Targeted Case Management

The Targeted Case Management (TCM) program assists eligible recipients in the following eight target groups to gain access to medical, social, educational and other support services:

- Children and adolescents who are non-severely emotionally disturbed (non-SED) with a mental illness
- Children and adolescents who are severely emotionally disturbed (SED)
- Adults who are non-seriously mentally ill (non-SMI) with a mental illness
- Adults who are seriously mentally ill (SMI)
- Individuals with Intellectual Disabilities (IID) and related conditions
- Developmentally delayed (DD) infants and toddlers
- Juveniles on probation (JPS)
- Child protective services (CPS)

Non-covered services

The following services are not covered under the TCM program:

- Client outreach
- Crisis intervention services
- Direct delivery of medical or clinical services
- Grooming and other personal services
- Individual, group, family therapy services
- Services that should be billed to another federal program (e.g., TANF IV-E)
- Training for daily living, work and social skills
- Training for housekeeping, laundry, cooking
- Transportation services
- Travel to and from appointments

Refer to Nevada Medicaid Services Manual, Chapter 2500 for complete state policy on the TCM program, including required case record documentation in Section 2502.10A.

Fee for Service (FFS) billing instructions

All services are billed in 15-minute increments (one hour equals 4 units). Enter the total number of units for the claim line in Field 24G.

Non-TCM services must be billed on a separate claim.

Use HCPCS code T1017 with the appropriate modifier(s) as shown below:

- HA - Child/Adolescent program
- HB - Adult program, non-geriatric
- HI - Integrated mental health, intellectual disabilities and developmental disabilities program
- HU - Funded by child welfare agency
- HX - Funded by county/local agency
- HY - Funded by juvenile justice agency
- TN - Rural providers customary service area

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Description	Code	Modifiers	Service limits
Non-SED Children	T1017	HA	30 hours per recipient per calendar month (17 years of age and younger)
SED Children	T1017	HA	30 hours per recipient per calendar month (17 years of age and younger)
SED Children, rural	T1017	HA, TN	30 hours per recipient per calendar month (17 years of age and younger)
Non-SMI adults	T1017	HB	30 hours per recipient per calendar month (18 years of age and older)
SMI adults	T1017	HB, HI	30 hours per recipient per calendar month (18 years of age and older)
IID/Related conditions	T1017	HI	30 hours per recipient per calendar month
DD Infants and toddlers (Health Division)	T1017	HA, HI	30 hours per recipient per calendar month (under age 3)
DD Infants and toddlers (DCFS)	T1017	HA, HI, HU	30 hours per recipient per calendar month (under age 3)
County JPS	T1017	HY, HX	30 hours per recipient per calendar month
County JPS	T1017	HY, HX	Monthly capitated rate (no service limits)
County CPS	T1017	HX, HU	30 hours per recipient per calendar month
County CPS	T1017	HX, HU	Monthly capitated rate (no service limits)

Targeted Case Management

Billing instructions

Providers may bill daily, weekly or monthly within timely filing guidelines.

Bill for dates that services were actually rendered. If services were rendered each day on the 1st first through the 5th of the month and also the 7th through the 10th, then bill the 1st through the 5th on one line and the 7th through the 10th on the next line.

HCPCS Code G9012

Effective with dates of service on or after February 1, 2015, PT 54 may bill code G9012 (Other specified case management, 15 minutes). Code G9012 requires prior authorization through the Nevada Division of Public and Behavioral Health (DPBH).

Do not use codes T1017 and G9012 for the same recipient on the same date of service.

Billing Instructions for Span Dating of TCM Services

For TCM services, **non-consecutive dates and services that are not the same unit/time amount** must not be span dated on a single claim line. Providers risk claim denials due to duplicate logic, overlapping dates and/or mutually exclusive edits.

When span dating, services must have been provided on every day within that span of dates and be for the same quantity of units on each day. In the following examples, it would be incorrect to submit a single span-dated claim line for the following services:

- The entire week or month when services were only performed on Thursday and Saturday within the same week; or
- The entire month was billed and services were only rendered on January 1 and January 10 (two days within the same month; see the example below); or
- If one hour, four units, were performed on January 1 and two hours, eight units were performed on January 2.

The claim should only contain dates of service the service was rendered on. If services were rendered January 1, January 5 and January 10, the claim would be submitted as follows with one line charge for each date of service:

01/01/16
01/05/16
01/10/16

When billing weekly or monthly, a single claim line cannot include dates from two calendar months. For example:

- A claim line with dates of service April 15-May 15 is not allowed, but a claim line with May 1-May 31 is acceptable, if services were provided on every day in the date span and the above criteria are met regarding same quantity of units provided on each day.
- A claim line with dates of service March 28-April 3 is not allowed, but one claim line with March 28-March 31 and a second claim line with April 1-April 3 is acceptable, if services were provided on every day in the date span and the above criteria are met regarding same quantity of units provided on each day.

Services billed must match services authorized. For example, if code T1017 with modifier HA was authorized, this same code/modifier combination must be entered in Field 24D on the CMS-1500 Claim Form.

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Prior authorization requirements

TCM services, except HCPCS code G9012, *do not* require prior authorization.

Referrals

TCM services *do not* require a physician's referral.

Managed care SED/SMI recipients

A newly eligible recipient is not allowed to opt out or disenroll from the Managed Care Organization (MCO).

Recipients in areas where MCO enrollment is mandatory may disenroll from the MCO when determined as SED or SMI.

An MCO must submit a notification form when/if:

- A recipient is determined as SED or SMI.
- A recipient determined as SED or SMI chooses to disenroll from the MCO. (If the recipient does not disenroll, the MCO must cover the services.)

If a recipient is eligible to disenroll, please use this form: SED/SMI Determination (NMO-6080).