

SECTION II - CHILDREN’S SERVICES TARGETED CASE MANAGEMENT
CONTENTS

200.000 CHILDREN’S SERVICES TARGETED CASE MANAGEMENT GENERAL INFORMATION

- 201.000 Arkansas Medicaid Participation Requirements for Children’s Services Targeted Case Management (TCM) Program
- 201.100 Qualifications of Children’s Services TCM Provider
- 202.000 Children’s Services Targeted Case Management Providers in Bordering and Non-Bordering States

210.000 PROGRAM COVERAGE

- 210.100 Introduction
- 211.000 Scope
- 212.000 Target Population Covered by Children’s Services
- 213.000 Description of Service Activities
- 214.000 Exclusions
- 215.000 Documentation Requirements
- 215.100 Documentation in Beneficiary Files
- 215.200 Reserved
- 215.300 Reserved
- 216.000 Electronic Signatures

240.000 PRIOR AUTHORIZATION

250.000 REIMBURSEMENT

- 250.100 Method of Reimbursement
- 251.000 Rate Appeal Process

260.000 BILLING PROCEDURES

- 262.000 CMS-1500 Billing Procedures
- 262.100 Children’s Services Targeted Case Management Procedure Code
- 262.200 National Place of Service (POS) Code
- 262.300 Billing Instructions – Paper Only
- 262.310 Completion of CMS-1500 Claim Form
- 262.400 Special Billing Procedures

200.000 CHILDREN’S SERVICES TARGETED CASE MANAGEMENT GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Children’s Services Targeted Case Management (TCM) Program 11-1-09

Children’s Services Targeted Case Management providers must meet the Provider Participation and enrollment requirements contained in Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

The Children’s Services Targeted Case Management staff must be licensed or certified in accordance with the requirements in Section 201.100 to serve their respective target population.

201.100 Qualifications of Children’s Services TCM Provider 1-1-05

Providers of Children’s Services targeted case management services must be certified and have a demonstrated capacity to provide all core elements of case management, which includes:

- A. Assessment

- B. Care or service plan
- C. Development
- D. Linking or coordination of services
- E. Reassessment
- F. Follow-up of services

The case management staff for targeted case management for Children's Services may include registered nurses, licensed social workers, pediatricians, registered dietitians, parent aides and clerical support staff who are credentialed or who are under the direct supervision of an appropriately credentialed case manager.

The qualifications for credentialed case manager include:

A. Registered Nurse

This individual must be licensed as a registered nurse by the Arkansas Board of Nursing and have satisfactorily completed a one-month (four-week) case management orientation provided by Children's Services.

B. Social Worker

This individual must be a licensed social worker in the State of Arkansas or be qualified through education, training or experience to work in a social work role and have satisfactorily completed a one-month (four-week) case management orientation provided by Children's Services.

C. Pediatrician

This individual must be a licensed M.D. in the State of Arkansas and have satisfactorily completed a one-month (four-week) case management orientation provided by Children's Services.

D. Parent Aide

This individual must be employed by Children's Services for the purpose of assisting families to access services and be a parent of a child with special health care needs. The parent aide must have satisfactorily completed the one-month (four-week) orientation provided by Children's Services. A parent aide cannot be a case manager of his or her own child.

E. Clerical Support Staff

This individual must have two years of experience with a program for children with special health care needs; experience with assisting families to obtain needed medical, social and educational services and must have demonstrated the ability to assist families appropriately to access needed services. The individual must have satisfactorily completed a two-week orientation training class with Children's Services.

**202.000 Children's Services Targeted Case Management Providers in
Bordering and Non-Bordering States**

1-1-05

The Arkansas Medicaid Children's Services Targeted Case Management Program is limited to in-state providers only.

210.000 PROGRAM COVERAGE

210.100 Introduction 1-1-05

Children's Services serves as the Title V (Children with Special Health Care Needs) Agency within the single state agency, the Department of Human Services.

211.000 Scope 1-1-05

Medicaid-covered Children's Services targeted case management services are services that assist beneficiaries in accessing needed medical, social and other support services appropriate to the beneficiary's needs.

Children's Services targeted case management services are covered when they are:

- A. Medically necessary
- B. Provided to outpatients only
- C. Provided at the option of the beneficiary and by the provider chosen by the beneficiary
- D. Provided to beneficiaries who have no reliable or available support to assist them in gaining access to needed care and services
- E. Services that directly affect the beneficiary but may not require the beneficiary's active participation (e.g., housing assistance)
- F. Furnished in accordance with a service plan

212.000 Target Population Covered by Children's Services 1-1-05

Children's Services targeted case managers are restricted to serving beneficiaries who are not receiving case management services under an approved waiver program, are not placed in an institution and are:

- A. Aged 0 to 21 years and meet the medical eligibility criteria of Children's Services
- B. Beneficiaries in the state's Title V Children with Special Health Care Needs Agency or
- C. SSI/TEFRA Disabled Children Program beneficiaries, aged 0 to 16 years, with any diagnosis.

213.000 Description of Service Activities 1-1-05

Children's Services must provide the following targeted case management activities:

- A. Needs Assessment
 1. A written comprehensive assessment (by Children's Services) of the child's needs, including analysis of recommendations (e.g., medical records) regarding the service needs of the child.
 2. Review of records of medical/psychological evaluations in order to assess the child's needs.
 3. Development of a service plan with the family.
 4. Assisting the beneficiary in accessing needed services.
- B. Service Plan

Monitoring the child's progress by making referrals to service providers through telephone, written or personal contacts; tracking the child's appointments; performing follow-up on

services rendered and performing periodic reassessments of the child's changing needs (including reviews of the child's medical records).

- C. Preparing and maintaining case records and documenting contacts, needed services, reports, and the child's progress, etc. These activities may apply to either the needs assessment or the service plan.

214.000**Exclusions****1-1-05**

Services not appropriate for Children's Services targeted case management and not covered under the Arkansas Medicaid Program include, but are not limited to:

- A. Targeted case management for beneficiaries who are receiving case management services through the DDS Alternative Community Services Waiver Program.
- B. The actual provision of services or treatment. Examples include, but are not limited to:
 - 1. Training in daily living skills.
 - 2. Training in work skills, social skills and/or exercise.
 - 3. Training in housekeeping, laundry and cooking.
 - 4. Transportation services.
 - 5. Counseling or crisis intervention services.
- C. Services that go beyond assisting individuals in gaining access to needed services. Examples include, but are not limited to:
 - 1. Supervisory activities.
 - 2. Paying bills and/or balancing the beneficiary's checkbook.
 - 3. Observing a beneficiary receiving a service, e.g., physical therapy, speech therapy and classroom instruction.
 - 4. Travel and/or waiting time.
- D. Case management services that duplicate services provided by public agencies or private entities under another program authorized for the same purpose. For example, targeted case management services provided to foster children duplicate payments made to a public agency and are therefore not reimbursable.
- E. Case management services that duplicate integral and inseparable parts of other Medicaid or Medicare services (for example, home health services) when provided on the same date of service.
- F. Case management services provided to inpatients. Discharge planning is a required service of inpatient facilities. These facilities include, but are not limited to acute care hospitals, rehabilitative hospitals, inpatient psychiatric facilities, nursing homes and residential treatment facilities.
- G. Case management services provided while transporting a beneficiary.
- H. Time spent billing for targeted case management services.
- I. Time spent determining medical and financial eligibility for Children's Services.
- J. Any activity related to Children's Services authorization and payment of services.

215.000**Documentation Requirements****11-1-09**

The Children's Services targeted case management providers must keep and properly maintain written records. Along with the required enrollment documentation, which is located in Section 141.000, the following records must be included in the provider's files.

215.100 Documentation in Beneficiary Files 11-1-09

The Children's Services targeted case manager must develop and maintain sufficient written documentation to support each service for which billing is made. All entries in a beneficiary file must be signed and dated by the Children's Services targeted case manager who provided the service, along with the individual's title. The documentation must be maintained in the beneficiary's case file.

Documentation should consist of, at a minimum, material that includes:

- A. When applicable, a copy of the original and all updates of the beneficiary's individualized education plan (IEP) or individualized family service plan (IFSP).
- B. The specific program services provided.
- C. The date services are provided.
- D. Updated progress notes describing the nature and extent of specific services provided. Progress notes are signed electronically.
- E. The beneficiary's name and Medicaid identification number.
- F. The name and title of the Children's Services targeted case manager providing the service.
- G. A copy of the original and all updates of the Children's Services beneficiary's service plan.

215.200 Reserved 11-1-09

215.300 Reserved 11-1-09

216.000 Electronic Signatures 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

240.000 PRIOR AUTHORIZATION 1-1-05

Prior authorization is not required for Children's Services targeted case management services.

250.000 REIMBURSEMENT

250.100 Method of Reimbursement 1-1-05

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time the service is provided and upon accurate completeness of the claim filed for the service. The provider is responsible for verifying the beneficiary is eligible for Medicaid prior to rendering services.

Children's Services targeted case management services must be billed on a per unit basis. One case management unit is the sum of all Children's Services targeted case management activities that occur within a day.

251.000 Rate Appeal Process 10-13-03

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate.

Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference for a full explanation of the factors involved and the program decision.

Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.

If the provider disagrees with the decision made by the Assistant Director, the provider may appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) management staff, who will serve as chairperson.

The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director of the Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The panel will hear the question(s) and will submit a recommendation to the Director of the Division of Medical Services.

260.000 BILLING PROCEDURES

262.000 CMS-1500 Billing Procedures

262.100 Children’s Services Targeted Case Management Procedure Code 2-1-22

Providers of Children’s Services targeted case management (TCM) must bill for services provided using the procedure code and modifiers shown in the table below. Providers must use this procedure code and the indicated modifiers when billing either electronically or on paper for Children’s Services TCM services.

[View or print the procedure codes for Children’s Services Targeted Case Management \(TCM\) services.](#)

262.200 National Place of Service (POS) Code 7-1-07

The national place of service code is used for both electronic and paper billing.

Place of Service	POS Code
Other locations	99

262.300 Billing Instructions – Paper Only 11-1-17

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. [View a sample form CMS-1500.](#)

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information.](#)

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

262.310 Completion of CMS-1500 Claim Form

9-1-14

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED SEX	Reserved for NUCC use. Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT? PLACE (State)	Required when an auto accident is related to the services. Check YES or NO. If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH SEX	Not required. Not required.
b. EMPLOYER'S NAME OR SCHOOL NAME	Not required.
c. OTHER CLAIM ID NUMBER	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

Field Name and Number	Instructions for Completion
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	<p>Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.</p> <p>Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.</p>
15. OTHER DATE	<p>Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.</p> <p>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:</p> <p>454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation</p>
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for Children's Services TCM. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.

Field Name and Number	Instructions for Completion
20. OUTSIDE LAB? \$ CHARGES	Not required. Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>Use "9" for ICD-9-CM.</p> <p>Use "0" for ICD-10-CM.</p> <p>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p>
22. RESUBMISSION CODE ORIGINAL REF. NO.	<p>Reserved for future use.</p> <p>Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.</p>
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	<p>CPT/HCPCS</p> <p>Enter the correct CPT or HCPCS procedure code from Section 262.100.</p>
MODIFIER	Modifier(s) if applicable.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do not include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

262.400 Special Billing Procedures

10-13-03

Not applicable to this program.