

# Targeted Case Management

## New CAP/Targeted Case Management (CTCM) Form for MR/DD Submissions to ValueOptions

- A new CAP/Targeted Case Management (CTCM) request for authorization form has been approved and MUST be used in conjunction with the new person centered plan (PCP) for MR/DD, Continued Need Reviews (CNR) and non-waiver DD Case Management.
- This information can be found in IU#70 and the March 2010 Medicaid Bulletin.
- ValueOptions has posted the new CTCM on their website for immediate use as of March 1, 2010.
- Due to changes in the PCP, the additional information required on the new CTCM, such as diagnoses and medications, is essential to the review process.
- The new CTCM form can be accessed at:

[http://www.valueoptions.com/providers/Network/North\\_Carolina\\_Medicaid.htm](http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm)



## CAP/Targeted Case Management (CTCM) Request for Authorization Form

[Use one form per provider]

**Requested Start Date for this Authorization:**

**DSM-IV Diagnosis:** (\*Dx code must appear on Axis I and II)

**Waiver Type:**

\*Axis I: 1)  2)

\*Axis II: 1)  2)

**Type of Request:**

Axis III: 1)  2)

Axis IV: 1)

Axis V: 1)

**Demographics:**

Member's Name:  DOB:

Current SNAP:  SNAP Index score:

Member's MID#:  Tel#:

SIS Index score:

Member's Address:

Medication-Dx:

Case Manager Name:  Tel#:

Provider of Service:  Prov ID#:

Provider Address/City/St:

Provider Contact Name:

Provider Contact Phone #:

LME:  Phone #:

Legal Guardian/LRP:  LG is paid Provider:

**Member's Current Location:**

**Additional Information/Justification:**

**Treatment Request:**

Service	DMA Svc Code	Units	Per	From (Date)	To (Date)
Select Service	Service Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Select Service	Service Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Select Service	Service Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Select Service	Service Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Select Service	Service Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Select Service	Service Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Signature of Person Completing This Form

Date

Phone Number of Person Completing This Form

**CAP/TCM 1**

## Service Codes from CTCM Form

<b>Service</b>	<b>Service Code</b>
Adult Day Health	S5102
Aug. Comm. Equipment	T2028
Aug. Comm. Repair	V5336
Crisis Respite	H0045 HI
Crisis Services	H2011
Day Supports- Inv.	T2021
Day Supports- Grp.	T2021 HQ
Specialized Equip & Supplies	T1999
Home Modifications	S5165
Home & Community Support -Indiv.	H2015
Home & Community Support -Group	H2015 HQ
Home Supports - Level 1	T2033
Home Supports - Level 2	T2014 HI
Home Supports - Level 3	T2020 HI
Home Supports - Level 4	T2033 HI
Home Supports - Level 5	T2016
Ind./Caregiver Train. & Educ.	S5110
Long Term Vocational Supports-Grp	H2023 HQ
Long Term Vocational Supports-Ind.	H2023

<b>Service</b>	<b>Service Code</b>
Personal Care Services	S5125
Enhanced Personal Care	T1019
Personal Emergency Response	S5161
Respite Care- Institutional	H0045
Respite Care- Non-Inst. - Indiv.	S5150
Respite Care- Non-Inst. -Group	S5150 HQ
Enhanced Respite Care- Non-Inst.	T1005
Respite Care Services-Nursing	T1005 TD
Respite Care Services-LPN Nurse	T1005 TE
Residential Supports - Level 1	H2016
Residential Supports - Level 2	T2014
Residential Supports - Level 3	T2020
Residential Supports - Level 4	H2016 HI
Supported Employ-Individual	H2025
Supported Employment Group	H2025 HQ
Specialized Consultative Services	T2025
Targeted Case Management	T1017 HI
Transportation	T2001
Vehicle Adaptations	T2039

## Discharge Residence from CTCM

<b>Discharge Residence</b>
Home Alone
Home w/ Others
Shelter
Correctional Facility
Respite
State Hospital
Residential Placement
Transfer to Medical
Transfer to Alternate Psych. Facility
Therapeutic Foster Care
DD Residential Facility
Independent Living/Supervised Living
Nursing Home/SNF/Asst. Living
Other

# Developmental Disability (DD) Case Management (Waiver and Non-waiver)

- Current authorizations with effective dates prior to March 1, 2010, will continue as authorized until the next annual continued need review (CNR) for CAP-MR/DD recipients and until the end of the current authorization period for non-waiver recipients.
- The three hour/12 unit limit policy will be applied at the next authorization period.

## Developmental Disability (DD) Case Management (Waiver and Non-waiver)

- Effective March 1, 2010, prior authorization of case management services for adults on the Supports and Comprehensive waivers is not required.
- These adults are eligible for up to three hours/12 units monthly as well as the additional 24 units for assessment, planning, and crisis management annually.

## Developmental Disability (DD) Case Management (Waiver and Non-waiver)

- Effective March 1, 2010, prior authorization of case management services for children on the Supports and Comprehensive waivers is not required *unless* the request exceeds the three hour/12 unit monthly limit or the 24 unit limit for assessment, planning and crisis situations.

## Developmental Disability (DD) Case Management (Waiver and Non-waiver)

- Effective May 1, 2010, non-waiver adults will require annual authorization and may be authorized for up to three hours/12 units per month and no more than six additional hours/24 units, per year, if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation.
- Effective May 1, 2010, non-waiver children will require annual authorization .

## Developmental Disability (DD) Case Management (Waiver and Non-waiver)

- Waiver and non-waiver children must be evaluated under the EPSDT requirements prior to reducing their current service level at their next annual review and for authorization requests that exceed the three hour/12 unit limit or the 24-unit limits for assessment, planning, and crisis management. See the section below regarding EPSDT.
- State funded case management authorization limits are based on each LME's benefit plan.

## Six Additional Hours/24 Units

(For completing an assessment, completing reauthorization or continued need review, or for a crisis/emergency situation)

- No more than six additional hours (24 units) may be available if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation.
- It is not necessary to bill all of the additional units on the same claim. These additional units can be used cumulatively within a rolling 365 day period.
- Any billing for assessments and crises case management above this annual limit will not be paid for adults 21 years of age and older. For children under 21 years of age, requests will be reviewed under EPSDT. (See EPSDT below.)

# Six Additional Hours/24 Units

(For completing an assessment, completing reauthorization or continued need review, or for a crisis/emergency situation)

- These six hours (24 units) are in addition to the three hours per calendar month.
- When billing for these additional six hours/24 units, **all programs must use the procedure code currently submitted for case management services and append an informational modifier SC to that detail.**

For example:

- CAP/C and CAP/DA would bill with T1016SC.
- CAP/MR-DD, Early Intervention would continue to bill with T1017HI and append a second modifier of SC.
- CAP/Choice would bill with T2041SC.

## EPSDT

- While the new limit on case management services has been reduced to no more than three hours (12 units) per calendar month and no more than six additional hours (24 units), if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation, these limits may not apply to children under 21 years of age.
- Federal law, 42 U.S.C. §1396d(r)(5), requires the State Medicaid agency to provide to Medicaid recipients under 21 years of age “necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the [Social Security] Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] Plan.”
- For more information about EPSDT and provider documentation requirements for EPSDT requests, please visit:

<http://www.ncdhhs.gov/dma/epsdt/>

## Recipient Due Process Children

- As indicated above, all requests for recipients under the age of 21 that exceed policy limits will be reviewed against the EPSDT criteria prior to taking adverse action, and the recipient or his/her legal guardian will receive a written notice explaining the decision.
- The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10), DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), as well as state the EPSDT criteria not met, and an explanation about how to appeal the decision should the recipient or his/her legal guardian so desire.

# Recipient Due Process Adults

- If the decision authorizes case management services to the policy limit (three hours per calendar month and/or six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days), the recipient or his/her legal guardian will receive a written notice explaining the decision.
- The notice will state the decision and effective date of the reduction to the policy limit, explain the reduction is based on [Session Law 2009-451](#), Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10) as well as DMA policy promulgated pursuant to [S.L. 2009-451](#), Section 10.68A.(c), and that pursuant to 42 CFR §431.210 and §431.220(b), the recipient is not entitled to appeal this decision.

# Recipient Due Process Adults

- Should less than three hours (12 units) per calendar month and/or less than six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days be authorized, the recipient or his/her legal guardian will receive a written notice explaining the decision, and that he/she is entitled to appeal the decision to authorize less than the policy limit.
- The notice will state the decision and effective date of the reduction, explain the reduction is based on [Session Law 2009-451](#), Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10), as well as DMA policy promulgated pursuant to [S.L. 2009-451](#), Section 10.68A.(c), and an explanation about how to appeal the decision should the recipient or his/her legal guardian so desire.
- **Recipient Notice Regarding Reductions in Case Management Services**  
A [notice](#) was sent at the end of January to recipients regarding these changes in case management. A copy of the notice can also be viewed on DMA's [Consumer Publications web page](#).

# Transition to Annual Authorization for Non-waiver DD TCM

- Effective May 1, 2010 all non-waiver DD TCM requests will be authorized on an annual schedule rather than the current process of quarterly authorizations. The annual schedule will be based on the birth month. The effective date of the annual authorization period will be the first day of the month following the birth month and the end of the authorization period will be the last day of the birth month.

*For example:*

*If the recipient's birthday is in June, the annual authorization period will be July 1, 2010 through June 30, 2011.*

- Any request submitted to VO on, or after, May 1, 2010 will be authorized through the last day of the recipient's birth month.

*For example:*

*A request with a start date of May 1, 2010 with the recipient's birth month of November, will have an authorization period of May 1 through November 30, 2010.*

# Transition to Annual Authorization for Non-waiver DD TCM cont.

- Requests received by VO prior to May 1, 2010 will be authorized for 90 days. Prior to the end of the 90 day period the Case manager is to submit a request with an end date of the last day of the birth month.

*For example:*

*A request with a start date of April 1, 2010 with the recipient's birth month of November will have an authorization period of April 1, 2010 through June 30, 2010.*

*The case manager will then submit a request, prior to June 30, 2010, with a start date of July 1, 2010 and an end date of November 30, 2010.*