Targeted Case Management – Child Welfare

PURPOSE

Targeted case management (TCM) services are defined as services furnished to assist members, eligible under the State Plan, who reside in a community setting or are transitioning to a community setting 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.

Agencies providing TCM – Child Welfare services must meet all of the following criteria:

- Have in place a training process that ensures staff have adequate knowledge relating to children involved in unsafe, crisis, and/or unstable situations; and
- Demonstrate the ability to be available 24 hours, 7 days a week to eligible members who need emergency case management services; and
- Ensure supervisors of case management staff have a minimum of a bachelor's degree in social work, psychology, sociology, counseling, human development, elementary education, early childhood education, special education, child development and family science, human resource management (human service track), or criminal justice; and supervisors must:
    - Successfully complete the North Dakota Health and Human Services (NDHHS) approved Wraparound Certification training, or be in "Provisionally Certified" status of successfully completing Wraparound Certification training within twelve months of beginning to provide case management; and
    - Maintain Wraparound Certification status through attending a NDHHS approved Wraparound Recertification training at least once every two years.

In order to meet the case management needs, two separate categories of individuals must be available to children served by the child welfare system.

Individuals who are not employed by a North Dakota federally recognized Indian Tribe or North Dakota Indian Tribal Organizations, and are providing case management services must meet all the following criteria:

- Bachelor's degree in social work, psychology, sociology, counseling, human development, elementary education, early childhood education, special education,

child development and family science, human resource management (human service track), or criminal justice. Previously enrolled individuals with a bachelor's degree in a closely related field will be allowed to remain enrolled and eligible to provide case management. NDHHS may approve future individuals with a bachelor's degree in a closely related field at NDHHS's discretion; and
- Successfully complete the NDHHS approved Wraparound Certification training, or be in "Provisionally Certified" status of successfully completing Wraparound Certification training within twelve months of beginning to provide case management; and
- Maintain Wraparound Certification status through attending a NDHHS approved Wraparound Recertification training at least once every two years.

Individuals performing case management services for North Dakota federally recognized Indian Tribes or North Dakota Indian Tribal Organizations must meet all the following criteria:
- Have at least six months experience in delivering services in a community or home setting to children involved in the child welfare system; and
- Demonstrate they possess the necessary cultural sensitivity and background knowledge to provide appropriate services to the Native American population they are serving; and
- Successfully complete the NDHHS required Wraparound Certification training, or be in "Provisionally Certified" status of successfully completing Wraparound Certification training within twelve months of beginning to provide case management; and
- Maintain Wraparound Certification status through attending a NDHHS approved Wraparound Recertification training at least once every two years.

ELIGIBLE MEMBERS

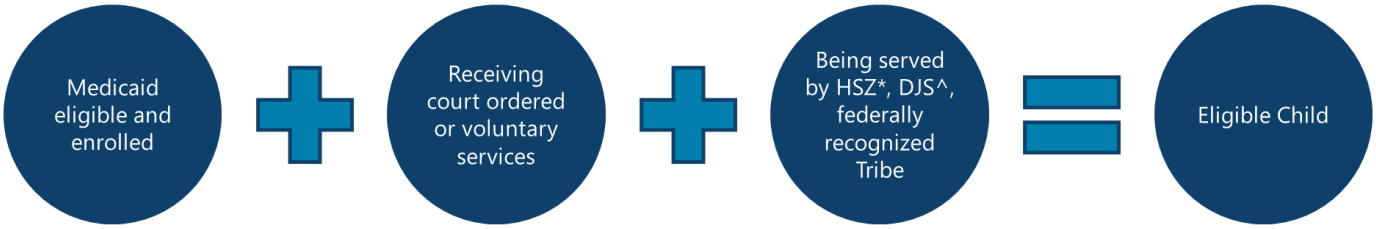
Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the through the Automated Voice Response System (AVRS) by dialing 1.877.328.7098.

members eligible for this TCM – Child Welfare must be in one of the following target groups:

Target Group #1

*Report of Suspected Child Abuse or Neglect

Target Group #2



*Human Service Zone
^Division of Juvenile Services

Target Group #3

*Interstate Compact for the Placement of Children

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

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 covered services include the following:

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

- taking a member 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; and
- 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 are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

Monitoring and follow-up activities including:

- 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.

The care plan is reviewed and updated at least quarterly to reflect the accomplishments and changing needs of the eligible member.

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:

- helping the eligible member access services;
- identifying needs and supports to assist the eligible member in obtaining services;
- providing case managers with useful feedback; and
- 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 (16 15-minute units). If additional services are medically necessary, the provider must submit a service authorization. Requests to exceed service limits may be submitted using SFN 481. Requests will be determined based on medical necessity, as defined at ND Administrative Code 75-02-02- 03.2.10.

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 Federal Financial Participation (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))

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 plan of care for each Medicaid 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 plan of care.

The case manager performing and billing for TCM must maintain a case record with documentation of TCM activities within the case activity log as follows:

- The Medicaid 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.

Case Activity Log Requirements

- Eligible member's plan of care;
- Date of service and provider signature;
- Explanation of any abbreviations used;
- Narrative supporting the units on the claim and summarizing the TCM activity that occurred.

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.

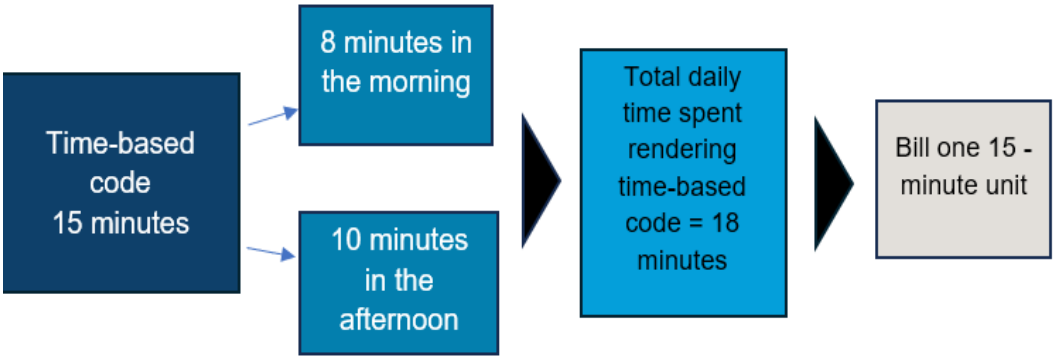
REIMBURSEMENT

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.

The billing code below is the only code allowed for North Dakota Medicaid TCM – Child Welfare Services.

Code	Code Description
T1017	Targeted Case Management, each 15 minutes

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. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual webpage.

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

FREQUENTLY ASKED QUESTIONS

Q: Is the time spent entering, while developing, the Protective Capacities Family Assessment (PCFA), Case Plan and Protective Capacities Progress Assessment (PCPA) into the computerized system by an enrolled provider billable for TCM?
A: Yes, but straight data entry of the plan is not billable.

Q: Is completing applications and referral paperwork and reviewing documents (evaluations, IEPs) allowed TCM billable services?
A: Yes, as long as the time relates to the development, monitoring or evaluation of the Care Plan, PCFA and PCPA.

Q: Are making collateral contacts are an allowed TCM billable service?
A: Yes, in the form of telephone, in-person, and e-mail contacts. 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 cumulated to arrive at total time billed.

Q: If an enrolled provider is calling and coordinating services, for example, making a half dozen phone calls to providers that take about two to three minutes per call, can they 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 for the same member, they can be claimed as a unit of TCM. If the cumulative time for one day is more than 8 minutes, one unit can be billed. Documentation must show how time was cumulated to arrive at the total time billed. A telephone call that does not result in a contact is not a billable TCM activity.

Q: Where must the documentation for TCM activity be located?
A: The justification for the time claimed as TCM must be documented in the case activity log. Within the case activity log, a reference can be made to the care plan; however, documentation that supports the TCM claimed MUST be in the case activity log.

Q: Is supervision time an allowed TCM billable service?
A: Yes, as long as the time billed is focused on assisting an enrolled provider in the development, monitoring or evaluation of the care plan for the eligible child. «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.»

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 be clear on the TCM-specific time separate from time in court.

Q: Can TCM be billed for foster care activities (including arranging for placement)?
A: No. TCM cannot be billed for direct services or foster care activities such as documentation required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster care providers, serving legal papers, home investigations, providing transportation, administering foster care subsidies and making placement arrangements.

Q: Can TCM be billed for case management services provided for someone else in the child's family unit? Example: the child in foster care's biological mother has a substance use disorder, and the case manager assists in arranging treatment services for the mother.
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 eligible child. Medicaid TCM is only billable for case management services for the Medicaid eligible child, who meets the target group eligibility criteria, even if services provided to others in the family unit will benefit the Medicaid eligible child.

Q: Can TCM be billed by Qualified Residential Treatment Programs (QRTPs) and treatment foster care providers for case management services provided to children enrolled in the Voluntary Treatment Program?
A: No, Medicaid TCM cannot be billed for children in the Voluntary treatment program since these children are not in foster care. They are enrolled in the Voluntary Treatment Program in order to access treatment services without the parent needing to relinquish custody for payment purposes.

Q: Can TCM be billed by QRTPs and treatment foster care providers for case management services provided to children who have been discharged from the QRTP or treatment foster care home, remain in the community and are in 'aftercare' services?
A: Yes, if the child is still eligible for TCM per the target groups. Aftercare services are time-limited supports intended to assist members in adjusting to life after treatment. Aftercare services include but are not limited to case coordination, navigation of community resources, ongoing communication with service providers, check-ins with the child and family, safety planning, transportation assistance, crisis case management and coordinated efforts to maintain stability.

Q: Can TCM be billed for children who are in juvenile detention or the Youth Correctional Center?
A: No. Children in correctional settings have their Medicaid suspended due to the federal Medicaid inmate payment exclusion.

Q: Can TCM be billed by a QRTP or a treatment foster care provider for 'aftercare' services when a child is placed in a Psychiatric Residential Treatment Facilities (PRTF)?
A: No. Aftercare services are not billable through TCM when a child is placed in a PRTF.

Q: Can preparing for Termination of Parental Rights (TPR) and the process of reviewing charts and evaluations, creating timelines and preparing case documents be billed to TCM?
A: No. TCM cannot be used to bill for direct services or foster care activities such as 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 and making placement arrangement.

Q: Can custodial agencies bill TCM for children in foster care who are placed at a Psychiatric Residential Treatment Facility (PRTF)?
A: Yes. Custodial agencies are responsible for providing face to face visits for children in their custody, regardless of the child's placement setting. TCM activities that occur during a child's placement at a PRTF is only billable for custodial agencies.

Q: Can PRTFs bill for TCM?
A: No. The PRTF rate is an all-inclusive, daily rate. This means that all costs including TCM are included in the daily rate.

Q: Can TCM be billed for children who are IV-E eligible?
A: Yes. The child's Title IV-E eligibility status does not impact the delivery of TCM services. In addition, there is no funding mechanism to bill IV-E for case management services, so Medicaid TCM may be billed.

Q: If multiple agencies and case management staff attend the same meeting for an eligible child, who bills for TCM?
A: Yes, Medicaid is aware that more than one agency (Human Service Zone, Division of Juvenile Services, Tribal Nation, QRTP or treatment foster care providers) may submit claims for the same child in the same month due to the complexity of the child's condition and circumstances. When the public custodian attends a meeting with other enrolled providers, the custodian has priority to bill Medicaid TCM.

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

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

Q: Are Child Protective Service Assessment activities an allowed TCM billable service?
A: No. The federal regulations within 42 CFR 440.169 clearly states that TCM is intended for case management services that are specifically tied to the case plan. In North Dakota, the eligible child's case plan refers to Section II of the PCFA and Section II of the PCPA (the child's needs and services as related to physical, dental, vision, mental/behavioral

health, social-emotional, developmental, educational providers, or other programs and services).

Q: Do findings of "Confirmed with Unknown Subject" and "Unconfirmed with Unknown Subject" fit within the target group?
A: Yes.

Q: Is TCM billable by qualified providers for children who are in a QRTP that is an Institution for Mental Diseases (IMD)?
A: Yes. Federal Medicaid funds are unavailable for services provided to members in IMDs, however ND Medicaid has configured its payment system to ensure that only state funds are used to pay for services provided to children in IMDs.

Q: Can TCM be billed when offering case management services to a family with an in-home safety plan?
A: Yes, as long as the services are provided to a child(ren) within the target group, regardless of safety plan type.

CONTACT

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POLICY UPDATES

July 2025

Section	Summary
	Format updates and clarifications added throughout.