Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Distribution: All Providers

Bulletin Number: MMP 24-61

Issued: December 23, 2024

Subject: Targeted Case Management Services for Children with Medical Complexity

Effective: February 1, 2025

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild, Children's Special Health Care Services (CSHCS)

The purpose of this bulletin is to establish coverage and reimbursement of Targeted Case Management (TCM) services for eligible beneficiaries with qualifying medical complexity. Coverage of Children with Medical Complexity Targeted Case Management (CMC TCM) services is effective for dates of service on or after February 1, 2025. CMC TCM services are carved out of the Medicaid Health Plan's capitation and are billed and reimbursed as a Fee-for-Service (FFS) benefit, consistent with applicable Medicaid policy.

In addition to this policy, a website will be established where various resources will be made available, including the program forms referenced in this policy and a CMC TCM case management handbook for program providers.

Children with medical complexity (CMC) are a small subset of children with special health care needs. CMC have significant chronic medical conditions that involve multiple organ systems, substantial health service needs, major functional limitations, and high health care resource use. Evidence indicates that intensive care coordination is an effective strategy for addressing these challenges.

I. General Information

The CMC TCM program provides intensive, targeted case management services to eligible beneficiaries with medical complexity. This integrated case management model improves access to services for eligible beneficiaries with chronic physical and mental health conditions and addresses their social determinants of health. The core elements of CMC TCM services include:

- assessment;
- plan of care;
- referral and coordination services; and
- monitoring/follow-up activities.

These services are made available through a case management entity. The CMC TCM case management entity offers outpatient, case management to eligible beneficiaries with medical complexity. The CMC TCM case management entity must be enrolled in Medicaid and not otherwise funded to provide similar services to the same population. The CMC TCM case management entity must be willing, qualified, and certified by the Michigan Department of Health and Human Services (MDHHS) to offer these services to a broad cross section of the eligible population.

The CMC TCM core team is the multi-disciplinary team based at the enrolled CMC TCM case management entity that delivers the CMC TCM services. Eligible beneficiaries work with the CMC TCM core team to receive the intensive case management services.

II. Beneficiary Eligibility

The CMC TCM services are voluntary services available to children under 21 years of age who are determined dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid (Title V/XIX), are enrolled in the CSHCS program only (Title V only) or are eligible for Medicaid (Title XIX) or Children's Health Insurance Program (CHIP). Additionally, they must meet **all** the following specified chronicity, complexity, and fragility criteria:

- have at least one CSHCS medically eligible condition that involves three or more organ systems; and
- have functional limitations, and are technologically dependent and/or a transplant candidate; and
- receive treatment from three or more different medical and/or surgical specialties at a hospital or medical university.

Eligible beneficiaries must also have experienced **at least one** of the following utilization criteria during the previous 12 months:

- one or more hospital admissions, with at least one hospital stay of five or more days; or
- ten or more visits with a medical or surgical specialist at a pediatric specialty clinic.

Beneficiaries who are too young to have met the utilization criteria may be eligible if they meet the above-stated chronicity, complexity, and fragility criteria and **both** of the following:

- a stay in the hospital totaling five or more days; and
- clinicians' anticipation that the beneficiary will be an intensive user of health resources (i.e., is expected to meet utilization criteria described above).

Non-eligible beneficiaries include incarcerated individuals in public institutions, beneficiaries receiving hospice services, or beneficiaries receiving case management services from another provider.

III. Enrollment

A. Provider Referrals

Eligible beneficiaries will be identified through a referral and screening process that is completed by the CMC TCM core team.

Providers knowledgeable about chronic complex physical health conditions, understand the benefits of intensive case management services, and/or have treated the beneficiary may submit referrals. The CMC TCM core team will consider referrals made by the following qualified health professionals:

- specialists/subspecialists
- emergency room physicians
- primary care physicians
- non-physician practitioners (NPPs)

B. Eligibility Determination

Upon receipt of the referral, the CMC TCM core team confirms the beneficiary's eligibility for CMC TCM services through a review of the beneficiary's medical records and utilization data. The CMC TCM core team notifies both the referring provider and the beneficiary and/or parent/guardian of their eligibility status. Eligible beneficiaries and their parents/guardians are offered a choice to receive the CMC TCM services.

All eligibility notifications must be in writing and provide information about the beneficiary's right to appeal decisions regarding eligibility.

To assist beneficiaries and their parents/guardians in making an informed choice concerning these services, MDHHS will provide a website where interested persons can learn more about the CMC TCM program and its state-certified case management entities.

Primary Point of Contact and Intake Meeting

Upon completion of the eligibility determination process, eligible beneficiaries will be provided a CMC TCM primary point of contact who is a member of the CMC TCM core team. The primary point of contact schedules the intake meeting with the beneficiary, the beneficiary's parents, or legal guardians. The intake meeting should be a face-to-face contact.

The purpose of the intake meeting includes, but is not limited to:

- confirming voluntary enrollment and CMC TCM case management entity selection;
- educating the beneficiary and/or parent/guardian about the CMC TCM services and answering questions;
- collecting the beneficiary's demographic and contact information, current legal status, medical and behavioral health history;

- completing needed authorizations related to the sharing of protected health information; and
- scheduling the initial in-person, comprehensive assessment with the CMC TCM core team.

C. Beneficiary Consent

Prior to receiving the CMC TCM services, beneficiaries and/or parents/guardians must select the CMC TCM case management entity of their choice and sign the CMC TCM Informed Consent form (BPHASA-2412). The CMC TCM medical director adds their signature to the form to acknowledge that the beneficiary has been accepted and maintains the form in the beneficiary's case record.

Once accepted into the CMC TCM program, the CMC TCM core team will notify MDHHS of the new CMC TCM beneficiary by submitting a client-specific CMC TCM Authorization form (BPHASA-2409) through the Community Health Automated Medicaid Processing System (CHAMPS) Document Management Portal (DMP). Upon receipt of the CMC TCM Authorization form, MDHHS will add the CMC TCM case management entity and their unique National Provider Identifier (NPI) number to the beneficiary's file. It is incumbent upon the CMC TCM case management entities to verify their authorization in CHAMPS prior to rendering billable services. CMC TCM case management entities who are not authorized to provide services for a beneficiary will not be eligible for CMC TCM payment.

D. Transfer of Care

A beneficiary or parent/guardian may change CMC TCM case management entities based on beneficiary/parent/guardian preference. The current CMC TCM case management entity on record must consult with the new CMC TCM case management entity about the case and transfer all applicable information and case records, including all completed assessments and the updated comprehensive, individualized plan of care, to the new CMC TCM case management entity.

Protected health information (PHI), personally identifiable information (PII), and sensitive or confidential information should only be shared in compliance with the privacy and security requirements of federal and state laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and the Michigan Mental Health Code, and using the most secure method and appropriate encryption standards. Only the minimum amount of PHI, PII, sensitive and/or confidential information necessary should be shared with the new CMC TCM case management entity.

To institute the change in case management entities, the current CMC TCM management entity on record must submit a CMC TCM Deauthorization Form (BPHASA-2410) to MDHHS to request disenrollment of a CMC TCM beneficiary from their program. Then, the new CMC TCM case management entity must submit a client-specific CMC TCM Authorization form (BPHASA-2409) through the CHAMPS DMP to add the beneficiary. It is incumbent upon the new CMC TCM case management entity to verify their authorization in CHAMPS prior to rendering a CMC TCM billable service. CMC TCM case management

entities who are not authorized to provide services for a beneficiary will not be eligible for CMC TCM payment.

E. Ongoing CMC TCM Service Participation

The beneficiary's involvement in the CMC TCM services is contingent upon their continued enrollment in Medicaid/CHIP and/or CSHCS. After the initial comprehensive assessment, the CMC TCM core team will offer the beneficiary and/or parent/guardian the opportunity to discuss and assess the beneficiary's continued need for intensive case management services, including: the beneficiary's needs and goals, progress and outcomes, case complexity (i.e., medical, social, psychological, and financial), support systems and resource availability, self-management capabilities, risk factors, and client's preferences. If the CMC TCM core team and beneficiary and/or parent/guardian mutually agree that the beneficiary continues to need and benefit from these services, enrollment can continue. Decisions and reasons to continue CMC TCM services should be noted in the beneficiary's case record.

F. CMC TCM Disenrollment

A CMC TCM program disenrollment is indicated if any of the following events occur:

- the beneficiary's Medicaid/CHIP and/or CSHCS enrollment ends
- the beneficiary transitions into hospice
- the beneficiary dies
- the beneficiary reaches age 21 years
- the beneficiary moves out of state
- if the beneficiary chooses to opt out by:
  - requesting to end services
  - participating in a different case management program
  - failing to participate in a comprehensive assessment and/or the development of the comprehensive, individualized plan of care as requested by the CMC TCM core team
  - failing to participate in a CMC TCM billable service for a continuous period lasting more than **three months**
- the medical director terminates the beneficiary's participation in services for fraud, abuse, misconduct, or other reasons

If the CMC TCM core team needs to terminate CMC TCM services for any reason, the CMC TCM core team is required to notify the beneficiary and/or parent/guardian in writing 45 days before their disenrollment from the program, document the reason for the disenrollment in the beneficiary's comprehensive, individualized plan of care, offer a meeting to discuss, and advise the beneficiary of their appeal rights for any service termination.

Additionally, CMC TCM case management entities are required to submit a CMC TCM Deauthorization Form (BPHASA-2410) to MDHHS to request the disenrollment of a CMC TCM beneficiary from the program. Forms are submitted via the CHAMPS DMP. Once services are terminated, the beneficiary will need to have their CMC TCM eligibility redetermined to resume CMC TCM services, unless otherwise approved by MDHHS.

G. Duplication of Services

Beneficiaries must not receive case management services from more than one case management program. If, while receiving CMC TCM services, non-CMC TCM case management programs are identified as providing case management services to the CMC TCM beneficiary, the preferences of the beneficiary/parent/guardian concerning which agency provides services must be considered when roles overlap.

i. Medicaid Health Plan (MHP) Coordination

The CMC TCM services are carved out of the MHP contract. CMC TCM case management entities must establish a process for the CMC TCM core team to provide written communication with health plan staff on a quarterly basis to share assessments and comprehensive, individualized plans of care for health plan beneficiaries receiving CMC TCM services, and to ensure no service duplication occurs for mutually served beneficiaries.

IV. Core Elements of CMC TCM Services

CMC TCM services are intensive, comprehensive, and fully integrated case management services, designed for children with medical complexity. To achieve their intended purpose, these services must not be implemented sporadically but should be delivered consistently by staff dedicated to the program, and at a minimum every month.

CMC TCM services are multi-disciplinary, team-based services that may be accessed in multiple settings, including the clinic or home, and either in-person or via telemedicine and include:

- assessment;
- plan of care;
- referral and coordination services; and
- monitoring/follow-up activities.

CMC TCM services focus on the completion of a comprehensive assessment to identify CMC needs. The comprehensive assessment is completed by the CMC TCM core team after the CMC TCM case management entity is added to the beneficiary's record. Guided by the outcome of this assessment, the CMC TCM core team works with the beneficiary and/or parent/guardian to develop a comprehensive, individualized plan of care that reflects the input and involvement of the beneficiary and/or parent/guardian. Ongoing care coordination, comprehensive transitional care, support, and/or referrals to medical, behavioral, school

and/or community-based support services, as well as monitoring and follow-up activities are provided through the collaborative efforts of the CMC TCM core team.

Beneficiary participation in CMC TCM is voluntary. Once enrolled, beneficiaries may opt out at any time. The beneficiary and/or parent/guardian indicates their desire to participate by signing the CMC TCM Informed Consent form (BPHASA-2412) and maintaining contact with and receiving services from the CMC TCM core team.

If a beneficiary and/or their parent/guardian declines CMC TCM services, the CMC TCM core team is required to document that in the beneficiary's case record. Beneficiaries who are notified of CMC TCM eligibility and choose not to receive CMC TCM services at that time, may elect to receive CMC TCM services in the future if they continue to meet the eligibility criteria.

Beneficiaries may not be compelled to accept CMC TCM services. Beneficiaries who decline or choose not to receive services may do so without jeopardizing their access to other necessary medical services. If a beneficiary and/or their parent/guardian declines CMC TCM services or decides to opt out of services after services have been initiated, the CMC TCM core team is required to document that event in the beneficiary's case record.

The CMC TCM core team is required to maintain beneficiary case records for all clients who are referred to the program for CMC TCM eligibility determination. For all enrolled beneficiaries, the CMC TCM core team must document the date of all contacts in the beneficiary's case record. Specifically, the case record must include the following information:

- The name of the individual;
- The dates of the case management services;
- The name of the case management entity (if relevant) and the person providing the case management service;
- The nature and content of the case management services provided and whether goals specified in the care plan have been achieved;
- Whether the individual had declined services in the care plan;
- The need for, and occurrences of, coordination with other case managers;
- A timeline for obtaining needed services; and
- A timeline for reevaluation of the plan.

A. Comprehensive Assessment

Case management services include a comprehensive assessment to determine the beneficiary's need for medical, educational, social, and/or other services. The assessment must be a written document. Comprehensive assessments are covered no more than once per year from the date of the initial comprehensive assessment, unless otherwise approved by MDHHS.

The entire CMC TCM core team assigned to the client is required to be part of the initial, comprehensive assessment with the beneficiary and/or parent/guardian. The initial comprehensive assessment is conducted as an in-person encounter. Subsequent comprehensive assessments can be conducted face-to-face. The purpose of the comprehensive assessment is to gather sufficient information to develop a comprehensive, individualized plan of care for the beneficiary.

B. Comprehensive, Individualized Plan of Care Development

The CMC TCM core team must develop and document a comprehensive, individualized plan of care based on the information collected from the comprehensive assessment. At a minimum, the plan of care must:

- specify goals and objectives that address the medical, social, educational and any other identified needs, including social determinants of health;
- identify a course of action to respond to the beneficiary's assessed needs;
- include the duration, scope, and amount of services needed, as well as identify the service provider and timeframes for initiating and/or completing the identified actions;
- describe the responsibilities of the beneficiary/parent/guardian associated with accomplishing the comprehensive, individualized plan of care; and
- at least quarterly, document progress toward achieving specified goals and objectives.

The CMC TCM core team must work with the beneficiary and/or their parent/guardian to develop the plan's goals/objectives and to identify a course of action to respond to the beneficiary's assessed needs. The comprehensive, individualized plan of care should address the physical and behavioral health needs of the beneficiary, along with any other needed resources such as housing, energy assistance, food and nutrition, vocational training, cultural and spiritual needs, and transportation needs. The plan of care should also address emergency situations and/or determine the steps to take during the exacerbation of symptoms.

Development of the comprehensive, individualized plan of care with the beneficiary/parent/guardian is conducted as a face-to-face encounter. To the maximum extent possible, the CMC TCM core team is required to ensure that the beneficiary and/or parent/guardian are actively involved in the development of the plan of care.

The CMC TCM core team should share the plan of care with the beneficiary/parent/guardian, and others, including medical and social service providers, as applicable and allowable. At a minimum, the comprehensive, individualized plan of care must be reviewed and/or updated quarterly depending on the needs of the beneficiary. Periodic reviews and updates of the plan of care are covered as monitoring and follow-up activities.

C. Referrals and Care Coordination Services

Working collaboratively with the beneficiary/parent/guardian, their specialists/subspecialists, and their primary care and/or other health care providers, members of the CMC TCM core team will facilitate and coordinate the services detailed in the comprehensive, individualized plan of care. The CMC TCM core team will also assist with referrals and other related activities to support the beneficiary in obtaining needed services. Ongoing referral and service coordination activities include face-to-face, and/or reciprocal telephonic or written contacts with, or on behalf of, the beneficiary/parent/guardian.

D. Monitoring and Follow-up Activities

Monitoring and follow-up activities include actions and contacts necessary to ensure the comprehensive, individualized plan of care adequately addresses the beneficiary's needs and is implemented. Monitoring activities may be conducted with the beneficiary/parent/guardian, service providers, or other entities. These activities also include ensuring that changes in the needs or status of the beneficiary are reflected in the plan of care, and that the beneficiary can access services contained in the plan and/or is receiving these services.

Monitoring and follow-up activities include face-to face encounters, and/or reciprocal telephonic or written contact with, or on behalf of, the beneficiary/parent/guardian. Telemedicine encounters may be provided at the discretion of the beneficiary and/or the beneficiary's parents/guardians.

i. Frequency of Monitoring and Follow-up Activities

Monitoring shall occur monthly, or more often if needed, to ensure the beneficiary's needs are met and to maintain a continuing relationship between the beneficiary, their parent/guardian, and any providers responsible for services. Frequency and scope of case management monitoring and follow-up activities must reflect the intensity of the beneficiary's physical health, behavioral health, and welfare needs identified in the comprehensive, individualized plan of care. The CMC TCM core team is required to discuss and document the proposed frequency of contacts with the beneficiary and/or their parent/guardian. The discussion must include the frequency of contacts with the beneficiary, any providers instrumental to the implementation of the plan of care, and any other individuals directly related to implementing services and supports on behalf of the beneficiary.

If the frequency of contacts is less than a monthly, reciprocal encounter, the CMC TCM core team documents the reason in the beneficiary's case record.

E. Service Availability and Accessibility

A CMC TCM core team member must be available and accessible 24 hours per day to a beneficiary and/or their parent/guardian.

F. Types of Encounters

The initial comprehensive assessment is conducted as an in-person encounter with the beneficiary, parent/guardian, and the entire team assigned to the beneficiary. Upon completion of the initial assessment, the beneficiary must be seen in-person at least once per year. This encounter can occur during any of the CMC TCM core services administered by members of the CMC TCM core team assigned to the beneficiary. Subsequent comprehensive assessments and plan of care development encounters must be face-to-face and involve CMC TCM core team members assigned to the beneficiary. Referrals and service coordination services and monitoring and follow-up activities can include face-to face encounters, and/or reciprocal telephonic or written contact with, or on behalf of, the beneficiary/parent/guardian conducted by any member of the CMC TCM core team.

G. Excluded Services

CMC TCM does not include activities that constitute the direct delivery of underlying medical, educational, social, and/or other services to which a beneficiary has been referred. Furthermore, case management services do not include activities that are an integral and inseparable component of another Medicaid-covered service.

Medical services provided by the CMC TCM core team members must be within their scope of practice, in consultation with the beneficiary's specialist(s), and at the request of the beneficiary and/or his/her parent/guardian. Allowable medical services are billed separately and in accordance with established Medicaid policy.

V. CMC TCM Case Management Qualifications

The CMC TCM case management entity must be enrolled in Michigan Medicaid and demonstrate their willingness and qualifications to provide the CMC TCM services, as described herein. All case management entities must be certified by MDHHS prior to providing CMC TCM services. Additionally, the approved CMC TCM case management entity must obtain a separate NPI number that will be used when submitting claims specifically for CMC TCM services.

CMC TCM case management entities will be required to complete a CMC TCM Program Application form (BPHASA-2411). By signing and submitting the BPHASA-2411, the CMC TCM case management entity attests they are able to meet both the CMC TCM case management entity and core team requirements and adhere to this policy, the State Plan, and other applicable MDHHS policies and procedures. A CMC TCM case management entity is designated as a service provider only after MDHHS receives and certifies the signed attestation. (Refer to the Provider Enrollment Section of the General Information for Providers chapter within the MDHHS Medicaid Provider Manual for additional enrollment information).

A. CMC TCM Core Team

Case management services must be provided by a multi-disciplinary team working under the authority of a CMC TCM case management entity that consists of licensed and unlicensed staff and licensed health professionals operating within their state law defined scope of practice. Teams must have adequate knowledge and experience to provide comprehensive and specialized case management services to children with very complex medical needs. Required CMC TCM core team members are as listed and include the following:

- pediatrician (Medical Director);
- non-physician practitioner (NPP);
- registered nurse (RN);
- licensed clinical social worker (LCSW);
- program coordinator; and
- administrative staff.

A licensed pediatric behavioral health provider is recommended to be part of the CMC TCM core team, as the CMC TCM core team identifies and is required to provide case management for all needs, including psychosocial needs. Additional team members may be added to consult regarding specific health concerns (i.e., dietician, respiratory and other therapists, etc.).

Qualifications of individual CMC TCM core team members, with dedicated time to the program, are as listed:

- At least one provider with medical/surgical experience with delivering pediatric hospital or specialty clinic services to medically complex individuals under the age of 21 who regularly experience hospitalization and/or surgery;
- At least one Medicaid-enrolled, licensed pediatrician in possession of or eligible for pediatric specialty board certification. Experience and/or training in palliative care recommended;
- At least one Medicaid-enrolled, licensed NPP with at least two years of professional pediatric experience. A NPP is a healthcare professional licensed as a nurse practitioner, physician assistant, or a clinical nurse specialist;
- At least one licensed master’s prepared Clinical Social Worker with at least two years of professional pediatric experience;
- At least one licensed RN with at least two years of professional pediatric experience;
- At least one individual with a Bachelor of Arts or Science in an academic, business, or medical discipline with experience as a hospital or clinic coordinator with a background in health care who is knowledgeable about case management or care coordination services for individuals with very complex health needs who have hospital admissions or have had/need surgery; and
- A program assistant with a background in health care operations, referrals, scheduling, and patient services.

Additionally, the CMC TCM core team is required to have:

- the ability to support full integration of psychosocial and clinical care;
- sufficient documentation that demonstrates staff has adequate knowledge and experience to provide comprehensive and intensive case management services to beneficiaries with very complex medical and psychosocial needs;
- referral and/or effective working relationships with specialists/subspecialists and other key health care and social service providers who are essential to the care of beneficiaries with complex medical and psychosocial needs (e.g., primary care, private duty nurses, and state and community-based organizations); and
- 24/7 on-call coverage to respond to medical and care coordination needs.

CMC TCM case management entities must enroll through the online MDHHS CHAMPS' Provider Enrollment (PE) subsystem to be reimbursed for fees for services rendered to beneficiaries.

CMC TCM core team members, whose services are directly reimbursable per MDHHS policy, must be separately enrolled in CHAMPS and authorized and approved to bill for services.

B. Telemedicine

Services specified as "face-to-face" per MDHHS telemedicine policy can either be performed in-person or via simultaneous audio/visual telemedicine. CMC TCM case management entities are required to follow Medicaid telemedicine policy requirements, as applicable. (Refer to the Telemedicine chapter of the MDHHS Medicaid Provider Manual.)

VI. Reporting Requirements

A. CMC TCM Case Management Entity Reporting

CMC TCM case management entities are responsible for reporting encounter, clinical outcomes, quality, cost, and other data as requested by MDHHS and/or its designee. MDHHS will require the CMC TCM case management entity to collect, maintain, and organize CMC TCM reporting data. MDHHS will also require the CMC TCM case management entity to send all requested reports to MDHHS in accordance with state defined timelines.

Additionally, CMC TCM case management entities may be requested to submit staffing reports, participate in site visits/audits, and assist in facilitating annual patient experience surveys. CMC TCM case management entities are required to respond to data requests as a condition of continued participation as a CMC TCM program. To the extent possible, MDHHS paid claims data will be utilized for monitoring and evaluation and MDHHS will rely on the CMC TCM case management entity for data not available through the claims system.

VII. Claims Submission

CMC TCM claims are billed according to instructions contained in the Billing & Reimbursement for Professionals Chapter of the MDHHS Medicaid Provider Manual. CMC TCM claims adhere to the Uniform Billing (UB) guidelines on the professional CMS-1500 claim format or the electronic Health Care Claim Professional (837) ASC X12N version 5010 information. CMC TCM claims must be submitted under the CMC TCM services unique NPI number. CHAMPS NPI claim editing will be applied to the billing, rendering, supervising, attending, servicing, and referring providers as applicable for payment.

Medicaid reimbursement for CMC TCM services may not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

CMC TCM services are carved out of the MHPs and are billed and reimbursed as an FFS benefit. All providers submitting claims for services must be Medicaid-enrolled. (Refer to the Billing & Reimbursement for Professionals chapter and the Billing & Reimbursement for Institutional Providers chapter of the MDHHS Medicaid Provider Manual for additional billing information.)

A. Allowable Procedure Codes

All claims submitted for CMC TCM services provided to beneficiaries must include the following Healthcare Common Procedure Coding System (HCPCS) procedure codes:

- **G0506 – Comprehensive assessment and care planning for patients requiring chronic case management services**. This code must be used when billing the comprehensive assessment and comprehensive, individualized plan of care services. This code is limited to one unit of service each year, per CMC TCM case management entity, per beneficiary, unless otherwise approved by MDHHS. This code is not reimbursable for dates of service (DOS) in the same calendar month for the same CMC TCM case management entity and beneficiary as T2023.

  Case management entities receive a flat fee per beneficiary for the completion of a comprehensive assessment and comprehensive, individualized plan of care that meets the coverage criteria. The rate of reimbursement for comprehensive assessment and care planning (G0506) under the CMC TCM program is $1,000.00.

- **T2023 – Targeted case management per month**. This code must be used to bill ongoing referral and care coordination services and monitoring and follow-up activities. This code is limited to one unit of service per calendar month, per CMC TCM case management entity, per beneficiary. This code is not reimbursable for DOS in the same calendar month for the same CMC TCM case management entity and beneficiary as G0506.

Ongoing referral and care coordination services and monitoring and follow-up activities are reimbursable for beneficiaries who have a completed comprehensive assessment and comprehensive, individualized plan of care. Periodic reassessments, reviews, and updates of the plan of care are reimbursable as part of the monitoring and follow-up activities.

Services are reimbursable only if a member of the CMC TCM core team has at least one face-to-face or reciprocal contact with the beneficiary and/or their parent/guardian during the billable month. The rate of reimbursement for targeted case management per month (T2023) under the CMC TCM program is $750.00.

B. Date of Service (DOS)

Case management entities should adhere to the following guidelines when determining the DOS:

- For activities related to the comprehensive assessment and comprehensive, individualized plan of care development (indicated by HCPCS procedure code G0506), the DOS is the date the plan of care is completed.

- For activities related to ongoing referral and coordination services and monitoring and follow-up activities (indicated by HCPCS procedure code T2023), indicate the last day of the month as the DOS on the claim form. The actual DOS for each case management service provided must be documented in the beneficiary's case record.

C. Place of Service (POS)

Case management entities should use a valid place of service (POS) code to indicate the setting in which services were provided. If services occurred in multiple settings, case management entities may bill using the most frequently occurring POS code; however, the actual POS must be indicated when documenting each case management activity in the beneficiary's case record.

D. Third Party Liability

Federal regulations require that all identifiable financial resources available for payment be billed prior to billing Medicaid. If a Medicaid-eligible child is presently covered by another resource and the CMC TCM case management entity does not bill the other resource, Medicaid cannot be billed for the services. (Refer to the Coordination of Benefits chapter of the MDHHS Medicaid Provider Manual for additional information.)

VIII. Training Opportunities

MDHHS will maintain an online CMC TCM Case Management Handbook, as well as provide training opportunities, to support case management entities who will be furnishing CMC TCM services to beneficiaries. These materials will assist CMC TCM case management entities in complying with the requirements of the CMC TCM policy, and to practice in accordance with accepted standards, guidelines, and applicable policies published in the MDHHS Medicaid Provider Manual.

Manual Maintenance

Information in this bulletin is time-limited and will not be incorporated into any policy or procedure manuals.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

An electronic version of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved

Meghan E. Groen, Director
Behavioral and Physical Health and Aging Services Administration

Michigan Department of Health and Human Services
Children's Special Health Care Services
Children with Medical Complexity Targeted
Case Management (CMC TCM)
Authorization Form

Instructions: This form is required to request authorization to enroll a patient in the CMC TCM program and to authorize the case management entity's NPI number.

Please fax this form to the document management portal (DMP) at 517-335-9491 or submit electronically in the DMP, located under external links in CHAMPS. If using the electronic method, please use the "Notice of Action" document name and "Provider Updates" document title.

Beneficiary's Name (Last, First, Middle)		
Date of Birth	CSHCS/Medicaid I.D.	Beneficiary's County
Requested Start Date		

CMC TCM Case Management Entity

Case Management Entity (Organization) Name	CMC TCM NPI Number
Program Name (if different)	

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY: Title XIX of the Social Security Act and Administrative rule 400.1104(a)

COMPLETION: Is voluntary, but is required if Medical Assistance program payment is desired.

Michigan Department of Health and Human Services
Children's Special Health Care Services
Children with Medical Complexity Targeted
Case Management (CMC TCM)
Deauthorization Form

Instructions: This form is required to notify CSHCS of a patient's discontinuation of services for any reason and to remove the CMC TCM case management entity NPI number for that patient.

Please fax this form to the document management portal (DMP) at 517-335-9491 or submit electronically in the DMP, located under external links in CHAMPS. If using the electronic method, please use the "Notice of Action" document name and "Provider Updates" document title.

Each box must be completed, including the reason for discontinuation of services.

<table>
<tr><td colspan="3">Beneficiary's Name (Last, First, Middle):</td></tr>
<tr><td>Date of Birth:</td><td>CSHCS/Medicaid ID:</td><td>Beneficiary's County:</td></tr>
<tr><td colspan="2">Case Management Entity (Organization) Name:</td><td>CMC TCM Case Management Entity NPI Number:</td></tr>
<tr><td colspan="2">Program Name (if different):</td><td>CMC TCM Core Team Member Requesting Deauthorization:</td></tr>
<tr><td colspan="3">Reason for Discontinuation of Services:</td></tr>
<tr><td colspan="3">Requested End Date:</td></tr>
<tr><td colspan="3">The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.</td></tr>
<tr><td colspan="3">AUTHORITY: Title XIX of the Social Security Act and Administrative rule 400.1104(a)
COMPLETION: Is voluntary, but is required if Medical Assistance program payment is desired.</td></tr>
</table>

Michigan Department of Health and Human Services
Children's Special Health Care Services (CSHCS)
Children with Medical Complexity Targeted Case Management (CMC TCM) Program
Application Form

The CMC TCM case management entity offers outpatient, intensive case management services to eligible Medicaid beneficiaries. The case management entity must be Michigan Medicaid enrolled and not otherwise funded to provide similar services to the same population. Please provide your organization's information.

CMC TCM Case Management Entity:		
CMC TCM Program Name (if different):		
Address:		City:
State:		Zip Code:
CMC TCM Program Contact Person Name:		
Phone:		Email Address:

Please provide information regarding the required CMC TCM Program core team:

Medical Director/Pediatrician (Medicaid Enrolled) Name:		
Provider NPI Number:	License:	Credentials:
Email Address:		
Non-Physician Practitioner Name:		
License:		Credentials:
Email Address:		
Registered Nurse Clinical Case Manager Name:		
License:		Credentials:
Email Address:		
Licensed Clinical Social Worker Name:		
License:		Credentials:
Email Address:		
Coordinator Name:		
Email Address:		
Administrative Staff Name:		
Email Address:		

Attestations

☐The CMC TCM case management entity will:

- Ensure that the beneficiary and/or parent/guardian are actively involved in developing the plan of care.
- Have program staff available to answer phone calls from CMC TCM patients and coordinate their care 24 hours per day, 7 days per week.
- Coordinate with MHPs and LHDs as necessary to ensure beneficiaries' needs are addressed.

☐ We acknowledge that our program meets the following provider qualifications:

- The capacity to provide all core elements of case management services including:
  - Comprehensive client assessment

- Comprehensive care/service plan development
- Linking/coordination of services
- Follow-up and monitoring of services
- Reassessment of the beneficiary's status and needs

- Sufficient number of qualified staff to meet the case management service needs of the target population
- An administrative capacity to ensure quality of services in accordance with State and Federal requirements
- A financial management capacity and system that provides a record of services and costs
- The capacity to document and maintain individual case records in accordance with State and Federal requirements.

☐ We attest that the CMC TCM case management entity will not bill for other case management services for patients receiving CMC TCM services.

☐ We acknowledge that if the CMC TCM core team needs to terminate CMC TCM services for any reason, the CMC TCM core team is required to notify the beneficiary and/or parent/guardian 45 days before the termination, document the reason for the termination in the beneficiary's comprehensive, individualized plan of care, offer a meeting to discuss, advise of appeal rights for any action related to eligibility, and submit a CMC TCM Deauthorization form (BPHASA-2410) to the document management portal.

☐ We understand that if a beneficiary appeals actions related to CMC TCM eligibility or services, a program physician will participate in the appeal with a representative of MDHHS to explain the action.

☐ We understand that failure to meet and maintain all policy requirements may result in termination of eligibility as an MDHHS CMC TCM program.

CMC TCM Case Management Entity Authorization *I hereby certify that all the above information is correct, to the best of my ability, as of the date of signature. I have read and will abide by the CMC TCM policy located in the CMC TCM section of the Special Programs chapter of the Michigan Medicaid Provider Manual and the State Plan. The undersigned individual or officer certifies by their signature that they are authorized to sign this attestation on behalf of the CMC TCM case management entity.*

CMC TCM case management entity (Organization) Signature:	
Typed/Printed Name:	Date:
CMC TCM Program Medical Director Signature:	
Typed/Printed Name:	Date:

MDHHS Clinic Development Analyst Authorization

☐ Approved	☐ Denied
Signature:	Date:
Type/Printed Name:	

Michigan Department of Health and Human Services Children's Special Health Care Services (CSHCS) Children with Medical Complexity Targeted Case Management (CMC TCM) Program Application Form	
MDHHS-CSHCS, Policy & Program Development Manager Authorization	
Signature:	Date:
Type/Printed name:	
MDHHS-Office of Medical Affairs, CSHCS Physician Consultant Approval	
Signature:	Date:
Type/Printed Name:	

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Michigan Department of Health and Human Services
Children's Special Health Care Services
Children with Medical Complexity Targeted Case Management
(CMC TCM)
Informed Consent Form

This form provides consent to enroll in the Children with Medical Complexity Targeted Case Management (CMC TCM) program at (insert program name). This form will be kept as part of your medical record. Please type or print all requested information.

Beneficiary Information

Beneficiary's Name (Last, First, Middle):	
Date of Birth:	CSHCS/Medicaid ID:
Address:	
Phone Number:	
Email Address:	

Parent/Guardian Information

Parent/Guardian Name (Last, First, Middle):	
Date of Birth:	Phone Number:
Address:	
Email Address:	

By enrolling in the CMC TCM program, I agree to:

- Maintain enrollment in the CSHCS and/or Medicaid program.
- Participate in a comprehensive assessment and individualized plan of care.
- Maintain contact with the CMC TCM core team while receiving services.
- Participate in appointments, referrals, and other TCM program services.
- Give consent for the CMC TCM team to share medical information with other healthcare providers.

By signing this form, I understand that:

- Enrollment in the CMC TCM program is voluntary, and I can disenroll at any time.
- While enrolled in the CMC TCM program, I may not receive TCM services from other State of Michigan TCM programs.
- Eligibility and access to other necessary medical services will not be impacted if I choose to decline or terminate services.
- I may be disenrolled from the CMC TCM program for the following reasons:
    - I do not receive a CMC TCM service within a three-month period;
    - I turn 21 years of age;
    - I become ineligible for Medicaid and/or CSHCS enrollment ends;
    - I transition into hospice;
    - I move out of state;
    - I fail to participate in a comprehensive assessment and/or development of a comprehensive individualized plan of care; or
    - If I comment fraud, abuse, or misconduct.
- If I am disenrolled from the CMC TCM program, I will need to reapply to resume CMC TCM services.
- I have the right to appeal any decision regarding my eligibility for the CMC TCM program. Also, appeal information will be provided upon any change in eligibility or upon request.

By signing this form, I confirm that:

- I have received information about the CMC TCM program and other programs which provide this service.
- I have been provided a CMC TCM point of contact and had an intake meeting.

Client Signature:	Date (MM-DD-YYYY)
☐I acknowledge that the child named in this form is too young or unable to sign on their behalf. Guardianship documents are required for beneficiaries over 18.	

Parent/Guardian Signature:	Date (MM-DD-YYYY)

Please return the completed form to the program staff for signature.

Program Medical Director Signature:	Date (MM-DD-YYYY)
By signing this form, I acknowledge that the client is eligible for the CMC TCM program and has been accepted into the program at (Provider to insert program name). I also acknowledge that the client and their family have reviewed this form with the client and our team has answered any questions. A copy of this consent form must be maintained within the client record at all times.	

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