).**

Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

The provider must be licensed or certified to serve their respective target population.

All group providers are "pay to" providers only. Group providers may bill and receive reimbursement only for services performed by a licensed/certified Medicaid enrolled case manager who is a member of the group.

202.000 Participation Requirements for Providers of Targeted Case Management for Beneficiaries Age Twenty-One (21) and Younger Eligible for Developmental Disabilities Services (DDS) 3-1-08

Providers of targeted case management services who are restricted to serving beneficiaries age twenty-one (21) and younger who are eligible to receive services from the Division of Developmental Disabilities Services (See section 212.000) must:

A. Be certified by the Division of Developmental Disabilities Services as having successfully completed a DDS Case Management Training Program or

B. Be certified as an individual recognized and funded by the Arkansas Department of Education as an early childhood coordinator who is responsible for implementing special education services under PL 99-457.

A copy of the applicant's certification must accompany the provider application and Medicaid contract. Subsequent certification renewals must be submitted to Provider Enrollment within 30 days of issuance to maintain continuous enrollment.

202.100 Participation Requirements for Group Providers of Targeted Case Management for Beneficiaries Age Twenty-One (21) and Younger Eligible for DDS 3-1-08

In situations where the case manager is a member of a group of case managers, each individual case manager and the group must both enroll according to the following criteria:

A. Each individual case manager in the group must enroll following the criteria established in section 201.000

B. The group must complete a provider application and Medicaid contract as an Arkansas Medicaid provider of targeted case management services. The Arkansas Medicaid Program must approve the provider application and the Medicaid contract.

All group providers are "pay to" providers only. Group providers may bill and receive reimbursement only for services performed by a licensed/certified Medicaid enrolled targeted case manager who is a member of the group.

203.000 Participation Requirements for Providers of Targeted Case Management for Beneficiaries Age Twenty-Two (22) and Older with a Developmental Disability Who Are Not Receiving DDS ACS Waiver Services 3-1-08

Providers of targeted case management who are restricted to serving persons age twenty-two (22) and older who have a developmental disability, but are not receiving DDS ACS waiver services, (See section 213.000) must be a Division of Developmental Disabilities Services Licensed Community Program.

A copy of the current license must accompany the provider application and Medicaid contract. Subsequent license renewals must be submitted to Provider Enrollment within 30 days of issuance to maintain continuous enrollment.

204.000 Participation Requirements for Providers of Targeted Case Management for Beneficiaries Age Sixty (60) and Older 3-1-08

Providers of targeted case management who are restricted to serving persons sixty (60) years of age and older must be certified by the Division of Aging and Adult Services as an organization qualified to provide targeted case management services.

In order to be certified by the Division of Aging and Adult Services, the provider must meet the following qualifications:

A. Be licensed as a Class A or Class B Home Health Agency by the Arkansas Division of Health, or a unit of state government or an agency

B. Be able to demonstrate one year of experience in performing case management services

C. Be able to demonstrate one year of experience in working specifically in the field of aging

D. Have an administrative capacity to insure quality of services in accordance with state and federal requirements

E. Have the financial management capacity and system that provides documentation of services and costs

F. Have the capacity to document and maintain individual case records in accordance with state and federal requirements

G. Be able to demonstrate that the provider has current liability coverage, and

H. Employ qualified case managers who must:

1. Be licensed in the state of Arkansas as a social worker, a registered nurse or a licensed practical nurse
2. Or have a bachelor's degree from an accredited institution
3. Or have performed satisfactorily as a case manager for a period of two (2) years

A copy of the current certification must accompany the provider application and Medicaid contract. Subsequent renewals must be submitted to Provider Enrollment within 30 days of issuance in order to maintain continuous enrollment.

211.000 Scope 3-1-08

Case management is an activity that assists individuals in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Medicaid covered

targeted case management is a **referral for service** that assists beneficiaries in accessing all medical, social, educational and other services appropriate to the beneficiary's needs.

Targeted case management services are covered when they are:

A. Medically necessary

B. Prescribed as the result of a Child Health Services/EPSDT screen for beneficiaries under age twenty-one (21) ineligible for DDS ACS waiver services

C. Provided to outpatients only

D. Provided by a qualified provider enrolled to serve the target group to which the beneficiary belongs

E. Provided at the option of the beneficiary and by the provider chosen by the beneficiary

F. Provided to beneficiaries who have no reliable and available supports to assist them in gaining access to the necessary care and services they need and

G. Referrals for service that directly affect the beneficiary but may not require the beneficiary's active participation, e.g., housing assistance.

A targeted case manager may maintain a maximum active caseload of 70 Medicaid beneficiaries at a time.

A. If a temporary situation arises based on a filled position becoming temporarily vacant and hiring for the position is in progress, a case manager may exceed the maximum of 70 active cases for no more than sixty (60) consecutive days.

B. The maximum number of active cases during a temporary situation, as described above, may not exceed 90.

212.000 Groups Eligible for Targeted Case Management Services

212.100 Beneficiaries Age Twenty-One (21) and Younger Who Are Not Receiving DDS ACS Waiver Services 3-1-08

This target population consists of beneficiaries who are age twenty-one (21) and younger who:

A. Experience developmental delays

B. Have diagnosed physical or mental conditions with a high probability of resulting in a developmental delay

C. Are determined at risk of having substantial developmental delay if early intervention services are not provided and

D. Are diagnosed with a developmental disability attributable to mental retardation, cerebral palsy, epilepsy, autism or any other medical condition considered to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or requires treatment and services similar to those required for such persons

E. Are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

212.200 Beneficiaries Age Twenty-One (21) and Younger Eligible for Developmental Disabilities Services 3-1-08

This target population consists of beneficiaries who are age twenty-one (21) and younger and who:

A. Experience developmental delays

B. Have a diagnosed physical or mental condition with a high probability of resulting in developmental delay

C. Are determined to be at risk of having substantial developmental delay if early intervention services are not provided and

D. Are diagnosed as having a developmental disability which is attributable to mental retardation, cerebral palsy, epilepsy, autism or any other medical condition considered closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or requires treatment and services similar to those required for such persons.

DDS certified case managers enrolled as Medicaid targeted case managers must obtain written verification that any beneficiary they wish to bill for has been certified as eligible to receive services from the Division of Developmental Disabilities Services. This documentation must be obtained from the DDS service coordinator responsible for the beneficiary's county of residence and must be maintained in the beneficiary's record. Providers may request a list of DDS service coordinators and their locations from the local DHHS county office.

212.300 Beneficiaries Age Twenty-Two (22) and Older with a Developmental Disability Who Are Not Receiving DDS ACS Waiver Services 3-1-08

This target population consists of beneficiaries who are age twenty-two (22) and older and who: are:

A. Diagnosed as having a developmental disability of mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or requires treatment and services similar to those required for such persons (Refer to section 203.000 for more information.)

B. Not receiving DDS ACS waiver services.

212.400 Beneficiaries Age Sixty (60) and Older 3-1-08

This target population consists of beneficiaries age sixty (60) and older who have limited functional capabilities in two or more ADLs or IADLs resulting in a need for coordination of multiple services and/or other resources or are in a situation or condition that poses imminent risk of death or serious bodily harm and who demonstrates the lack of mental capacity to comprehend the nature and consequences of remaining in that situation or condition.

212.410 Regulations for ElderChoices Program Case Management 3-1-08

A. A plan of care developed by the DHHS RN for the ElderChoices Program replaces any other plan of care. The ElderChoices plan of care must include all appropriate ElderChoices services and certain non-waiver services appropriate for the beneficiary.

B. If services are currently provided to an ElderChoices client, the provider must report these services to the DHHS RN. Before beginning or revising services to an ElderChoices client, the DHHS RN must be contacted to ensure that the plan of care is revised and approved. All changes in service or client circumstances must be reported to the DHHS RN immediately. Certain services provided to an ElderChoices client that are not included in the plan of care may be subject to recoupment by the Medicaid Program.

C. An ElderChoices plan of care may not be revised by anyone other than the DHHS RN. All services, regardless of the funding source, must be documented by the TCM provider in the beneficiary's TCM case file. Non-Medicaid funded services, such as food stamps, housing, etc., must be included in the overall TCM assessment and on the TCM service

plan. These type services that are not required on the waiver plan of care may be implemented without prior approval by the DHHS RN.

D. If a temporary situation arises based on a filled position becoming temporarily vacant and the hiring of the position is in process, a case manager may exceed the maximum of 70 active cases for no more than 60 consecutive days. The maximum number of active cases during a temporary situation, as described above, may not exceed 90 Medicaid beneficiaries. If the TCM agency temporarily stops accepting referrals, written notification must be sent to the DHHS RN with an effective date. Once referrals are being accepted again, written notification must be sent to the DHHS RN with an effective date. This will ensure all TCM agencies are fairly represented and it will avoid unnecessary referrals, which would ultimately delay services being provided to the beneficiary.

213.000 Covered Case Management Services 3-1-08

The following provides examples of case management services that are covered by Arkansas Medicaid. The list includes but is not limited to:

A. Assessment of the eligible individual to determine service needs

This assessment process refers to assessing the individual's service needs to assist in accessing services that currently may or may not be in place. It does not refer to a medical assessment or replace any eligibility requirement for any Medicaid program.

B. Development or assisting in the development of an individualized care plan, specific to the beneficiary's needs

This is a service plan that meets the requirements of the TCM program. It does not replace any required plan of care or service plan for a Medicaid waiver program or any other Medicaid program.

C. Referral(s) to help the beneficiary obtain needed services

D. Monitoring and follow-up contacts

E. Scheduling appointments related to gaining access to medical, social, educational and other services appropriate to the beneficiary's needs

This includes, but is not limited to, medical appointments, transportation services and appointments with DHHS.

F. Face to face or telephone contacts with the beneficiary and/or other individuals for the purpose of assisting in the beneficiary's needs being met

1. Communications through FAX or email are covered when the purpose of the communication is to gather information from an individual other than the beneficiary AND the purpose of the communication meets the TCM service definition.
2. Billable communication is limited to time spent sending emails and/or faxes. Receiving faxes and/or emails is not a billable TCM service. Hard copies of emails and faxes must be maintained in the beneficiary's file for audit purposes by the Arkansas Medicaid Program or its representatives. Documentation must support all claims for Medicaid reimbursement, as is currently required by the Medicaid Program.
3. Communications through fax or email is not billable when communication is with the beneficiary.

G. Arranging for assistance to be provided to an applicant in completing the application for types of assistance

1. Case management does not cover completion of this type of paperwork by the case manager; however, it does allow the case manager to arrange for someone else to assist in this manner.

2. The time the case manager spends gathering information and documents required by the application for assistance is a covered TCM service.
3. Documentation in the case file must support all activities for which Medicaid is billed.

H. Conferencing with others, on behalf of the applicant, to assist in the application process for accessing services is covered

These type contacts must be documented.

I. Referral for energy assistance

J. Referral for legal assistance

K. Referral for emergency housing

214.000 Exclusions 3-1-08

Services that are not appropriate for targeted case management services and are not covered by the Arkansas Medicaid Program include, but are not limited to:

A. Targeted case management services provided to beneficiaries who are receiving case management services through the DDS Alternative Community Services (DDS ACS) Waiver Program

B. The actual **provision** of services or treatment Examples include, but are not limited to:

1. Training in daily living skills
2. Training in work skills, social skills and/or exercise
3. Grooming and other personal care services
4. Training in housekeeping, laundry, cooking
5. Transportation services (Arranging for transportation for a beneficiary is covered.)
6. Counseling and/or crisis intervention services
7. Contacts made by the TCM to vendors verifying that services or goods, such as wheelchairs, air conditioners, canes, commodities, etc. are available or ready for delivery
8. Delivery of services or goods, such as wheelchairs, air conditioners, canes commodities, etc.
9. Inspection of services or goods, such as wheelchairs, wheelchair ramps, air conditioners, installation of air conditioners, commodities, etc.

C. Services that go beyond assisting individuals in gaining access to needed services. Examples include, but are not limited to:

1. Supervisory activities, including supervisory duties required in other programs such as personal care and home health
2. Paying bills and/or balancing the beneficiary's checkbook
3. Completing and or delivering application forms, paper work, evaluations and reports: This exclusion includes completion of paperwork for any type of assistance, i.e., HEAP, food stamps, Medicaid and/or SSI.
4. Observing a beneficiary receiving a service, e.g., physical therapy, speech therapy, classroom instruction
5. Escorting beneficiaries to scheduled medical appointments
6. Attending meetings, conferences or court hearings to provide information regarding the beneficiary and/or the beneficiary's family
7. Home visits to observe the beneficiary and family's interactions or the condition of the home for child or adult protection purposes
8. Verifying Medicaid eligibility through telephone calls, AEVCS, or by any other means

9. Travel and/or waiting time
10. Administrative activities associated with Medicaid eligibility determination, application processing, and verification of status of pending application, telephone calls requesting information regarding steps in the application process

    Follow-up calls on pending applications are not a targeted case management function. These calls are not covered.
11. Attending meetings, hearings, appeals, conferences, and/or court hearings to provide information regarding the beneficiary and/or the beneficiary's family

    This includes staffing for personal care. Information shared between two departments of the same agency in order to best serve the beneficiary is the responsibility of the agency providing care. This service is not part of case management.
12. Nursing services, checking blood pressure, post operative care, etc. Case managers must refer a beneficiary to a home health agency or other appropriate agency for such care and monitoring.

    Time spent making a referral is covered.
13. Training, accessing resource information, any activity associated with gaining knowledge on community services available in the area of responsibility

    This is the responsibility of the TCM agency and the targeted case manager in order to successfully provide the TCM service.
14. Staffing meetings
15. Medicaid eligibility determinations, Medicaid intake processing, Medicaid preadmission screening for inpatient care, and prior authorization for Medicaid services and utilization review
16. Medicaid outreach (methods to inform or persuade beneficiaries or potential beneficiaries to enter into care through the Medicaid system
17. Client outreach in which a provider attempts to contact potential recipients of a service, including TCM

    The attempt to contact individuals who may or may not be eligible for case management services or other Medicaid services is not considered a coverable TCM service.

D. Case management services that duplicate services provided by public agencies or private entities under other program authorities for the same purpose.

   For example, targeted case management services provided to foster children duplicate services provided by a public agency and are therefore not covered.

E. Case management services that duplicate integral and inseparable parts of other Medicaid or Medicare services, e.g., Home Health, Rehabilitative Services for Persons with Mental Illness (RSPMI) and Children's Medical Services, when provided on the same date of service

F. Case management services provided to inpatients

   Discharge planning is a service required of physicians, other practitioners and inpatient facilities. Case management is not a covered service for any date the beneficiary is an inpatient of a facility or institution. These facilities include, but are not limited to, acute care hospitals, rehabilitative hospitals, inpatient psychiatric facilities, nursing homes and residential treatment facilities.

G. Case management services provided while transporting a beneficiary

A physician must prescribe all services provided by an enrolled targeted case management provider. However, the physician is not medically responsible for the services and does not supervise the TCM provider or the service provider.

Targeted case management services for beneficiaries under age twenty-one (21) who are not eligible for DDS must be prescribed as a result of a Child Health Services/EPSDT screen. The prescription must be renewed within the applicable periodicity schedule, not to exceed a maximum of twelve (12) months. The original and all subsequent renewed prescriptions must be signed and dated by the physician (no stamped signatures will be accepted) and must be filed and retained by the targeted case manager in the beneficiary's record. Obtaining the physician's orders and prescriptions is not a covered TCM service.

Targeted case management services for all other target groups must be prescribed after the physician examines the beneficiary. The prescription must be renewed every 12 months. The initial and all subsequent renewed or revised prescriptions must be signed and dated by the physician (no stamped signature will be accepted) and must be filed and retained by the targeted case manager in the beneficiary's record. It is the responsibility of the TCM provider to ensure the MD order for TCM services is complete, signed and dated.

If a beneficiary is required to participate in the ConnectCare Primary Care Case Management (PCCM) Program, the beneficiary's PCP must write the prescription for targeted case management services after the physician has examined the beneficiary. Additional information regarding the PCP Program may be found in section I.

216.000 Documentation in Beneficiary Files 3-1-08

The targeted case manager must develop and maintain sufficient written documentation to support each service for which billing is made. Written description of services provided must emphasize how the goals and objectives of the service plan are being met or are not being met. All entries in a beneficiary's file must be signed and dated by the targeted case manager who provided the service, along with the individual's title. The documentation must be kept in the beneficiary's case file.

Documentation must consist of, at a minimum, material that includes:

A. The prescription for targeted case management services

B. The dates of the Child Health Services/EPSDT screens for beneficiaries under the age of twenty-one (21) ineligible for DDS ACS waiver services

C. When applicable, a copy of the original and all updates of the beneficiary's individualized education plan (IEP)

D. The specific services rendered

E. The type of service rendered: assessment, service management and/or monitoring

F. The type of contact: face to face or telephone

G. The date and actual clock time for the service rendered

This must include the start time and the stop time for each TCM service.

H. The beneficiary's name and Medicaid number

I. The name of the provider agency, if applicable, and person providing the service

The targeted case manager providing the service must initial each entry in the case file. If the process is automated and all records are computerized, no signature is required. However, there must be an agreement or process in place showing the responsible party for each entry.

J. The place of service (Where the service took place: e.g. office, home)

K. The number of units billed

L. Updates describing the nature and extent of the referral for services delivered

M. For non-DDS ACS beneficiaries under the age of twenty-one (21), a copy of the original and all updates, of the beneficiary's service plan

N. DDS beneficiary's certification of eligibility for DDS services

O. Description of how TCM and other in-home services are meeting beneficiary's needs

P. Progress notes on beneficiary's conditions, whether deteriorating or improving and the reasons for the change

1. While the targeted case manager may not be considered a medical professional, progress notes are intended to describe a beneficiary's overall condition, including any changes since the last contact, the reason for the change, etc.

2. This requirement is not asking the targeted case manager to diagnose, treat, or offer medical opinions. However, the targeted case manager must record information provided by the beneficiary or others on behalf of the beneficiary that pertains to the service plan goals and progress toward those goals.

Q. Process for tracking the date the beneficiary is due for reevaluation by the Division of County Operations

The tracking is to avoid a beneficiary's case from being closed unnecessarily.

1. The TCM agency may establish a tickler system that meets the requirements of the TCM program.

2. The Medicaid Program has not established a specific tickler system that must be uniformly used by all providers.

R. Documentation, as described above, is required each time a TCM function is provided for which Medicaid reimbursement will be requested

217.000 Record Keeping Requirements 3-1-08

DHHS requires retention of all records for five (5) years. All medical records shall be completed promptly, filed and retained for a minimum of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish records upon request may result in sanctions being imposed.

A. The provider must contemporaneously create and maintain records that completely and accurately explain all evaluations, care diagnoses and any other activities of the provider in connection with any Medicaid beneficiary.

B. Providers furnishing TCM services must have a written prescription signed by a physician ordering TCM services. When verbal orders are received, a written prescription must be obtained within fourteen (14) business days of the date the prescription is written or received through verbal order.

C. The provider must maintain a copy of each relevant prescription in the Medicaid beneficiary's records and follow all prescriptions and care plans.

D. TCM providers must maintain TCM prescriptions and care plans. This does not require the TCM provider to maintain a copy of all prescriptions and care plans that may have been developed by other Medicaid programs, such as DME, Home Health, etc.

E. Providers must adhere to all applicable professional standards of care and conduct.

F. The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary.

1. All documentation must be available at the provider's place of business.

2. When records are stored off-premise or are in active use, the provider may certify, in writing, that the records in question are in active use or in off-premise storage and set a date and hour within three (3) working days, at which time the records will be made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.
3. If an audit determines that recoupment is necessary, there will be no more than thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted.

217.100 Requirements for Time Records and the Tickler System 3-1-08

Each TCM must maintain a tickler system for tracking purposes.

A. The tickler system must track and notify of the following activities:

1. Each active TCM beneficiary
2. Expiration date of any Medicaid waiver plan of care applicable to a given beneficiary
3. Medicaid eligibility date
4. The beneficiary's case reevaluation date, as established by DHHS, Division of County Operations

B. It is the responsibility of the case manager to maintain a tickler system, as described above, for those beneficiaries in their specific caseload. However, the record keeping requirements and documentation requirements must be maintained in the beneficiary's file.

218.000 Description of Services 3-1-08

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

218.100 Assessment/Service Plan Development 3-1-08

This component is an annual face-to-face contact with the beneficiary and contact with other professionals, caregivers or other parties on behalf of the beneficiary. Assessment is performed for the purpose of collecting information about the beneficiary's situation and functioning and to determine and identify the beneficiary's problems and needs.

The maximum units allowed for this service may not exceed twelve (12) units per assessment/service plan visit when providers are dealing with beneficiaries age 21 and over.

This component includes activities that focus on needs identification. Activities, at a minimum, include:

A. The assessment of an eligible beneficiary to determine the need for any medical, educational, social and other services. Specific assessment activities include:

1. Taking beneficiary history
2. Identifying the needs of the beneficiary
3. Completing related documentation
4. Gathering information from other sources, such as family members, medical providers and educators, if necessary, to form a complete assessment of the Medicaid eligible beneficiary

B. An assessment may be completed between annual assessments, if the TCM deems it necessary.

1. Documentation in the beneficiary's case file must support the assessment, such as life-changing diagnoses, major changes in circumstances, death of a spouse, change in primary caregiver, etc.
2. Any time an assessment is completed, the circumstances resulting in a new assessment rather than a monitoring visit must be documented and must support the activity billed to Medicaid.
3. **For beneficiaries age twenty two and older, reassessments performed between annual assessment visits are limited to eight (8) units per reassessment.** Documentation in the beneficiary's case file must support the reassessment, such as a life-changing diagnosis, major changes in circumstances, death of a spouse, change in a primary caregiver, etc. Any time an assessment is completed, the circumstances resulting in a new assessment rather than a monitoring visit must be documented and must support the activity billed to Medicaid.

C. Service plan development builds on the information collected through the assessment phase and includes ensuring the active participation of the Medicaid-eligible beneficiary. The goals and actions in the care plan must address medical, social, education, and other services needed by the Medicaid-eligible beneficiary. Service plans must:

1. Be specific and explain each service needed by the beneficiary
2. Include all services, regardless of payment source
3. Include support services available to the beneficiary from family, community, church or other support systems and what needs are met by these resources
4. Identify immediate, short term and long term ongoing needs as well as how these needs/goals will be met
5. Assess the beneficiary's individualized need for services and identify each service to be provided along with goals

D. The assessment and the service plan may be accomplished at the same time, during the same visit, or separately.

1. However, for the assessment and the service plan for beneficiaries age 21 and over, **the total time in completing the assessment and developing the service plan may not exceed 12 units per beneficiary, regardless of whether the two are completed on the same date of service or different dates of service.**
2. **For beneficiaries age 21 and over, the total time spent on the assessment and service plan development process may not exceed 12 units.**

NOTE: Annual reassessments and service plan development are allowed, in fact, encouraged. This policy does not prohibit annual reassessments and service plan development. Reassessments may be conducted any time the case manager deems it appropriate, however, when reassessments are performed more frequently than annually, justification for conducting a full reassessment, rather than a monitoring visit, must be included in the documentation contained in the case record.

218.200 Service Management/Referral and Linkage 3-1-08

This component includes activities that help link Medicaid eligible beneficiaries with medical, social, educational providers and/or other programs and services that are capable of providing needed services. For example, making referrals to providers for needed services and scheduling appointments may be considered case management. This component details:

A. Functions and processes that include contacting service providers selected by the beneficiary and negotiation for the delivery of services identified in the service plan. Contacts with the beneficiary and/or professionals, caregivers or other parties on behalf of the beneficiary may be a part of service management.

B. For beneficiaries age 60 and over, the transfer of information to the DHHS RN via the AAS-9511, AAS-9510, or other communication form is not a covered service.

This activity is required but it is considered administrative paperwork and is not a billable TCM activity.

See section 262.100 for the appropriate procedure code.

218.300 Service Monitoring/Service Plan Updating 3-1-08

This component includes activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the Medicaid-eligible beneficiary.

The maximum units allowed for this service may not exceed four (4) units per monitoring visit when providers are dealing with beneficiaries age 21 and over.

A. The activities and contacts may be with the Medicaid-eligible beneficiary, family members, providers or other entities.

B. They may be as frequent as necessary, within established Medicaid maximum allowable limitations, to help determine such things as:

1. Whether services are being furnished in accordance with a Medicaid eligible beneficiary's plan of care
2. The adequacy of the services in the plan of care
3. Changes in the needs or status of the Medicaid-eligible beneficiary

C. Monitoring is allowed through regular contacts with service providers at least every other month to verify that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contacts with the beneficiary, at least monthly, that the beneficiary continues to participate in the service plan and is satisfied with services.

1. A face to face monitoring contact with the beneficiary must be completed once every three months. Required contacts with the service providers may be conducted through face to face contact or by telephone. Communication with service providers by email or fax are allowed as described in section 213.000, F.1.
2. A contact is not considered a covered monitoring contact unless the required monitoring form is completed, dated, signed by the targeted case manager, and filed in the beneficiary's case file.

D. Updating includes:

1. Reexamining the beneficiary's needs
2. Identifying changes that have occurred since the previous assessment
3. Altering the service plan
4. Measuring the beneficiary's progress toward service plan goals. Service plans should not be updated more than quarterly unless there is a significant change in the beneficiary's needs.

E. Non-Covered Services include:

1. The updating of a tickler system
2. A case management agency is not allowed to monitor or update an activity when the service being monitored or updated is provided to the beneficiary by the same agency.
3. However, the same agency is allowed to be both the TCM agency and the agency providing a direct service, such as personal care, home delivered meals, or PERS.

4. However, the agency is not allowed to bill for a TCM monitoring contact when monitoring the **quality of care or the quality of the service** provided by the same agency or when the purpose of the contact is to monitor the progress of a service being in place, delivered, having started, effective date, etc.
5. In addition, TCM is not allowed when monitoring is required through the direct service policy, such as with PERS providers.
6. Monitoring the PERS service is a part of the certification policy for all PERS providers. Additional monitoring of the PERS service by a TCM is not a covered TCM service.

F. Examples of case monitoring and service plan updating are shown below:

1. Example # 1

   Provider "A" has been chosen by the beneficiary to provide home delivered meals. The beneficiary has also chosen provider "A" for case management services. Case management by provider "A" may not be billed for any activity associated with the provision of home delivered meals. It is the responsibility of the direct service provider to ensure quality services are provided. In this example, the home delivered meal provider is responsible for ensuring meals are delivered timely and to the beneficiary's satisfaction. Case management activity does not include monitoring the provision of home delivered meals by the same agency.

   This same policy applies to any service where the case management agency is the same agency providing the in-home service.

2. Example # 2

   Provider "B" has been chosen by the beneficiary to provide personal care. The beneficiary has also chosen provider "B" for targeted case management services. Case management by provider "B" may not be billed for any activity associated with the quality of the personal care services being provided by the same agency. It is the responsibility of the direct service provider to ensure quality services are provided.

   In this example, the personal care provider is responsible for ensuring personal care services are provided to the satisfaction of the beneficiary and according to the plan of care (POC) that includes the personal care service. This includes whether or not the aide performs the duties assigned, arrives timely, stays the assigned period of time, is courteous and meets the requirements established for the Personal Care Program by the Arkansas Medicaid Program.

G. A TCM provider is allowed to bill a monitoring contact when the monitoring is for the purpose of verifying the services included on the POC are sufficient based on the beneficiary's current condition. This is also true when the case manager is contacted by the beneficiary.

1. If the monitoring contact is billed, based on this purpose, documentation must support the reason for the contact, the results of the contact and any changes requested to the POC.
   a. NOTE: This type activity, when based on the beneficiary's condition and the sufficiency of the services in place, may be billed regardless of whether or not the case manager and the direct service provider are the same agency.
   b. If the monitoring contact, whether initiated by the case manager or the beneficiary, is not addressing **quality of care**, the monitoring contact is billable, if it meets the definition described in this manual.
2. The same policy applies to the personal emergency response system (PERS) service. The TCM provider may test the PERS unit when completing a monitoring visit, if the PERS unit is not provided by the same agency as the TCM service.
   a. Since the PERS providers are required to test their units monthly, if they

choose to meet that requirement by having their targeted case managers test the units while in the home, this is not considered a covered service.

b. It does, however, meet the requirement established for the PERS providers, if results of the testing are documented by the PERS provider and available for audit.

H. All requests from case managers to increase or decrease services or change service providers will be verified by the DHHS RN and justified by the DHHS RN prior to any changes being made to the waiver plan of care. This applies when the beneficiary is a participant in a home and community based waiver program.

See section 262.100 for the appropriate procedure code and modifier.

219.000 Contacts with Non-Eligible or Non-Targeted Individuals 3-1-08

Contacts with non-Medicaid eligible individuals outside the TCM targeted group are allowed when the purpose of the contact is directly related to the management of the eligible individual's care. It may be appropriate to have family members involved in all components related to the beneficiary's case management because they may be able to help identify needs and supports, assist the eligible individual to obtain services, provide case workers with useful feedback and alert them to changes.

Contacts with non-Medicaid eligible individuals or individuals outside the TCM targeted group are not allowed when the case management is being provided to an individual not eligible for Medicaid TCM as described in this provider manual.

220.000 Benefit Limits 3-1-08

Based on the state fiscal year (SFY) July through June, beneficiaries age twenty-one (21) and older are limited to one hundred four (104) hours (416 units) of targeted case management services per year.

Regardless of the overall SFY benefit limit, each waiver plan of care must specify the number of units being authorized and documentation must reflect how those units are utilized. Utilization must be reasonable, documented, and justified in the case record, based on the beneficiary's overall medical condition, support services available to the beneficiary, and in-home services currently in place.

If a TCM beneficiary is also a home and community based waiver beneficiary, such as ElderChoices, the waiver plan of care supersedes any other plan of care. Therefore, the number of units authorized on the waiver plan of care may not be exceeded unless prior approved by the DHHS RN. **Approval will not be granted after the services are already provided**.

For audit purposes, the authorization must be in writing, placed in the beneficiary's file, and available for auditors.

241.000 Individuals Exempt from Prior Authorization (PA) 3-1-08

Prior authorization (PA) is not applicable for targeted case management (TCM) services for those beneficiaries who are twenty-one (21) years of age and older, who have been diagnosed with a developmental disability, nor for beneficiaries sixty (60) years of age and older (ElderChoices Program).

242.000 Prior Authorization and Documentation Requirements for Medicaid Eligible Beneficiaries Under Age 21 3-1-08

Prior authorization for TCM services for Medicaid eligible beneficiaries under age twenty-one (21) is required.

The Arkansas Foundation for Medical Care, Inc., (AFMC) must approve all requests for prior authorization for targeted case management services for Medicaid eligible beneficiaries under age 21.

The following information **must** be submitted to AFMC for Child Health Services (EPSDT) beneficiaries and for DDS eligible beneficiaries under the age of 21:

A. Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21 - form DMS-601. **View or print form DMS-601.**

B. Prescription or Arkansas Medicaid Primary Care Physician Managed Care Program Referral Form (DMS-2610) signed by the beneficiary's PCP and written within the last sixty (60) days **View or print form DMS-2610**.

C. Service Plan

D. For DDS eligible beneficiaries under age 21, forms DDS/FS #0001a and DDS/FS #0009 completed by the DDS service coordinator or an authorized Licensed Community Program staff person

E. For Child Health Services (EPSDT) beneficiaries under age 21, medical documentation substantiating the diagnosis, must accompany the DMS-601, the prescription and the service plan **View or print form DMS-601**.

F. Applications completed by a targeted case manager for all siblings under age 21 in a family group must be submitted to AFMC on the same date

NOTE: A family group should be managed by only one case manager for any targeted case management service.

The PA request and documentation must be submitted by mail or fax to Arkansas Foundation for Medical Care, Inc., (AFMC). **View or print AFMC contact information**.

242.100 Prior Authorization Request for Targeted Case Management for Medicaid Eligible Beneficiaries Under Age 21 3-1-08

Requests for prior authorization must be submitted to the Arkansas Foundation for Medical Care Inc., (AFMC) using Form DMS-601 titled **Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21**. **View or print form DMS-601.** Requests may be submitted to AFMC via mail, facsimile, UPS or FedEx. The documentation submitted with the prior authorization request must support the medical necessity of the requested services.

A medical necessity determination will be made within fifteen (15) working days of receipt of a completed prior authorization request. For prior authorization requests meeting the medical necessity requirements, AFMC will issue an authorization number designation, the length of services, procedure codes and units approved for the requesting provider. For denied requests, a letter containing case specific rationale that explains why the request was not approved will be mailed to the requesting provider and to the Medicaid beneficiary.

242.330 Provider Initiated Reconsideration of Denied Prior Authorization Determinations 3-1-08

The provider may request reconsideration of the denial within thirty–five (35) calendar days of the denial date. Requests must be made in writing and include additional documentation to substantiate the medical necessity or program criteria of the requested services. Reconsideration is available only once per prior authorization request. **A subsequent prior authorization request will not be reviewed if it contains the same documentation submitted with the previous authorization and reconsideration requests.**

If the decision is reversed during the reconsideration review, an approval is forwarded to all relevant parties specifying approved units and services. When the denial is upheld, AFMC will notify the provider and the Medicaid beneficiary in writing of the review determinations.

242.340 Appeal Process for Medicaid Beneficiaries 3-1-08

When an adverse decision is received from AFMC, the beneficiary may request a fair hearing of the reconsideration decision regarding the denial of services from the Department of Health and Human Services (DHHS).

The appeal request must be made in writing and received by the Appeals and Hearings Section of the Department of Health and Human Services within thirty (30) days of the date on the letter from AFMC explaining the denial. Appeal requests must be submitted to the Department of Health and Human Services Appeals and Hearing Section. **View or print the DHHS Appeals and Hearing Section contact information.**

250.000 REIMBURSEMENT

250.100 Method of Reimbursement 3-1-08

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time the service is provided and upon accurate completeness of the claim filed for the service. The provider is responsible for verifying the beneficiary is eligible for Medicaid prior to rendering services.

Targeted case management services must be billed on a per unit basis, as reflected in a daily total, per beneficiary, per TCM service. One unit equals 15 minutes.

One (1) unit = 5 - 15 minutes
Two (2) units = 16 - 30 minutes
Three (3) units = 31 - 45 minutes
Four (4) units = 46 - 60 minutes

Providers must accumulatively bill for a single date of service. Providers are not allowed accumulatively bill for spanning dates of service. For example, a targeted case manager may make several referrals on behalf of a beneficiary on Monday and then again on Tuesday. The targeted case manager is allowed to bill for the total amount of time spent on Monday and the total amount of time spent on Tuesday, but is not allowed to bill for the total amount of time spent both days as a single date of service.

All billing must reflect a daily total, per TCM service, base on the established procedure codes. No rounding is allowed.

A. **Example 1**:

Case management documents reflect:

10:00 a.m. to 10:02 a.m.: Scheduled food stamp appointment and reviewed list of required information with the county eligibility worker. (Referral and Linkage)

11:00 a.m. to 11:06 a.m.: Contacted beneficiary's daughter and verified hospitalization dates of service and discussed any change in beneficiary's condition and any additional services needed. (Service Monitoring)

1:30 p.m. to 1:36 p.m.: Called DHHS RN and reported hospitalization of client and conversation with client's daughter (also sent 9511).

TOTAL BILLING: 6 minutes (1 unit) (CALL TO DHHS RN AND PAPERWORK IS NOT BILLABLE. Two minute Referral and Linkage does not equal a unit, therefore, is not billable.)

B. **Example 2:**

Case management documentation reflects:

8:30 a.m. to 8:36 a.m.: Contacted beneficiary and discussed need for diapers and durable medical equipment, as requested by DHHS RN. Also scheduled home visit. (Monitoring)

10:00 a.m. to 10:02 a.m.: Scheduled transportation for eligible client. (Referral and Linkage)

10:30 a.m. to 11:00 a.m.: Delivered diapers and 3 pronged cane to eligible client.

TOTAL BILLING: 6 minutes (1 unit). (DELIVERY OF DIAPERS AND CANE IS NOT BILLABLE. Two minute Referral and Linkage does not equal a unit and is not billable.)

C. Example 3:

8:15 a.m. to 8:20 a.m.: Telephone call to DHHS County Office to verify status of pending food stamp application.

9:00 a.m. to 9:06 a.m.: Telephone call to applicant to report information regarding pending application.

9:15 a.m. to 9:16 a.m.: Telephone call to city staff to see if commodities were in and ready for distribution.

9:50 a.m. to 10:30 a.m.: Took client to grocery store and to pick up commodities.

TOTAL BILLING: 0 minutes. No activity is a covered TCM service.

262.100 Targeted Case Management Procedure Codes 3-1-08

The procedure code in this section must be billed either electronically or on paper with the proper modifier indicated. Prior authorization is required when billing for beneficiaries under age 21. There are benefit limits for TCM services for beneficiaries age 21 and over. See section 242.000 for prior authorization requirements and section 220.000 for information about benefit limits.

The column labeled All, U21 and 21+ indicates that the procedure code or the procedure code along with a particular modifier must be used when billing for all ages, for beneficiaries under age 21 or for those age 21 and over.

The following procedure codes and modifiers must be used to bill for targeted case management services:

⁂ (…) This symbol, along with text in parenthesis, indicates the Arkansas Medicaid description of the service.

National Code	Modifier	All U21 21+	Local Code Description
T1017		U21	⁂ (Assessment/Service Plan Development)
T1017	U2	21+	⁂ (Assessment/Service Plan Development)
T1017	U4	All	⁂ (Service Management/Referral and Linkage)
T1017	U1	U21	⁂ (Service Monitoring/Service Plan Updating)
T1017	U3	21+	⁂ (Service Monitoring/Service Plan Updating)