KANSAS MEDICAL ASSISTANCE PROGRAM
Fee-for-Service Provider Manual

Targeted Case Management
Mental Health

Updated 08.2015
Part II
TARGETED CASE MANAGEMENT-MENTAL HEALTH
FEE-FOR-SERVICE PROVIDER MANUAL

Introduction

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Forms
All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

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Targeted case management (TCM) mental health (MH) is designed to provide services to assist Medicaid beneficiaries with severe and persistent mental illness (adults) or serious emotional disturbance (youth) in resolving or minimizing the effects of the mental and emotional impairment for which clinical and/or hospital services have previously been provided. This service is provided under a treatment plan approved by the psychiatrist or physician skilled in the treatment of mental disorders. The goal is to enhance independent functioning through which the beneficiary is integrated into and/or maintained within the community, so that institutionalization is not as likely or frequent.

This goal-directed service is for adults with severe and persistent mental illness or children with severe emotional disturbance through which the beneficiary is assisted in obtaining access to needed medical, social, educational, and other services. All interventions provided shall be related to specific goals set forth in the beneficiary’s treatment plan. Documentation in progress notes is required for each billed service.

**Enrollment**
All providers must enroll in the Kansas Medical Assistance Program (KMAP) and receive a provider number for TCM-MH services. Reference the Provider page of the KMAP website or contact EDS Provider Enrollment by phone at 785-274-5914 for more information.

**HIPAA Compliance**
As a KMAP participant, providers are required to comply with compliance reviews and complaint investigations conducted by the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation.

**Access to Records**
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. Providers must also supply records to the Department of Health and Human Services upon request.

The provider is required to supply records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's office upon request from such office as required by the Kansas Medicaid Fraud Control Act, K.S.A. 21-3844 to 21-3855, inclusive, as amended.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review, or investigation, including the relevant questioning of the provider’s employees. The provider shall not charge a fee to retrieve and copy documents and records related to compliance reviews and complaint investigations.
TARGETED CASE MANAGEMENT-MENTAL HEALTH
BILLING INSTRUCTIONS

7000. Updated 08/15

Introduction to the CMS 1500

Providers must use the CMS 1500 paper or equivalent electronic claim form (unless submitting electronically) when requesting payment for medical services provided under KMAP. Claims can be submitted on the KMAP secure website or billed through Provider Electronic Solutions (PES). When a paper form is required, it must be submitted on an original red claim form and completed as indicated. Any CMS 1500 claim form not submitted on the red claim form will be returned to the provider.

An example of the CMS-1500 and instructions are available on the KMAP public and secure websites on the Forms page under the Claims (Sample Forms and Instructions) heading. A claim form is in the Forms section at the end of this manual.

Any of the following billing errors may cause a CMS 1500 claim to deny or be sent back to the provider:

- The Kansas MMIS uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized unless submitted in the correct fields as instructed. Claim information must be submitted in the correct fields as instructed.
- Staples on the claim form.
- A CMS 1500 claim form carbon copy.

The fiscal agent does not furnish the CMS 1500 claim form to providers. Refer to Section 1100 of the General Introduction Provider Manual.

Complete, line-by-line instructions for completion of the CMS-1500 are available in the General Billing Provider Manual.

Submission of Claim

Send completed first page of each claim and any necessary attachments to:
Kansas Medical Assistance Program
Office of the Fiscal Agent
PO Box 3571
Topeka, KS 66601-3571
Enter procedure code **T1017** (Targeted Case Management, per 15 minutes) in field 24D of the CMS 1500.

One unit = 15 minutes
BENEFITS AND LIMITATIONS

8100. COPAYMENT  Updated 08/15

TCM-MH services are exempt from copayment requirements.
BENEFITS AND LIMITATIONS

8300. BENEFIT PLANS  Updated 08/15

KMAP beneficiaries are assigned to one or more KMAP benefit plans. These benefit plans entitle the beneficiary to certain services. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the *General Benefits Fee-for-Service Provider Manual* for information on the plastic State of Kansas Medical Card and eligibility verification.
Targeted Case Management

Targeted case management services are defined as those services which will assist the beneficiary in gaining access to medical, social, educational, and other needed services. Targeted case management includes any or all of the following services:

Assessment of an eligible beneficiary to determine service needs by:
- Taking the beneficiary’s history
- Identifying the beneficiary’s needs and completing the related documentation
- Gathering information, if necessary, from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the beneficiary

Development of a specific support/care plan that:
- Is based on the information collected through the assessment
- Specifies the goals and actions necessary to address the medical, social, educational, and other service needs of the beneficiary
- Includes activities that ensure the active participation of the beneficiary
- Works with the beneficiary (or the beneficiary’s legal representative) and others to develop goals and identify a course of action to respond to the assessed needs of the beneficiary
- Involves treatment planning with beneficiaries, families, and natural supports, which includes:
  - Documentation of the individualized treatment plan
  - Development of goals and objectives based on a strengths assessment
  - Monitoring of the plan to ensure it meets the beneficiary’s needs
  - Modifications to the plan when service changes are identified

Referral and related activities that help the beneficiary obtain needed services, including:
- Activities that help link the beneficiary with medical, social, and educational providers
- Other programs and services that are capable of providing needed services:
  - Referrals to providers
  - Scheduling appointments for the beneficiary
  - Collateral contacts: phone and written correspondence, as well as face-to-face contacts with other social service agencies, schools, housing and employment resources, and medical services
  - Access to supports: assist beneficiaries in obtaining access to needed medical, social, educational, and other services. In addition, the service would assist with applications for benefits and arrange transportation to needed services
  - Coordination for youth: coordination of services and supports identified in a beneficiary’s wraparound plan which has as its objective the assurance of an integrated, comprehensive plan of supports and services which includes family members, natural supports, and relevant community providers/stakeholders
Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is implemented and adequately addresses the beneficiary’s needs. Related activities may involve the beneficiary, family members, providers, or other entities and are conducted as frequently as necessary to determine whether:

- Services are being furnished in accordance with the beneficiary’s care plan
- Services in the care plan are adequate
- There are changes in the needs or status of the beneficiary and, if so, making necessary adjustments in the care plan and service arrangements with the providers

Provider Qualifications

- Have at least a B.A. or B.S. degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education, with one year of experience substituting for one year of education.
- Possess demonstrated interpersonal skills, ability to work with persons with severe and persistent mental illness and/or severe emotional disturbance, and ability to react effectively in a wide variety of human service situations.
- Meet the specifications outlined in the State of Kansas Department for Children and Families (DCF) of Social and Rehabilitation Services licensing standards in regard to any ongoing requirements, including completion of training requirements according to a curriculum approved by the state.
- Pass Kansas Bureau of Investigation, DCF—Department of Social and Rehabilitation Services child abuse check, adult abuse registry, and motor vehicle screens.
- Receive regularly scheduled clinical supervision from a person meeting the qualifications of a qualified mental health professional or a licensed mental health practitioner approved by the state or its designee with experience regarding this specialized mental health service.

Limitations

Caseload size must be based on the needs of beneficiaries and their families with an emphasis on successful outcomes and beneficiary satisfaction. The needs identified in the individualized treatment plan must be met. The following general ratio should serve as a guide: one full-time equivalent to 35 beneficiaries.

Individuals who provide TCM services to a beneficiary may not provide other direct services to that beneficiary.