

Targeted Case Management for Behavioral Health

PURPOSE

Targeted case management (TCM) services are defined as services furnished to assist members, eligible under the State Plan, in gaining access to needed medical, social, educational and other services necessary for appropriate care and treatment.

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as a locum tenens provider must enroll in ND Medicaid and be listed on the claim form. Please refer to [provider enrollment](#) for additional details on enrollment eligibility and supporting documentation requirements.

An agency providing TCM services must meet all the following criteria:

1. Demonstrate the ability to be available 24 hours, 7 days a week to members who need emergency case management services; and
2. Ensure supervisors of case management staff have a bachelor's degree and experience with case management.
3. Attest that individuals providing targeted case management have reviewed the competencies or standards of practice in one of the following:
 - [The Substance Abuse and Mental Health Services Administration \(SAMHSA\) Core Competencies for Integrated Behavioral Health and Primary Care](#); or
 - [The Case Management Society of America standards of practice](#).
4. Ensure that individuals providing case management have general knowledge, training and/or experience working with members with behavioral health conditions.
5. Case managers enrolled with ND Medicaid possess the necessary cultural sensitivity and background knowledge to provide appropriate services.

Individuals providing TCM:

- Must have a bachelor's degree.
- If the individual does not have a bachelor's degree, they will be allowed to enroll to provide TCM if they have at least five years of supervised experience working with members with behavioral health conditions in a role with case management functions such as member assessment, care plan development and maintenance, referral and appointment scheduling, monitoring and follow-up activities.
- Individuals enrolled prior to May 1, 2020, will be allowed to remain enrolled and eligible to provide targeted case management, if they remain actively providing targeted case management services.

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the [ND Medicaid MMIS Portal](#) or through the Automated Voice Response System by dialing 1.877.328.7098.

To be eligible for this service,

Adults must:

- Be Medicaid eligible; and
- Be 18 years of age or over.
- Have a behavioral health condition expected to last a year or longer; and
- Demonstrate at least a moderate level of functional impairment (a score of 25 or greater on the World Health Organization Disability Assessment Schedule (WHODAS) or a score of 5 or lower on the Daily Living Activities (DLA) 20) that interferes with or limits one or more major life activities; and
- Meets at least one of the following:
 - Undergone psychiatric treatment more intensive than outpatient services more than once related to their behavioral health condition; or
 - Has a history of documented problems resulting from their behavioral health condition for at least one year verified by family or local provider; or
 - Has experienced a single episode of continuous structured supportive residential care other than hospitalization for at least two months.

Children must:

- Be Medicaid eligible; and
- Be less than 21 years of age; and
- Have a behavioral health condition expected to last a year or longer; and
- Demonstrate at least a moderate level of functional impairment (a score of 25 or greater on the World Health Organization Disability Assessment Schedule (WHODAS) or a score of 5 or lower on the Daily Living Activities (DLA) 20) which substantially limits the child's role or functioning in family, school or community activities; and
- Be determined:
 - To be having a psychiatric crisis or emergency which requires emergency intervention to prevent institutional placement; or
 - To need long-term behavioral health services.

Exclusions for the Target Populations

Functional impairments that are temporary and expected responses to stressful events in the environment are not included.

For case management services provided to the target populations in medical institutions:

Target group is comprised of members transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Freedom of choice ([42 CFR 441.18\(a\) \(1\)](#)):

The State assures that the provision of case management services will not restrict a member's free choice of providers in violation of section 1902(a) (23) of the Act.

- Eligible members will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
- Eligible members will have free choice of any qualified Medicaid providers of other medical care under the plan.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The [General Provider Policies](#) details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

Targeted Case Management includes the following:

Comprehensive assessment and periodic reassessment of member needs to determine the need for medical, educational, social or other services. These assessment activities include:

- taking the member's history;
- identifying the member's needs and completing related documentation; and
- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible member.

Development (and periodic revision) of a specific care plan based on the information collected through the assessment that:

- specifies the goals and actions to address the medical, social, educational, and other services needed by the member;
- includes activities such as ensuring the active participation of the eligible member, and working with the member (or the member's authorized health care decision maker) and others to develop those goals;
- identifies a course of action to respond to the assessed needs of the eligible member.

Referral and related activities (such as scheduling appointments for the member) to help the eligible member obtain needed services including:

- activities that help link the member with medical, social, educational providers, or other programs and services that can provide needed services to address identified needs and achieve goals specified in the care plan.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible member's needs, which may be with the member, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring to determine whether the following conditions are met:
 - services are being furnished in accordance with the member's care plan;
 - services in the care plan are adequate;
 - changes in the needs or status of the member are reflected in the care plan; and
 - monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Review Requirements: The care plan is reviewed and updated at least every six months to reflect the accomplishments and changing needs.

Collateral Contacts: Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible member's needs and care, for the purposes of:

- 1) helping the eligible member access services;
- 2) identifying needs and supports to assist the eligible member in obtaining services;
- 3) providing case managers with useful feedback; and
- 4) alerting case managers to changes in the eligible member's needs ([42 CFR 440.169\(e\)](#)).

Case management services are coordinated with and do not duplicate activities provided as part of institutional services and discharge planning activities.

SERVICE AUTHORIZATION REQUIREMENTS

Services are limited to four hours per day. If additional services are medically necessary, the provider may request service authorization from the North Dakota Medicaid Program.

NON-COVERED SERVICES

GENERAL NON-COVERED SERVICES

The [Noncovered Services Policy](#) contains a general list of services that are not covered by North Dakota Medicaid.

TCM does not include, and Federal Financial Participation (FFP) is not available for, services defined in [§440.169](#) when the case management activities are an integral and inseparable component of another covered Medicaid service ([State Medicaid Manual \(SMM\) 4302.F](#)).

Case management does not include, and FFP is not available for, services defined in [§440.169](#) when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible member has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering

and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. ([42 CFR 441.18\(c\)](#))

The target group does not include members between ages 22 and 64 who are served in [Institutions for Mental Disease](#) (IMD) or individuals who are inmates of public institutions. ([State Medicaid Directors Letter \(SMDL\), July 25, 2000](#))

DOCUMENTATION REQUIREMENTS

GENERAL REQUIREMENTS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the [Provider Requirements Policy](#).

The following list contains the minimum contents required for the care plan for each member receiving TCM services.

- Name
- Age
- Family composition
- Current residency
- Education level or current educational setting
- Work status/employment
- Placement history (including facility, admission and discharge date)
- Narrative history or background of member
- Presenting concerns
- Diagnosis (if applicable-all Axes)
- Behavioral patterns
- Names of Practitioners that are providing care/services to the member
- Legal responsible party
- Treatment goals/primary plan of action
- Summary of progress/goals
- Medical needs (if available)
- Current health status (if available)
- Medication list (if available)
- Immunization record (if available)
- Recent medical appointments (if available)

Each member should have a primary point of contact. The primary point of contact should be delineated and easily identifiable in the member's care plan.

Providers delivering and billing for TCM must maintain case records that include the following items to support services billed. TCM activity must be documented as follows:

- The member's name;
- The date of the TCM service;
- Each note or note page must include the provider of the TCM service;
- The nature, content, and time units (total time) of the TCM services received;

- Whether goals specified in the care plan have been or are being achieved;
- The need for and occurrences of coordination with other case managers;
- A timeline for obtaining needed services;
- A timeline for reevaluation of the plan,
- Whether the member has declined services in the care plan.

General Documentation Checklist

- The documentation must link to the eligible member's care plan.
- Abbreviations used are standardized and consistent.
- The narrative supports the units of TCM claimed.
- The documentation supports what has occurred in TCM.
- The activity documented is consistent with the intent of ND Medicaid TCM services.

Reimbursement is based on the factors above. Documentation must be rooted in the official electronic record, if applicable or official record format of the agency.

ND Medicaid or its federal oversight agencies may conduct pre or post payment documentation review to ensure that the above criteria are met. Handwriting on printed documentation is not an accepted practice to fulfill documentation requirements if an audit is done. Such actions could be construed as alteration of a medical record.

Failure to comply with above criteria may result in claim denial and recoupment of Medicaid payment.

REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The [Timely Filing Policy](#) contains additional information.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The [Third Party Liability Policy](#) contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

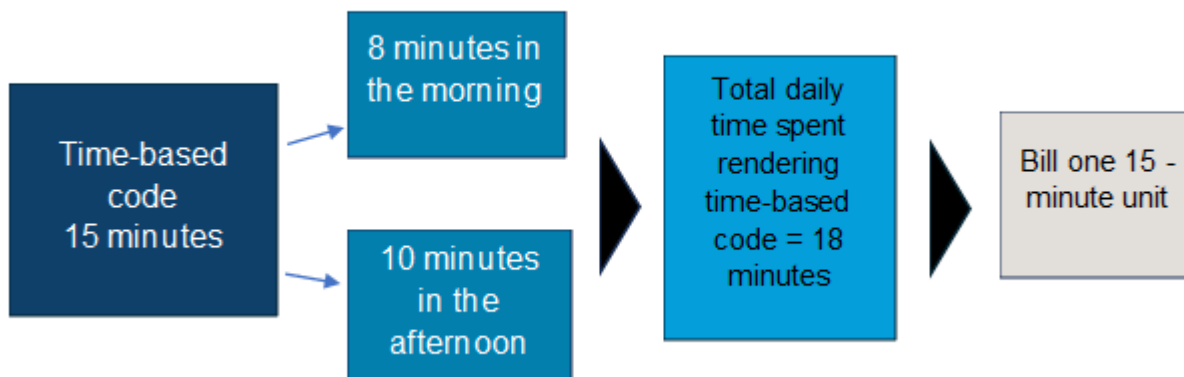
Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The [Client Share Policy](#) contains additional information.

REIMBURSEMENT

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

T1016 is the only code allowed for North Dakota Medicaid TCM for behavioral health.

When billing for one code that is billed in units (i.e. 15 minutes) throughout a day, report the total amount of units on one claim line.



CLAIM FORM

Targeted Case Management must be billed using the CMS 1500 claim form or 837P.

REFERENCES

- [North Dakota Administrative Code](#)
- [North Dakota Century Code](#)
- [Code of Federal Regulations](#)

FREQUENTLY ASKED QUESTIONS

- Q:** Is providing transportation for an member an allowed TCM billable service?
- A:** No, however, if while transporting an member to a visit, appointment, therapy, etc., there is discussion about their care plan goals, tasks, updating information, this specific time can be billed for TCM. Documentation must be clear that while transporting the specified TCM activities occurred.

The TCM activity must occur during the transportation time to bill for TCM. Example: If TCM services were provided and then transportation occurred, this transportation time is **not** billable. However, if while transporting an member to a medical appointment, coordination, monitoring, and assessment of member's current needs occurred to determine if a change in care plan is warranted, that specific time is billable for TCM.

Billable time is commensurate with the time spent providing TCM activities and is not linked to the time spent traveling or providing transportation.

- Q:** Can TCM be billed for providing activities such as picking up medication boxes, helping a member move living locations, taking an member shopping, waiting for an member while they are in an appointment, or participating with an member in an activity such as fishing, bowling?
- A:** No, these activities are not allowable TCM activities. If during these activities, allowable TCM services were provided, with clear documentation of the context and time spent on these services, the specific TCM time is billable.

Billable time during these events is commensurate with the time spent providing TCM activities and not tied to the length of the event/activity. Example: During a bowling activity, the case manager spent time discussing with the member an upcoming medical appointment and was assessing whether the service continued to be appropriate plus a plan to make a referral for physical therapy was discussed and detailed. This excursion resulted in two hours of time (8 units) spent bowling and TCM was provided for two (2) units during this time. Appropriate TCM billing is for two (2) units.

If a case manager attends a member's medical appointment, the necessity to be present during the appointment must be documented and the TCM service provided during the appointment must be documented. The focus of the case manager's documentation must be the TCM services provided and how it ties back to the member's care plan.

- Q:** Is the time spent entering, while developing, the care plan into the computerized system by a provider billable for TCM?
- A:** Yes, but straight data entry of the plan is not billable for TCM.
- Q:** Is completing applications and referral paperwork and reviewing documents (evaluations, IEP's, SSI) allowed TCM billable services?
- A:** Yes, if the time relates to the development, monitoring or evaluation of the care plan or is assisting in linking the member to needed services.
- Q:** Is making collateral contacts an allowed TCM billable activity?
- A:** Yes, in the form of telephone, in-person, and e-mail contacts. Content of the collateral contact must pertain to the Medicaid member. Copies of emails must be included in file and time spent must be included. If the cumulative time for one day is more than 8 minutes, one unit can be billed. Documentation must show how time was accumulated to arrive at total time billed.

- Q:** If a case manager is making telephone calls and coordinating services, for example a half dozen phone calls to providers are made and each take two to three minutes, can the time be combined and billed as 1 unit?
- A:** Assuming the content of the calls relates to the TCM allowed activities, if several calls are made on the same day for the same member, they can be claimed as one unit of TCM. If the cumulative time for one day is greater than 8 and less than 15 minutes, one TCM unit can be billed. Documentation must show how time was accumulated to arrive at the total time billed. A telephone call that does not result in a contact is not a billable TCM activity.
- Q:** Is supervision time an allowed TCM billable service?
- A:** Yes, if the time billed is focused on assisting a staff person in the development, monitoring or evaluation of the care plan for the member. However, the supervising practitioner must be enrolled with ND Medicaid and the two practitioners are not allowed to bill for the same service at the same time.
- member
- Q:** Is TCM allowed for court related time?
- A:** Only the time spent with the member/family discussing the planning process either before or after court involvement activity is billable. Time spent in the courtroom is not billable. Documentation must define the TCM-specific time and be separated from time in court. Activities directed toward investigation and evaluating facts involving a petition for involuntary treatment are allowable TCM activities.
- Q:** Is coordinating services for other individuals in the member's home billable for TCM?
- A:** No. Centers for Medicare and Medicaid Services (CMS) guidance is very clear that services must be provided to, or directed exclusively toward, the treatment of the Medicaid member.
- Q:** If multiple agencies and case management staff attend the same meeting for an eligible member, who bills for TCM?
- A:** The TCM provider is the only provider able to bill for this service.
- Q:** There are occasions where the case manager assists a person to acquire or renew skills to aid in the member gaining independence and increasing their ability to live successfully in a community; are these allowable TCM activities?
- A:** No. These activities, while valuable, are not allowable TCM activities. The agency must ensure that the agency and its staff are appropriately enrolled with ND Medicaid for the service they are providing.
- Q:** Case managers may provide assistance to members that doesn't fit allowable TCM activities; how should these activities be documented and billed?
- A:** Examples of some of these activities are delivering medication boxes, picking up groceries or helping an member move to another location. These types of activities are not billable under TCM.
- Q:** If a case manager provides transportation for an member and no TCM services are delivered, what code should be used?

- A:** Providing transportation alone is not billable under TCM. The agency must ensure that the agency and its staff are appropriately enrolled with ND Medicaid for the service they are providing.
- Q:** Case managers can be in situations where they need to provide crisis intervention to the Medicaid member. Is this an allowable TCM activity?
- A:** No, this is not an allowable TCM activity. The agency must ensure that the agency and its staff are appropriately enrolled with ND Medicaid for the service they are providing.

Please note, these answers are subject to change and practices will need to be modified if future federal/state guidance alters the answers provided.

CONTACT

Questions about this policy may be sent to dhsmed@nd.gov.

POLICY UPDATES

May 2025

Section	Summary
Eligible Members	Removed DLA testing requirements
Eligible Providers	Updated cultural sensitivity requirements

July 2025

Section	Summary
	Added DLA and WHODAS back in as requirements after being removed due to an oversight.