

SECTION II - TARGETED CASE MANAGEMENT

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200.000 TARGETED CASE MANAGEMENT GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Providers of Targeted Case Management 11-1-09

Targeted case management (TCM) services providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual to be eligible to participate in the Arkansas Medicaid Program:

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

NOTE: Individual employees of the Department of Human Services (DHS) are excluded from enrolling as Medicaid providers for the Targeted Case Management Program.

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/EPSTD 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.

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** **11-1-09**

Group providers of Targeted Case Management must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

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

- A. Each individual case manager within the group must enroll following the criteria established in Sections 201.000 and 201.100.
- B. All group providers are "pay to" providers only. The service must be performed and billed by a Medicaid-enrolled case manager within 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.

202.100 **Participation Requirements for Group Providers of Targeted Case Management for Beneficiaries Age Twenty-One (21) and Younger Eligible for DDS** **11-1-09**

Group providers of Targeted Case Management must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

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

- A. Each individual case manager within the group must enroll following the criteria established in Sections 201.000 and 202.000.
- B. All group providers are "pay to" providers only. The service must be performed and billed by a Medicaid-enrolled case manager within 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.

204.000 **Participation Requirements for Providers of Targeted Case Management for Beneficiaries Ages Sixty (60) and Older Including ARChoices in Homecare Waiver Participants** **7-1-20**

Providers of targeted case management who are restricted to serving persons sixty (60) years of age and older or serving persons ages twenty-one (21) and older with a physical disability and those sixty-five (65) and older who participate in the ARChoices in Homecare (ARChoices) 1915(c) waiver must be certified by the Division of Provider Services and Quality Assurance (DPSQA) as an organization qualified to provide targeted case management services.

In order to be certified by DPSQA, the provider must meet the following qualifications:

- A. Be located in the state of Arkansas;
- B. Be licensed as a Class A or Class B Home Health Agency or Private Care Agency by the Arkansas Department of Health or a unit of state government or be a private or public incorporated agency whose stated purpose is to provide case management to the elderly or adults with physical disabilities;
- C. Be able to demonstrate one year of experience in performing case management services. (Experience must be within the past three (3) years);
- D. Be able to demonstrate one year of experience in working specifically with individuals in the targeted group. (Experience must be within the past three (3) years);
- E. Have an administrative capacity to ensure quality of services in accordance with state and federal requirements;
- F. Have the financial management capacity and system that provides documentation of services and costs;
- G. Have the capacity to document and maintain individual case records in accordance with state and federal requirements;
- H. Be able to demonstrate that the provider has current liability coverage; and
- I. Employ qualified case managers who reside in or near the area of responsibility and who meet at least one of the following qualifications:
 - 1. Licensed in the state of Arkansas as a social worker (Licensed Master Social Worker or Licensed Certified Social Worker), a registered nurse or a licensed practical nurse;
 - 2. Have a bachelor's degree from an accredited institution in a health and human services or related field; or
 - 3. Have two years' experience in the delivery of human services, including without limitation having performed satisfactorily as a case manager for a period of two (2) years (experience must be within the past three (3) years).

A copy of the current certification must accompany the provider application and Medicaid contract.

205.000 Targeted Case Management Providers in Bordering and Non-Bordering States 10-13-03

The Arkansas Medicaid Targeted Case Management Program is limited to in-state providers only.

206.000 The Role of the Child Health Services (EPSDT) Program 10-13-03

The Child Health Services (EPSDT) program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth up to their 21st birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with screening, diagnostic and treatment services delivered on a periodic basis.

- A. Early and periodic screening and diagnosis and treatment (EPSDT) is a health care program designed for:
 - 1. health evaluations as soon after birth as possible and repeated at regular recommended times,
 - 2. detection of physical or developmental health problems and
 - 3. health care, treatment and other measures to correct or improve any defects or chronic conditions discovered.
- B. Child Health Services (EPSDT) providers are encouraged to refer to the EPSDT provider manual for additional information.

210.000 PROGRAM COVERAGE

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 Ages Twenty-One (21) and Younger Who Are Not Receiving DDS ACS Waiver Services 1-1-16

This target population consists of beneficiaries who are ages 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;
- D. Are diagnosed with a developmental disability attributable to an intellectual disability, cerebral palsy, spina bifida, Down syndrome, epilepsy, autism or any other medical condition considered to be closely related to an intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with an intellectual disability or requires treatment and services similar to those required for such persons; and
- E. Are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

212.200 Beneficiaries Ages Twenty-One (21) and Younger Eligible for Developmental Disabilities Services 1-1-16

This target population consists of beneficiaries who are ages 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 an intellectual disability, cerebral palsy, spina bifida, Down syndrome, epilepsy, autism or any other medical condition considered closely related to an intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with an intellectual disability 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 DHS county office.

212.300 **Beneficiaries Ages Twenty-Two (22) and Older with a** **1-1-16**
Developmental Disability Who Are Not Receiving DDS ACS Waiver
Services

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

- A. Diagnosed as having a developmental disability of an intellectual disability, cerebral palsy, spina bifida, Down syndrome, epilepsy, autism or any other condition of a person found to be closely related to an intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with an intellectual disability 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 Ages Sixty (60) and Older including ARChoices in** **1-1-16**
Homecare Waiver Participants

This target population consists of beneficiaries ages sixty (60) and older as well as beneficiaries ages twenty-one (21) and older with a physical disability or ages sixty-five (65) and older who participate in the ARChoices waiver 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 Participants Ages Sixty (60) and Older and including** **1-1-16**
ARChoices in Homecare Waiver Participants Case Management
Providers

- A. A plan of care developed by the DAAS RN for the ARChoices in Homecare (ARChoices) Program replaces any other plan of care. The ARChoices plan of care must include all appropriate ARChoices services and certain non-waiver services appropriate for the beneficiary.
- B. If services are currently provided to an ARChoices client, the provider must report these services to the DAAS RN. Before beginning or revising services to an ARChoices client, the DAAS 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 DAAS RN immediately. Certain services provided to an ARChoices client that are not included in the plan of care may be subject to recoupment by the Medicaid Program.
- C. An ARChoices plan of care may not be revised by anyone other than the DAAS 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 DAAS 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 90 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 110 Medicaid beneficiaries. If the TCM agency temporarily stops accepting referrals, written notification must be sent to the DAAS RN with an effective date. Once referrals are being accepted

again, written notification must be sent to the DAAS 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**10-1-12**

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 DHS.

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. Assisting in or arranging for assistance in the completion of an application for types of assistance

1. The time the case manager spends gathering information and documents required by the application for assistance is a covered TCM service.
2. 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**10-1-12**

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. Delivering application forms, paper work, evaluations and reports.
 - 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 beneficiaries 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

215.000

Physician's Role

1-1-16

A physician must prescribe all services provided by an enrolled targeted case management provider unless the participant is in the ARChoices waiver and the service is authorized by the

DAAS RN. 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.

NOTE: As stated in this manual, an ARChoices in Homecare (ARChoices) waiver plan of care developed by the DAAS RN for the ARChoices Program replaces any other plan of care. The ARChoices plan of care must include all appropriate ARChoices services and certain non-waiver services appropriate for the beneficiary. This most often includes Targeted Case Management. The service providers and the ARChoices beneficiary must review and follow the signed authorized plan of care. Each service included on the ARChoices plan of care must be justified by the DAAS RN. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary and other factors deemed appropriate by the DAAS RN.

For ARChoices participants whose waiver plan of care includes TCM at the time the DAAS RN signs the plan of care, the ARChoices plan of care, signed by a DAAS RN, will serve as the authorization for TCM services for one year from the date of the DAAS RN's signature. No additional TCM order signed by a physician is required.

216.000 Documentation in Beneficiary Files

10-1-12

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. Time spent recording required documentation is a billable TCM service.

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

217.000 Reserved 11-1-09

217.100 Requirements for Time Records and the Tickler System 10-1-12

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 DHS, 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 1-1-16

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 TCM assessment is a comprehensive assessment that includes medical, social, educational, and other services. It goes beyond the assessment process used in determining eligibility for the 1915(c) waiver program(s). It addresses all facets of the individual's everyday life in determining how any problem or need might be met and what services are available in the individual's community.

For TCM beneficiaries ages 60 and older or the ARChoices participants, the maximum units allowed for this service may not exceed twelve (12) units per assessment/service plan visit. All references to units are in 15 minute increments.

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 ages twenty-one 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 or their authorized representative. 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

NOTE: The TCM service plan is a comprehensive care plan that includes medical, social, educational, and other services that have been identified and included on the service plan for purposes in meeting the identified goals. The TCM service plan goes beyond the ARChoices waiver plan of care developed by the DAAS RN. The TCM service plan addresses all facets of the individual's everyday life in determining how a problem or need will be met and what services are available in the individual's community.

- 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 ages 21 and older, 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.

TCM service plans must be renewed, at least, annually.

218.200 Service Management/Referral and Linkage

1-1-16

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 addressing identified needs and achieving goals specified in the service plan. 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 participating in a DAAS HCBS waiver program, the transfer of information to the DAAS RN via the AAS-9511, AAS-9510, or other communication form is not a covered service.

See Section 262.100 for the appropriate procedure code.

218.300 Service Monitoring/Service Plan Updating

7-1-20

This component includes activities and contacts that are necessary to ensure the TCM 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 six (6) units per monitoring visit when providers are dealing with beneficiaries ages twenty-one (21) and older.

- 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; and
 - 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 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 every other month, 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 (3) 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 face-to-face contact is not considered a covered monitoring contact unless the required monitoring form is completed according to instructions, dated, signed by the targeted case manager, and filed in the beneficiary's case record.
- D. Updating includes:

1. Reexamining the beneficiary's needs;
2. Identifying changes that have occurred since the previous assessment;
3. Identifying hospitalizations or other extended absences from the home;
4. Altering the TCM service plan; and
5. 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.

Monitoring and follow-up activities include making necessary adjustments in the TCM care plan and service arrangements with providers, according to established program guidelines.

Face-to-face monitoring contacts must be completed as often as deemed necessary, based on the professional judgment of the TCM, but no less frequent than established in Medicaid TCM program policy.

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; and
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 TCM 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 DHS RN and justified by the DHS 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**

1-1-16

Based on the state fiscal year (SFY) July through June, beneficiaries ages twenty-one (21) and older are limited to fifty (50) hours (200 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 ARChoices, 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 DHS 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.

240.000	PRIOR AUTHORIZATION	10-13-03
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240.010	Prior Authorization (PA) Required for Beneficiaries Under 21	1-1-16
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Prior authorization (PA) is required and must be obtained before providing targeted case management services for Medicaid eligible beneficiaries under the age of 21.

241.000	Individuals Exempt from Prior Authorization (PA)	1-1-16
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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, nor beneficiaries ages 21 and older or 65 and older who are participating in the ARChoices P

242.000	Prior Authorization and Documentation Requirements for Medicaid Eligible Beneficiaries Under Age 21	8-1-21
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DHS or its designated vendor must approve all requests for prior authorization for targeted case management services for Medicaid eligible beneficiaries under age **twenty-one (21)**. **View or print contact information to obtain instructions for submitting the request.**

The following information must be submitted for Child Health Services (EPSDT) beneficiaries and for DDS eligible beneficiaries under the age of **twenty-one (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 **twenty-one (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 **twenty-one (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 **twenty-one (21)** in a family group must be submitted on the same date.

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

242.100 Prior Authorization Request for Targeted Case Management for Medicaid Eligible Beneficiaries Under Age 21 8-1-21

Requests for prior authorization must be submitted using the Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21 Form (DMS-601). [View or print form DMS-601.](#) 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, an authorization number designation, the length of services, procedure codes and units approved for the requesting provider **will be issued**. For denied requests, a letter containing case-specific rationale that explains why the request was not approved will be **sent** to the requesting provider and to the Medicaid beneficiary.

242.310 Approved Targeted Case Management Requests 10-13-03

For approved cases, an approval listing will be mailed to the requesting provider detailing the procedure codes, total number of service time increments, beginning and ending dates of service and the authorization number assigned to the case.

242.320 Denied Targeted Case Management Requests 10-13-03

For denied requests, a denial letter with the reason for denial will be mailed to the requesting provider.

242.330 Provider Initiated Reconsideration of Denied Prior Authorization Determinations 8-1-10

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, DMS will notify the provider and the Medicaid beneficiary in writing of the review determinations.

242.340 Appeal Process for Medicaid Beneficiaries 8-1-10

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

The appeal request must be made in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty (30) days of the date on the letter from DMS explaining the denial. View or print the DHS Appeals and Hearing Section contact information.

250.000 REIMBURSEMENT

250.100 Method of Reimbursement 10-1-12

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, based 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 DHS RN and reported hospitalization of client and conversation with client's daughter (also sent 9511).

TOTAL BILLING: 6 minutes (1 unit) (CALL TO DHS RN AND ADMINISTRATIVE 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 DHS RN. Also scheduled home visit. (Referral and Linkage)

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: 8 minutes (1 unit). (DELIVERY OF DIAPERS AND CANE IS NOT BILLABLE.)

C. Example 3:

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

9:00 a.m. to 9:15 a.m.: Telephone call to applicant to report information regarding pending application. Client has no food and asks case manager about local Food Pantry. Case Manager contacts food pantry and arranges for food to be delivered to client's home. (Referral and Linkage)

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

TOTAL BILLING: 15 minutes for Referral and Linkage.

251.000**Rate Appeal Process****10-13-03**

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

When the provider disagrees with the decision made by the Assistant Director, Division of Medical Services, the provider may appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services. The Rate Review Panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff who will serve as chairperson.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The panel will hear the question(s) and will submit a recommendation to the Director of the Division of Medical Services.

260.000**BILLING PROCEDURES****261.000****Introduction to Billing****7-1-20**

Targeted case management providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

262.000**CMS-1500 Billing Procedures****262.100****Targeted Case Management Procedure Codes****1-1-16**

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 ages 21 and older. See Section

242.000 for prior authorization requirements and Section 220.000 for information about benefit limits.

The column labeled U21, 21+, and 60+ indicates that the procedure code or the procedure code along with a particular modifier must be used when billing for beneficiaries under age 21, for those ages 21 and older who have been diagnosed with a developmental disability, or for those ages 60 and older.

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	U21 21+ 60+	Local Code Description
T1017		U21	** (Assessment/Service Plan Development)
T1017	U2	21+	** (Assessment/Service Plan Development)
T1017	U5	60+	** (Assessment/Service Plan Development)
T1017	UA	21+ in ARChoices	** (Assessment/Service Plan Development)
T1017	U4	U21, 21+	** (Service Management/Referral and Linkage)
T1017	U6	60+	** (Service Management/Referral and Linkage)
T1017	UB	21+ in ARChoices	** (Service Management/Referral and Linkage)
T1017	U1	U21	** (Service Monitoring/Service Plan Updating)
T1017	U3	21+	** (Service Monitoring/Service Plan Updating)
T1017	U7	60+	** (Service Monitoring/Service Plan Updating)
T1017	UC	21+ in ARChoices	** (Service Monitoring/Service Plan Updating)

262.200 National Place of Service(POS) Codes

7-1-07

The national place of service code is used for both electronic and paper billing.

Place of Service	POS Codes
Doctor's Office	11
Patient's Home	12
Other Locations	99

262.300 Billing Instructions—Paper Claims Only

11-1-17

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. [View a sample form CMS-1500.](#)

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information.](#)

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

262.310 Completion of CMS-1500 Claim Form

9-1-14

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED SEX	Reserved for NUCC use. Not required.
c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9 a and d are required. Name of the insured individual's employer and/or school.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT? PLACE (State)	Required when an auto accident is related to the services. Check YES or NO. If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH SEX	Not required. Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a, 9c and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

Field Name and Number	Instructions for Completion
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	<p>Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.</p> <p>Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.</p>
15. OTHER DATE	<p>Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.</p> <p>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:</p> <p>454 Initial Treatment</p> <p>304 Latest Visit or Consultation</p> <p>453 Acute Manifestation of a Chronic Condition</p> <p>439 Accident</p> <p>455 Last X-Ray</p> <p>471 Prescription</p> <p>090 Report Start (Assumed Care Date)</p> <p>091 Report End (Relinquished Care Date)</p> <p>444 First Visit or Consultation</p>
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for targeted case management services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. LOCAL EDUCATIONAL AGENCY (LEA) NUMBER	Insert LEA number.
20. OUTSIDE LAB?	Not required.
\$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>Use "9" for ICD-9-CM.</p> <p>Use "0" for ICD-10-CM.</p> <p>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p>
22. RESUBMISSION CODE ORIGINAL REF. NO.	<p>Reserved for future use.</p> <p>Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.</p>
23. PRIOR AUTHORIZATION NUMBER	<p>The prior authorization or benefit extension control number if applicable.</p>
24A. DATE(S) OF SERVICE	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	<p>Two-digit national standard place of service code. See Section 262.200 for codes.</p>
C. EMG	<p>Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.</p>
D. PROCEDURES, SERVICES, OR SUPPLIES	<p>CPT/HCPCS</p> <p>Enter the correct CPT or HCPCS procedure code from Section 262.100.</p>
MODIFIER	<p>Modifier(s) if applicable.</p>

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. * Do not include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number	Instructions for Completion
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

262.400 Special Billing Procedures

262.410 Completion of Form Medicare/Medicaid Deductible and Coinsurance 10-13-03

Medicare billing is not applicable to targeted case management services.

262.420 Services Prior to Medicare Entitlement 7-1-07

Services that have been denied by Medicare with the explanation "Services Prior to Medicare Entitlement" may be filed with Medicaid. These services should be filed on the CMS-1500 claim form. A copy of the Medicare denial should be attached to the claim.

A note of explanation should accompany these claims in order that they may receive special handling.

262.430 Services Not Medicare Approved 10-13-03

Services that are not Medicare approved for patients with joint Medicare/Medicaid coverage usually are not payable by Medicaid.