Restrictions, continued

Supervision	Medicaid will not reimburse for internal supervision between the mental health targeted case management supervisor and the mental health targeted case manager.
Behavioral Health Overlay Services Recipients	Medicaid will not reimburse mental health targeted case management services for children who are receiving behavioral health overlay services under the Medicaid Community Behavioral Health Services Program, except for case management activities clearly done in preparation for the child's discharge from behavioral health overlay services (last 90 days).
Incomplete Assessment or Service Plan	Medicaid will not reimburse mental health targeted case management services provided to a recipient who does not have a written assessment and current service plan developed in accordance with the requirements in this chapter. Note: See Assessment and Service Plan in this chapter for the requirements.
No Recipient Contact	Medicaid will not reimburse for mental health targeted case management services for unsuccessful attempts to contact the recipient, e.g., a home visit when the recipient is not at home, a phone call when the recipient does not answer, or leaving a message on voice mail, e-mail, or an answering machine.
Duplication of Services	Medicaid will not reimburse mental health targeted case management services: • If the Medicaid reimbursement for mental health targeted case management would duplicate payments for the same services through another funding source. ◦ If the services overlap with or are duplicative of mental health targeted case management services provided to the recipient by the same agency or by any other agency. All Medicaid case managers associated with a recipient must coordinate with each other to ensure non-duplication of services. ◦ For a targeted case manager simply being present during a face-to-face therapeutic activity.

Restrictions, continued

Transportation	Medicaid will not reimburse mental health targeted case management provider agencies for transporting recipients. The Medicaid transportation program provides transportation for Medicaid recipients to medically-necessary, Medicaid-compensable services. Medicaid contracts with a vendor, who arranges for non-emergency transportation services for Medicaid recipients.
Travel	Reimbursement for travel time is incorporated into the unit rate and may not be billed separately.

Assessment

Assessment	Each mental health targeted case management recipient must receive a thorough assessment which will serve as the basis for the development of the recipient's service plan. The assessment is a holistic review of the recipient's emotional, social, behavioral, and developmental functioning within the home, school, work, and community. The assessment must be updated annually
Who Must Provide	The recipient's mental health targeted case manager is required to conduct the assessment.
Time Frame for Development of the Assessment	The case management assessment must be completed within the first 30 days that the recipient receives mental health targeted case management services, and prior to the development of the service plan.
Home Visit Requirement	The mental health targeted case manager must make at least one home visit prior to completion of the assessment to evaluate the safety and well being of the recipient. The home visit should be conducted in the setting in which the recipient resides. If the mental health targeted case manager is unable to make a home visit, he must conduct a face-to-face interview in another setting. Written justification must be provided in the recipient's case record explaining why the home visit could not be made. The mental health targeted case manager and his supervisor must sign the written justification.

Assessment, continued

Information Sources for the Assessment

The assessment must include information from the following sources:

- The recipient;
- The agency or individual who referred the recipient for mental health targeted case management services;
- The recipient's family and friends (with appropriate consent);
- Other agencies that are providing services to the recipient;
- The school district (for recipients under the age of 18 or who are still attending school); and
- Previous treating providers, including inpatient and outpatient treatment (If collateral information cannot be obtained, the mental health targeted case manager must provide written justification in the recipient's case record.)

Assessment Components

The assessment must include all of the following components:

- Presenting problem(s) and history, including the recipient's, legal representative's and family's assessment of his situation (with appropriate consent);
- Psychiatric and medical history including medications and side effects;
- Recipient's current and potential strengths;
- Resources that are available to the recipient through his natural support system;
- Recipient's school placement, adjustment and progress (if applicable);
- Recipient's relationship with his family and significant others;
- Identification and effectiveness of services currently being provided; and
- Assessment of the recipient's needs and functioning abilities in the following areas:
  - Mental health maintenance and abstinence from substance abuse or use;
  - Family support and family education;
  - Education, vocational, or job training;
  - Housing, food, clothing, and transportation;
  - Medical and dental services,
  - Legal assistance;
  - Development of environmental supports through support groups peer groups, activities, community services, friends, landlords, employers and
  - Assistance with establishing financial resources.

Assessment

Assessment, continued

Assessment Documentation Requirements

The following assessment documentation requirements must be met:

- The assessment must be an identifiable document in the recipient's case record. Supporting documentation (e.g., copies of findings, evaluations and discharge summaries) gathered to complete the assessment must be filed in the recipient's case record.
- The assessment must include documentation that the mental health targeted case manager made a home visit prior to the completion of the assessment or written documentation by the case manager with sign-off by the case manager's supervisor, explaining why this requirement could not be met.
- The assessment must be reviewed, signed, and dated by the case manager's supervisor prior to the completion of the service plan, which is described below.

Service Plan

Service Plan	Each recipient must have an individualized service plan written within 30 days of initiation of services by his mental health targeted case manager or case management team. The service plan must include measurable short and long-term goals for the recipient and must outline the comprehensive strategy for assisting the recipient in achieving these goals.
Service Plan Requirements	The service plan must: • Be an identifiable document; • Be developed in partnership with the recipient and the recipient's parent, guardian, or legal custodian (if applicable); • Describe the recipient's service needs and the activities that the mental health targeted case manager will undertake in partnership with the recipient; • Contain measurable goals and objectives derived from the recipient's assessment; • Have identified time frames for achievement of goals; • Include the name of the individual or agency responsible for providing the specific assistance or services; • Be consistent with the recipient's treatment plan(s); • Be signed and dated by the recipient, the recipient's parent, guardian or legal custodian (if the recipient is under 18 years of age), the recipient's mental health targeted case manager (must include title), and the mental health targeted case manager's supervisor (must include title); and • Be retained in the recipient's case record.
Exception to the Requirement for the Recipient's Signature	If the recipient's age precludes the recipient's participation in the development and signing of the service plan, the recipient's parent, guardian or legal custodian must sign the service plan, unless an exception listed on the next page is met.
Copies of the Service Plan	Copies of the service plan must be provided to the recipient or the recipient's guardian if the recipient is under age 18, and with the recipient's consent, to other service providers involved in the development or implementation of the service plan. This information must be documented in the recipient's case record.

Service Plan, continued

Exceptions to the Requirement for Signature of Parent, Guardian, or Legal Custodian

There are exceptions to the requirement for a signature by the recipient's parent, guardian, or legal custodian if the recipient is under age 18. Written documentation and justification of the exception must be provided in the recipient's case record. The following are the exceptions

- Recipients in the custody of the Department of Juvenile Justice that have been court ordered into treatment or require emergency treatment such that delay in providing treatment would endanger the mental or physical well being of the recipient. The signature of the parent, guardian, or legal custodian must be obtained as soon as possible after emergency treatment is administered.
- For recipients in the care and custody of the DCF (foster care or shelter status), the child's caseworker must sign the service plan if it is not possible to obtain the parent's signature. The caseworker and foster parent must participate in the service planning. In cases in which the DCF is working toward reunification, the parent or designated or identified future caregiver must be involved and should sign the service plan.

Service Plan Review

The service plan review is a process conducted to ensure that services, goals, and objectives continue to be appropriate to the recipient's needs and to assess the recipient's progress and continued need for mental health targeted case management services. The recipient's eligibility for continued mental health targeted case management services must be re-evaluated during the service plan review. The activities, discussion, and review process must be clearly documented. The recipient, the mental health targeted case manager, and the mental health targeted case manager's supervisor must sign and date the service plan review.

Frequency of the Service Plan Review

The service plan must be reviewed and revised as significant changes occur in the recipient's condition, situation, or circumstances, but no less frequently than every six months. Documentation of the service plan review must be recorded in the recipient's case record.

Covered Services

Covered Services for All Target Groups

The following services are covered for all mental health target groups:

- Conducting the assessment in accordance with the criteria outlined in this chapter.
- Developing the recipient's service plan in accordance with the criteria outlined in this chapter.
- Working with the recipient and the recipient's family to address issues related to implementation of the service plan. Services where the family is involved must clearly be directed to meeting the identified needs of the recipient.
- Assessing the effectiveness of the service plan in meeting the identified needs of the recipient.
- Linking and facilitating the recipient with appropriate services and resources identified in the service plan through referrals to reach desired goals.
- Advocating for the acquisition of services and resources necessary to implement the service plan by representing or defending recipients through direct intervention
- Coordinating the delivery of services as specified in the service plan with the help of the recipient, the recipient's family, and the recipient's natural support system
- Monitoring service delivery to evaluate the recipient's progress.
- Documenting mental health targeted case management activities in accordance with the documentation requirements in this chapter.
- Crisis Intervention/Support by assisting recipients in crisis in getting access to the necessary resources in order to cope with the situation
- Case management services may be billed in conjunction with any Medicaid reimbursable service for the purpose of providing and communicating critical information that would assist the recipient (not to exceed two units per event).
- Arranging for and coordinating after care services upon discharge from a residential or inpatient facility when discharge planning is not covered by the facility's per diem.
- Participating in the recipient's individualized treatment plan development or individualized services plan review under the Medicaid community behavioral health services program (Time billed must be clearly justified as time dedicated to the recipient).
- Providing mental health targeted case management services in preparation for a child's discharge (last 90 days) from Behavioral Health Overlay Services (BHOS)
- Conducting a clinical care Medicaid recipient staffing, in which the case manager is meeting with either the recipient's treatment team or one-on-one with one of the following individuals: psychiatrist, psychiatric ARNP, physician, therapist, teacher, attorney, guardian ad litem, or any other professional who is directly serving the recipient

Covered Services, continued

Case Load Limitations	Maximum average caseloads are as follows: • Children's mental health targeted case management – 20 recipients per each targeted case manager. • Adult mental health targeted case management – 40 recipients per each targeted case manager. If a mental health targeted case manager has a combined caseload, a child counts as two. The mental health targeted case manager must be certified to serve both target groups

Intensive Case Management Team Services

Introduction	Intensive case management team services provide team case management to adults with serious and persistent mental illness to assist the recipient to remain in the community and avoid institutional care. Intensive team case managers coordinate needs assessment, services planning, and provide service oversight.
Service Exclusions	Medicaid does not reimburse team case managers for providing: • Services that are medical or clinical in nature or services that provide direct care (i.e., psychotherapy and skills training services); or • Services that are duplicative of those provided by other mental health targeted case managers.
Case Load Limitations	The maximum average caseload size for a team is 15 recipients per each team case manager.
Documentation for Intensive Case Management Team Services	Documentation for intensive case management team services must reflect that services are coordinated with, but separate and distinct from, the other team case managers' services.

Medicaid 30-Day Certification

Covered Services	Medicaid reimburses the same mental health targeted case management services for recipients in the 30-day period as for recipients in the children's mental health and adult mental health target groups. Note: See this chapter for covered services.
Reimbursement	Services rendered during the 30-day certification period are reimbursed using the policies and procedure codes for either children's or adult mental health targeted case management services, depending upon the age of the recipient.
Documentation During the 30-Day Certification Period	The recipient's case record must include complete case notes of all contacts and written justification for continuing or discontinuing services after 30 days or if a child turns 18 during the 30-day period.

Documentation Requirements

Introduction

In addition to the general Medicaid record keeping requirements and the specific documentation requirements listed for each target group, the documentation requirements described in this section apply to all mental health targeted case management services.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for general Medicaid record keeping requirements.

Recipient Case Record

The recipient's case record must contain the recipient's certification form, assessment, service plan, service plan review(s), documentation of the home visit, and the service documentation described below.

Documentation Requirements for Case Notes

The case manager's case notes must include the following information for each mental health targeted case management activity:

- Case manager's name, signature, title, and date. Photocopied signatures, stamped signatures, or signatures of anyone other than the person rendering the service are not acceptable;
- Recipient's name;
- Service provided;
- Date of the service;
- Services beginning and ending time on the clock (e.g., 2:00 p.m. to 3:25 p.m.);
- Location of the service;
- Updates when the recipient changes residence, enters or is discharged from an inpatient hospital or state mental hospital, experiences a significant change in mental status, experiences a significant change that impacts his life and support system, changes custody, changes educational placement, or changes employment; and
- Detailed case notes that:
  1. Clearly reflect how the case manager's efforts are linked to the services and goals in the recipient's service plan;
  2. Describe the recipient's progress or lack of progress relative to the service plan; and
  3. If a substitute case manager provided the service, explain the circumstances requiring the provision of services by a substitute case manager.

If more than one contact to a recipient is made in a day, all contacts should be summarized in one case note.

Documentation Requirements, continued

Documentation Reviews	The provider must submit files for retrospective reviews upon request to the area Medicaid office, AHCA, or staff designated by Medicaid

Reimbursement Information, continued

Units of Service

Targeted case management services are reimbursed in time increments. Each time increment is called a unit of service. Fifteen minutes equals one unit of service.

If multiple units are provided on the same day, the actual time spent must be totaled and rounded to the nearest unit. If the minutes total ends in a 7 or less, round down to the nearest 15-minute increment. If the minutes total ends in 8 or more, round up to the nearest 15-minute increment. For example, 37 minutes is billed as two units of service; 38 minutes is billed as three units of services.

One Claim Submission per Date of Service

To receive reimbursement, the mental health targeted case management agency must total the amount of time that a mental health targeted case manager (children's or adult) provided mental health targeted case management services and submit one claim for the appropriate number of units of service per day.

Entering Providers Numbers on the Claim Form

The targeted case management agency must enter its group provider number as the pay-to provider and the case management supervisor's provider number in the field titled treating provider on the claim form. Under no circumstances may the mental health targeted case management supervisor's Medicaid number be entered as the pay-to provider number.

Note: See Chapter 1 in the Medicaid Provider Reimbursement Handbook, Non-Institutional 081, for additional information on entering provider numbers on the claim form.

Reimbursement Limitations

Medicaid will reimburse:

- Up to 344 units of children's mental health or adult mental health targeted case management per month, per recipient.
- Up to 48 units of intensive case management team services per recipient, per day, per case management team.

Exceptions to Service Limits

Requests to exceed service limits for recipients under age 21 must be made through Medicaid's prior authorization process.

Procedure Code Table

Each procedure code on the Procedure Codes and Fee Schedule, Appendix A, corresponds to a specific target group. The maximum fee shows the maximum amount that Medicaid will reimburse for the procedure code per unit of service, and the maximum units shows the maximum number of units that Medicaid reimburses per recipient, per date of service.

CHAPTER 3
MENTAL HEALTH TARGETED CASE MANAGEMENT PROCEDURE CODES AND FEE SCHEDULE

Overview

Introduction

This chapter identifies the targeted case management procedure codes and the maximum fees that Medicaid reimburses.

In This Chapter

This chapter contains:

Reimbursement Information

Procedural Code Origination

The procedure codes listed in this handbook are Level II Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the standard code set described in HCPCS Level II Expert code book. Please refer to the HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert code book is copyright 2005 by Ingenix, Inc. All rights reserved.

Effective October 1, 2003, in compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation.

All previously used "local codes" can no longer be processed by the Florida Medicaid claims processing system for Medicaid payment for dates of service after October 1, 2003.

Procedure Code Modifiers

Definition of Modifier

For certain types of services, a two-digit modifier must be entered on the Non-Institutional 081, claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.

The modifiers are entered in the field next to the procedure code field in item 33, under Modifier.

Targeted case management providers must use the modifiers with the procedure codes listed on Appendix A, Procedure Codes and Fee Schedule, when billing for the specific services in the procedure code descriptions. The modifiers listed in Appendix A can only be used with the procedure codes listed. Use of modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, for additional information on entering modifiers on the claim form.

Provider Abuse

Abuse

Abuse means provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary, coded incorrectly on the claim, or that fail to meet professionally recognized standards for health care. Abuse includes recipient activities that result in unnecessary cost to the Medicaid program. Abuse may also include a violation of state or federal law, rule or regulation.

Note: See the Florida Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook for information regarding recipient overutilization or fraud of prescription drugs.

Overpayment

Overpayment includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claims, unacceptable practices, fraud, abuse or mistake.

Provider Fraud

Fraud

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

AHCA shall require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.

Person

"Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

FRAUD

FRAUD

AGENCY FOR HEALTH CARE ADMINISTRATION

Report Medicaid Fraud

Search

Medicaid Fraud and Abuse Online Complaint Form (to report suspected fraud and/or abuse in the Florida Medicaid system)

Medicaid Fraud: Protect Your Tax Dollars

WHY IT IS IMPORTANT

The Medicaid program is funded with both state and federal tax dollars. It is designed to pay for health care for low-income and vulnerable Floridians (children, pregnant women, disabled adults and seniors) who need care. When people get benefits they don't deserve, or when providers are paid for services that were not supplied, it wastes your tax dollars and takes services away from those who need them.

MEDICAID FRAUD

Medicaid fraud means an intentional deception or misrepresentation made by a health care provider or a Medicaid recipient with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under federal or state law related to Medicaid.

Concerns associated with suspected Medicaid fraud by eligible Medicaid recipients may be reported to the Florida Department of Financial Services, Division of Public Assistance fraud hotline at 1-866-762-2237.

Suspected Medicaid fraud by ineligible recipients may be reported to the Florida Department of Children and Families, Office of Public Benefits Integrity at http://www.myflfamilies.com/service-programs/public-benefits-integrity.

The Office of Medicaid Program Integrity of the Inspector General at the Agency for Health Care Administration accepts complaints associated with Medicaid billing fraud. These complaints may be filed online using the Medicaid billing fraud online complaint form or by telephone at 1-888-419-3456.

To report suspected Medicaid fraud by health care providers you may also contact the Office of Attorney General at 1-866-966-7226 or file a complaint online at http://myfloridalegal.com.

THINGS YOU CAN LOOK FOR

Upcoding

Providers bill Medicaid using codes that describe the amount of time spent with the patient. If a patient sees a health care provider for ten (10) minutes on a simple matter and the provider bills for an hour-long, complex visit, that is upcoding.

Unbundling

Some billing codes used by providers are all-inclusive and "bundle" several laboratory tests into one code. If the provider breaks the bundled code into several parts to achieve a higher reimbursement rate, that is unbundling. For example: A Lipid Panel is a laboratory test that includes three different component tests. Unbundling occurs when the three component tests are billed instead of the Lipid Panel.

WHAT FRAUD LOOKS LIKE

Most providers who commit Medicaid fraud fall into one or more of these categories:

- billing for patients who did not really receive services,
- billing for a service and/or equipment that wasn't provided,
- billing for items and services that the patient no longer needs,
- overcharging for equipment or services,
- concealing ownership or associations in a related company,
- paying a "kickback" in exchange for a referral for medical services or equipment,
- billing more than once for the same service,
- using false credentials such as diplomas, licenses or certifications, or
- ordering tests or prescriptions that the patient does not need.

HOW TO REPORT FRAUD

You can help protect your tax dollars by reporting suspected fraud by phone, through the Internet or by regular mail. You can do this without giving your name, but if you agree to give your name and other contact information, that helps the investigators to obtain future information.

Before you make a report, try to get as much information as possible, including:

- the name of the person you suspect of committing fraud. This might be a person receiving medical benefits or a health care professional hospital, nursing home, or other facility that provides Medicaid services
- the Medicaid ID number
- the date of services
- the amount of money involved, and/or
- a description of the acts that you suspect involve fraud

WHAT YOU DO TO PREVENT FRAUD

- Do not give your Medicaid card number to anyone except your doctor, hospital or other health care provider
- Do not ask your doctor or other medical provider for medical care you do not need.
- Be suspicious if you are offered free screenings or tests in exchange for your Medicaid card number.
- Ask questions if someone wants you to have services or treatments that you feel you do not need. If necessary, get a second opinion from another health care provider.
- Do not accept money or gifts from anyone who offers to buy medicine that you have received through Medicaid.

Those who report fraud may be entitled to a reward if they report a criminal case that results in a fine, penalty or forfeiture of property. To find out more, call the Attorney General at 1-866-966-7226. FS 409.9203 Rewards for reporting Medicaid fraud

Provider Responsibility

Provider Responsibility

When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

- Have actually been furnished to the recipient by the provider prior to submitting the claim;
- When required by federal or state law, the provider rendering the service is actively licensed or certified to provide the service;
- Are Medicaid-covered goods or services that are medically necessary;
- Are of a quality comparable to those furnished to the general public by the provider's peers.
- Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such co-payments, coinsurance, or deductibles as are authorized by AHCA;
- Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state and local law; and
- Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

Must

Right to Review Records

In accordance with s. 409.907 and 409.913, F.S., authorized state and federal agencies and their authorized representatives may audit or examine a provider or facility's Medicaid-related records. This examination includes all records that the agency finds necessary to determine whether Medicaid payments were or are due and applies to the provider's records and records for which the provider is the custodian. The provider must give authorized state and federal agencies and their authorized representatives access to all Medicaid patient records and to other information that cannot be separated from Medicaid-related records. The provider must send, at his expense, legible copies of all Medicaid-related information to the authorized state and federal agencies and their authorized representatives upon request.

Administrative Sanctions

Administrative Sanctions

AHCA shall impose sanctions on providers in accordance with Section 409.913, F.S. and Rule 59G-9.070, F.A.C. A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to five percent or greater, in which the provider participated or acquiesced.

Sanctions include the following:

- Suspension from participation in the Medicaid Program;
- Termination from participation in the Medicaid Program;
- Imposition of fines;
- Imposition of liens against provider assets;
- Prepayment reviews of claims;
- Comprehensive follow-up reviews; and
- Corrective-action plans.

Violation Definition

Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered to be a separate violation.

Each instance of the following actions is considered to be a separate violation:

- Improper billing of a Medicaid recipient;
- Including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report the cost is not allowable;
- Furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment;
- Knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request or cost report;
- Inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and
- Filing a false or erroneous Medicaid claim leading to an overpayment to a provider.

Administrative Sanctions, continued

Examples of Sanctionable Violations

AHCA may seek any remedy provided by law when

- The provider's license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state;
- The provider has failed to make available or refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of AHCA, the Attorney General, a state attorney, or the federal government;
- The provider has not furnished or has failed to make available such Medicaid-related records as AHCA has found necessary to determine whether Medicaid payments are or were due and the amounts thereof;
- The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered.

Criminal History Check, continued

Exemption for Government Entities with Previous Criminal History Checks

If a government agency or government-owned facility already obtains criminal history checks on its employees, Medicaid does not require another check if the following criteria are met:

- The government agency or government-owned facility submits documentation in the form of a letter or official form from the screening agency, which specifies the applicant's name and dates of the FDLE and FBI criminal history checks;
- The previously completed criminal history check is no more than 12 months old as of the date of receipt of the application; and
- Medicaid reserves the right, on a case-by-case basis, to reject any criminal history check deemed questionable, or to require that a new criminal history check be completed and the appropriate fee submitted to cover payment required by FDLE.

Criminal history check exemption policies for government agencies apply to hospital taxing districts, such as the North Broward Hospital District; state agencies, such as county health departments; and state university system facilities, such as the University of Florida, Shands Teaching Hospital.

Criminal History Check by Other Agencies

Medicaid accepts proof of level 2 criminal history checks conducted by other Florida agencies or departments that have been completed in compliance with Chapter 435, F.S., and section 408.809 F.S., within 12 months of receipt of the application.

The provider must submit a letter or official form from the agency that conducted the criminal history check with the Enrollment Application. The letter or form must specify the applicant's name, Social Security Number, date the criminal history check was completed, the level of the screening and the results.

Medicaid Provider Enrollment will review the information and approve or deny the application.

APPENDIX B
AGENCY CERTIFICATION
CHILDREN'S MENTAL HEALTH TARGETED CASE MANAGEMENT

Agency Name _____

Agency Address _____

_____

Phone Number ( ) _____ Medicaid Provider # _____

Is hereby certified to provide targeted case management services and meets the following criteria:

Administrative:

1. Is knowledgeable of and agrees to comply with the statutes, rules and policies that affect the target population.
2. Has the ability to administer case management services to the target population.
3. Has established linkages within the local network of mental health treatment providers and other resources in the service area.
4. Has a quality improvement program with written policies and procedures.
5. Will ensure that case managers are certified within three months from their date of hire
6. Will provide mental health targeted case managers with supervision (as described in the Mental Health Targeted Case Management Coverage and Limitations Handbook).
7. Will cooperate with and participate in monitoring conducted by the Agency for Health Care Administration and the Department of Children and Families, Mental Health Program Office and the district or regional Substance Abuse and Mental Health program office.
8. Has the capacity to manage utilization of mental health targeted case management services and to conduct utilization review of these services on a regular basis.
9. Has the financial management capacity and system to provide documentation of costs.
10. Has the ability to maintain and produce documentation that verifies that mental health targeted case managers have participated in case management training as required and approved by AHCA.

Programmatic:

1. Ensures that all mental health targeted case management services are provided by certified case managers.
2. Provides mental health targeted case management for recipients who ask or are referred for service and who meet eligibility requirements.
3. Maintains average caseloads of 20 or fewer recipients per mental health targeted case manager.
4. Maintains programmatic records that include clearly identified mental health targeted case management certifications for eligibility, assessments, service plans and service documentation.

_____ _____

Provider Administrator Date

_____ _____

Area Medicaid Office Designated Representative Date

All fee-for-service providers must have a fully executed certification form on file and all managed care organizations must ensure all certification criteria are met.

AHCA-Med Serv Form 022, June 2007 (incorporated by reference in 59G-4.199)

APPENDIX C
AGENCY CERTIFICATION
ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT

Agency Name _____

Agency Address _____

Phone Number (___) _____ Medicaid Provider # _____

Is hereby certified to provide targeted case management services and meets the following criteria:

Administrative:

1. Is knowledgeable of and agrees to comply with the statutes, rules and policies that affect the target population.
2. Has the ability to administer case management services to the target population.
3. Has established linkages within the local network of mental health treatment providers and other resources in the service area.
4. Has a quality improvement program with written policies and procedures.
5. Will ensure that case managers are certified within three months from their date of hire.
6. Will provide mental health targeted case managers with supervision (as described in the Mental Health Targeted Case Management Coverage and Limitations Handbook).
7. Will cooperate with and participate in monitoring conducted by the Agency for Health Care Administration and the Department of Children and Families, Mental Health Program Office and district or regional Substance Abuse and Mental Health program office.
8. Has the capacity to manage utilization of mental health targeted case management services and to conduct utilization review of these services on a regular basis.
9. Has the financial management capacity and system to provide documentation of costs.
10. Has the ability to maintain and produce documentation that verifies that mental health targeted case managers have participated in case management training as required and approved by AHCA.

Programmatic:

1. Ensures that all mental health targeted case management services are provided by certified case managers.
2. Provides mental health targeted case management for recipients who ask or are referred for service and who meet eligibility requirements.
3. Maintains average caseloads of 40 or fewer recipients per mental health targeted case manager.
4. Maintains programmatic records that include clearly identified mental health targeted case management certifications for eligibility, assessments, service plans and service documentation.

_____ _____

Provider Administrator Date

_____ _____

Area Medicaid Office Designated Representative Date

All fee for service providers must have a fully executed certification form on file and all managed care organizations must ensure all certification criteria are met.

AHCA-Med Serv Form 023, June 2007 (incorporated by reference in 59G-4.199)

APPENDIX D
AGENCY CERTIFICATION
INTENSIVE CASE MANAGEMENT TEAM SERVICES
ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT

Agency Name _____

Agency Address _____

_____

Phone Number (___) _____ Medicaid Provider # _____

Meets the following criteria for intensive case management team services:

1. Is certified to provide adult mental health targeted case management services.
2. Serves recipients who meet the eligibility requirements for intensive case management team services as specified in the Mental Health Targeted Case Management Coverage and Limitations handbook.
3. Certifies individuals to receive intensive case management team services.
4. Responds 24 hours a day, seven days a week to the needs of recipients served by the team.
5. The maximum average caseload size for a team with four or more case managers shall be 15 persons per each team case manager. The maximum average caseload size for a team with three case managers shall be seven persons per each team case manager. The maximum average caseload size for a team with less than three case managers shall be six persons per each team case manager.
6. Transfers an individual from an intensive case management team to an individual case manager when the recipient and the team agree that intensive case management team services are no longer needed or when the individual refuses intensive case management team services.

_____ _____

Provider Administrator Date

_____ _____

Area Medicaid Office Designated Representative Date

All fee for service providers must have a fully executed certification form on file and all managed care organizations must ensure all certification criteria are met.

AHCA-Med Serv Form 024, June 2007 (incorporated by reference in 59G-4.199)

APPENDIX E
CASE MANAGEMENT SUPERVISOR CERTIFICATION
CHILDREN'S MENTAL HEALTH TARGETED CASE MANAGEMENT

Applicant Name _____

Agency Name _____

Agency Address _____

_____

Phone Number (___) _____ Medicaid Provider # _____

Is hereby certified as having met the requirements for supervision of children's mental health targeted case management. This individual is employed by an agency certified to provide children's mental health targeted case management services and meets the following criteria:

- A master's degree from an accredited university or college with a major in counseling, social work, psychology, criminal justice, nursing, rehabilitation, special education, health education, or a related human services field and three years of full time or equivalent professional experience serving the target population; or
- A bachelor's degree from an accredited university or college and five years of full time or equivalent case management experience serving the target population; and
- Has completed or agreed to complete AHCA-approved mental health targeted case management training within three months of initially supervising Medicaid services. If the training is not completed within three months, the provider agency must request that the Medicaid fiscal agent disenroll the supervisor. The provider agency cannot continue to bill Medicaid for services rendered by the case management supervisor.

_____ _____

Case Management Supervisor Date

_____ _____

Provider Administrator Date

AHCA-Med Serv Form 025, July 2006 (incorporated by reference in 59G-4.199, F.A.C.)

APPENDIX F
CASE MANAGEMENT SUPERVISOR CERTIFICATION
ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT

Applicant Name _____

Agency Name _____

Agency Address _____

_____

Phone Number (___) _____ Medicaid Provider # _____

Is hereby certified as having met the requirements for supervision of adult mental health targeted case management. This individual is employed by an agency certified to provide adult mental health targeted case management services and meets the following criteria:

- A master's degree from an accredited university or college with a major in counseling, social work, psychology, criminal justice, nursing, rehabilitation, special education, health education, or a related human services field and three years of full time or equivalent professional experience serving the target population; or
- A bachelor's degree from an accredited university or college and five years of full time or equivalent case management experience serving the target population; and
- Has completed or agreed to complete AHCA-approved mental health targeted case management training within three months of initially supervising Medicaid services. If the training is not completed within three months, the provider agency must request that the Medicaid fiscal agent disenroll the supervisor. The provider agency cannot continue to bill Medicaid for services rendered by the case management supervisor.

_____ _____

Case Management Supervisor Date

_____ _____

Provider Administrator Date

AHCA-Med Serv Form 026, July 2006 (incorporated by reference in 59G-4.199, F.A.C.)

APPENDIX G
CASE MANAGER CERTIFICATION
CHILDREN'S MENTAL HEALTH TARGETED CASE MANAGEMENT

Agency Name _____

Agency Address _____

_____

Phone Number (___) _____ Medicaid Provider # _____

Is hereby certified as having met the requirements for provision of children's mental health targeted case management. This individual is employed by an agency certified to provide children's mental health targeted case management services and meets the following criteria:

1. Has a bachelor's degree from an accredited university or college, with a major in counseling, social work, psychology, criminal justice, nursing, rehabilitation, special education, health education or a related human services field and has a minimum of one year of full-time or equivalent experience working with children with serious emotional disturbance; or
   Has a bachelor's degree from an accredited university or college and three years of full-time or equivalent experience working with children with serious emotional disturbance.
2. Has completed AHCA-approved case management training or will complete AHCA-approved case management training within three months.
3. Has knowledge of available resources in the service area for children with serious emotional disturbance.
4. Is knowledgeable of and will comply with state and federal statutes, rules and policies that effect the target population.

_____ _____
Case Manager Date

_____ _____
Case Manager's Supervisor Date

_____ _____
Provider Administrator Date

AHCA-Med Serv Form 027, July 2006 (incorporated by reference in 59G-4.199, F.A.C.)

APPENDIX H
CASE MANAGER CERTIFICATION
ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT

Agency Name _____

Agency Address _____

_____

Phone Number (___) _____ Medicaid Provider # _____

Is hereby certified as having met the requirements for provision of adult mental health targeted case management. This individual is employed by an agency certified to provide adult mental health targeted case management services and meets the following criteria:

1. Has a bachelor's degree from an accredited university or college with a major in counseling, social work, psychology, criminal justice, nursing, rehabilitation, special education, health education, or a related human services field (a related human services field is one in which major course work includes the study of human behavior and development) and has a minimum of one year of full time or equivalent experience working with adults experiencing serious mental illness; or

   Has a bachelor's degree from an accredited university or college and three years full time or equivalent experience working with adults experiencing serious mental illness.
2. Has completed AHCA-approved case management training or will complete AHCA-approved case management training within three months.
3. Has knowledge of available resources in the service area for adults with serious mental illnesses.
4. Is knowledgeable of and will comply with state and federal statutes, rules and policies that effect the target population.

_____ _____
Case Manager Date

_____ _____
Case Manager's Supervisor Date

_____ _____
Provider Administrator Date

AHCA-Med Serv Form 028, July 2006 (incorporated by reference in 59G-4.199, F.A.C.)

APPENDIX I
CHILDREN'S CERTIFICATION
CHILDREN'S MENTAL HEALTH TARGETED CASE MANAGEMENT

Child's Name _____

Is hereby certified to meet all the following children's mental health targeted case management criteria:

1. Is enrolled in a Department of Children and Families children's mental health target population;
2. Has a mental health disability (i.e., serious emotional disturbance or emotional disturbance) which requires advocacy for and coordination of services to maintain or improve level of functioning;
3. Requires services to assist him or her in attaining self sufficiency and satisfaction in the living, learning, work and social environments of his or her choice;
4. Lacks a natural support system with the ability to access needed medical and social environments of his or her choice;
5. Requires ongoing assistance to access or maintain needed care consistently within the service delivery system;
6. Has a mental health disability (i.e., serious emotional disturbance or emotional disturbance) duration that, based upon professional judgment, will last for a minimum of one year;
7. Is in out-of-home mental health placement or at documented risk of out-of-home mental health placement; and
8. Is not receiving duplicate case management services from another provider; or
9. Has relocated from a Department of Children and Families district or region where he or she was receiving mental health targeted case management services.

_____ _____

Case Manager Date

_____ _____

Case Manager's Supervisor Date

Form must be filed in the recipient's case record.

AHCA-Med Serv Form 029, July 2006 (incorporated by reference in 59G-4.199, F.A.C.)

APPENDIX J
ADULT CERTIFICATION
ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT

Recipient's Name _____ Medicaid ID # _____

Is hereby certified as meeting all of the following adult mental health targeted case management criteria.

1. Is enrolled in a Department of Children and Families adult mental health target population
2. Has a mental health disability (i.e., severe and persistent mental illness) which requires advocacy for and coordination of services to maintain or improve level of functioning;
3. Requires services to assist in attaining self sufficiency and satisfaction in the living, learning, work and social environments of choice;
4. Lacks a natural support system with the ability to access needed medical, social, educational and other services;
5. Requires ongoing assistance to access or maintain needed care consistently within the service delivery system;
6. Has a mental health disability (i.e., severe and persistent mental illness) duration that, based upon professional judgment, will last for a minimum of one year;
7. Is not receiving duplicate case management services from another provider;
8. Meets at least one of the following requirements (check all that apply):

    a. Is awaiting admission to or has been discharged from a state mental health treatment facility;
    b. Has been discharged from a mental health residential treatment facility;
    c. Has had more than one admission to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities in the past 12 months;
    d. Is at risk of institutionalization for mental health reasons (provide explanation);
    e. Is experiencing long-term or acute episodes of mental impairment that may put him or her at risk of requiring more intensive services (provide explanation); or

9. Has relocated from a Department of Children and Families district or region where he or she was receiving mental health targeted case management services.

_____ _____
Case Manager Date

_____ _____
Case Manager's Supervisor Date

Form must be filed in the recipient's case record.

AHCA-Med Serv Form 030, July 2006 (incorporated by reference in 59G-4.199, F.A.C.)

APPENDIX K
ADULT CERTIFICATION
INTENSIVE CASE MANAGEMENT TEAM SERVICES
ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT

Recipient's Name: _____ Medicaid ID #: _____

Is hereby certified as meeting all the following Intensive Care Management criteria.

_____ 1. Is enrolled in a Department of Children and Families adult mental health target population.

_____ 2. Meets at least one of the following requirements (check all that apply):

_____ a. Has resided in a state mental health hospital for at least six months in the past 36 months. List the facilities and dates of admission and discharge.

_____

_____

_____

_____

_____

_____

_____ b. Resides in the community and has had two or more admissions to a state mental health hospital in the past 36 months. List the state facility and dates of admission.

_____

_____

_____

_____

_____ c. Resides in the community and has had three or more admissions to a crisis stabilization unit (CSU), short-term residential facility (SRT) or inpatient psychiatric unit, or any combination of these facilities within the past 12 months. List the facilities and dates of admissions and discharges:

_____

_____

_____

_____

AHCA-Med Serv Form 031, July 2006 (incorporated by reference in 59G-4.199, F.A.C.)

APPENDIX L
MEDICAID 30-DAY CERTIFICATION FOR CHILDREN'S OR ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT

Recipient's Name: _____

DOB: _____ Medicaid ID #: _____

Is hereby certified as meeting the following criteria:

____ The recipient has been referred by Medicaid's utilization management service after a denied admission to or discharge from an inpatient psychiatric unit; or

____ The recipient has been admitted to an inpatient psychiatric unit and has been identified by AHCA's utilization management service as high risk.

This certification is effective for 30 days. To receive Medicaid reimbursement for services beyond 30 days, the recipient must be determined eligible for children's or adult mental health targeted case management and must receive services in accordance with policy.

_____ _____

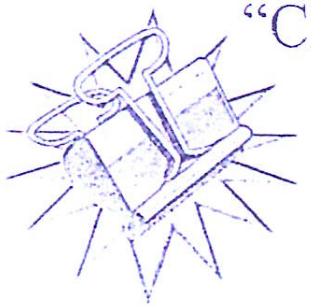
Area Medicaid Office Designated Representative Date

All fee for service providers must have a fully executed certification form on file and all managed care organizations must ensure all certification criteria are met.

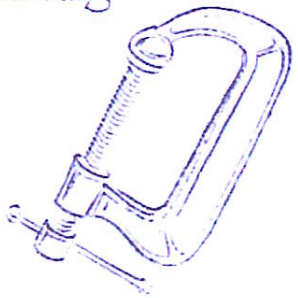
Form must be filed in the recipient's case record.

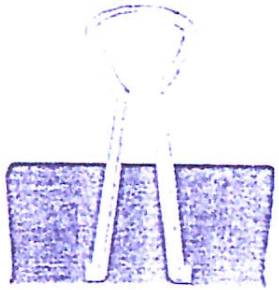
AHCA-Med Serv Form 032, June 2007 (incorporated by reference in 59G-4.199)

Definition – *Getting a Grip on TCM*



"CLAMP" – a useful mnemonic tool for remembering TCM eligible services





C - Coordinating

L - Linking

A - Accessing

M - Monitoring

P - Planning

Examples: TCM Services

- Obtaining, coordinating, maintaining resources and services (e.g., housing, entitlements, employment, legal assistance, education, transportation, etc.)

- Planning, arranging, coordinating, obtaining, monitoring, liaising or following up on specific aspect of treatment (e.g. medical tx, substance abuse treatment, appointments with other providers)

- Working with and collaborating with collaterals external to the agency including family members, landlords, employers

- Engaging the client in services (new or unengaged clients)

Examples: Non-TCM Services

- *Directly assisting with personal care or ADLs* (activities of daily living), e.g., assisting with budgeting, cooking, shopping, laundry, moving residences, payee services, etc.
- Performing routine services including courier services, e.g., running errands or picking up and delivering food stamps or entitlement checks, etc.
- Providing other services that are billable through Medicaid, e.g., medical exams, treatment, therapy, counseling, etc.
- *Transporting* a client or family member
- Unsuccessfully attempting to provide a service such as calling and leaving a message; no shows, cancellations, etc.