Targeted Case Management Policy

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Case management consists of services which help beneficiaries gain access to needed medical, social, education, and other services.

Case managers assist with patient services through assessment, providing person centered service plans, referrals for services, monitoring/follow-up, and person-to-person contact. Additional services include but are not limited to:

- Assistance with navigating the service system and gaining access to services.
- Coordination of services using multiple service providers and agencies; establishing crisis plans to meet the health and safety needs of the consumers served.
- Securing and managing funding for services.
- Working with the individual, their parent(s)/guardian; other members of the service team to develop an individualized integrated care plan.
- Coordination and monitoring of ongoing services; monitoring progress toward goals in the care plan as well as the health and safety of each consumer served.
- Monitoring the individual to assess the health, safety, and wellbeing of the individual.

Targeted case management services are those aimed specifically at special groups of enrollees such as those with developmental disabilities or chronic mental illness, described by each state plan.

Reimbursement Guidelines

For reimbursement, refer to applicable state regulatory guidance for billing instructions, program usage, limitations, and patient qualifications for targeted case management. State applicable fee schedules do apply as well. A code that is on this list may NOT be reimbursed by a particular state Medicaid agency and this guidance would not apply. Where state guidance is not present, CMS guidelines will prevail for this policy, however, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Molina Healthcare retains the authority to deny, review, audit, and recover claims based on medical necessity as outlined in this policy.

Procedure Codes used for Case Management:

These codes are **CPT® (Current Procedural Terminology)** codes maintained by the American Medical Association and used primarily in medical and outpatient clinical settings:

- **Complex Chronic Care Management (CCM) – CPT Codes**
  - **99490** – Chronic care management services, 20 minutes of clinical staff time per calendar month, directed by a physician or other qualified healthcare professional.
  - **99439** – Each additional 20 minutes (add-on to 99490).
  - **99491** – CCM services provided personally by physician or other qualified professional, at least 30 minutes.
  - **99437** – Each additional 30 minutes personally by physician/qualified professional (add-on to 99491).
- **Transitional Care Management (TCM) – CPT Codes**
  - **99495** – TCM with communication (within 2 business days), face-to-face visit within 14 days.
  - **99496** – TCM with communication (within 2 business days), face-to-face visit within 7 days.
- **Principal Care Management (PCM) – CPT Codes**
  - **99424** – PCM for a single high-risk condition; physician/qualified healthcare provider; 30 minutes/month.
  - **99425** – Each additional 30 minutes (add-on to 99424).
  - **99426** – PCM by clinical staff under supervision; 30 minutes/month.
  - **99427** – Each additional 30 minutes (add-on to 99426).

These are **HCPCS Level II** codes used for Medicaid and Medicare billing, especially for non-physician case management like social services, behavioral health, and state-funded programs:

- **General Case Management**
  - **T1016** – Case management, each 15 minutes.
    Used in Medicaid programs for targeted or general case management across various populations.
  - **T1017** – Targeted case management, each 15 minutes.
    Often used for behavioral health, child welfare, and home/community-based services (HCBS).
  - **T2017** – Habitation, residential, waiver; 15 minutes
  - **T2023** – Targeted case management, **per month**.
    Used in Medicaid waiver and mental health programs to bill a bundled monthly unit.
- **Mental Health and SUD Case Management**
  - **H0032** – Mental health service plan development by non-physician.
  - **H0031** – Mental health assessment, by non-physician.
  - **H0034** – Medication training and support, per 15 minutes
  - **H2011** – Crisis intervention service, per 15 minutes
  - **H2012** – Behavioral Health Day Treatment, per hour
  - **H2014** – Skills training and development, per 15 minutes
  - **H2017** – Psychosocial rehabilitation, 15 minutes (often paired with case management).
  - **H2021** – Community-based wraparound services, per 15 minutes (used for children with SED).
  - **H2022** – Intensive case management, per diem (for high-risk SMI/SED populations).
  - **H2023** – Supported employment – individual employment support (may involve job-related case mgmt).

- **H2024** – Supported employment, per diem.

- **Other State/Program-Specific Case Management Codes**

  - **G9001** – Coordinated care fee, initial setup, and education.
  - **G9002** – Coordinated care fee, maintenance/ongoing.
  - **G9007** – Coordinated care fee, team conference (physician and nonphysician).
  - **S9484/S9485** – Crisis intervention mental health services (may involve brief case mgmt).

Medical Necessity

TCM Services billed require the following criteria to be met:

- The member has a documented need for coordinating care and services.
- The members are part of a population that is a designated receiver of TCM.
- A comprehensive case management assessment and individualized service plan have been completed.
- The member receives a minimum threshold of allowable case management activities within the billing period.

TCM can only be billed by providers who are Case Managers defined by state regulations and can include licensed or credentialed case managers, nurses, social workers, or qualified professionals.

Documentation required to meet medical necessity requires the following in the member's medical record.

- A signed and dated case management assessment.
- A member specific service plan with measurable goals
- Dated case notes showing the frequency, duration, and type of services delivered.
- Evidence of member contact or case activity during the month of service

Limitations and Exclusions

Procedure Code 99490:

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

- Requires ≥20 minutes of clinical staff time (non-face-to-face), under general supervision of a physician or qualified provider.
- If 20 minutes are not met in a calendar month, do not bill 99490.
- Only one practitioner may bill 99490 per patient per calendar month—no duplicate payments allowed.
- If multiple practitioners provide CCM, only one may bill (typically whoever has established the care plan and ongoing relationship).
- 99490 cannot be billed in the same month as:

  - 99491–99439 (physician/qualified professional CCM codes),
  - 99487–99489 (complex CCM),
  - 99484 (behavioral health integration),
  - G2058 (additional CCM time),
  - CPT 99091 (data review),
  - RPM codes (99453–99458)

CMS may allow limited overlap with RPM, but documentation must support distinct services.
Patient Consent Required

- Written or verbal patient consent must be documented prior to the start of services.
- Patients must be informed that cost-sharing may apply (e.g., coinsurance).

EHR and Care Plan Requirements

- Must use certified EHR technology (CEHRT) to record and share care plan components.
- Comprehensive, patient-centered care plan required—includes problem list, goals, interventions, responsible parties, and assessment schedule.

Note: 99439 is an Add-on code for 99490

Procedure code 99439:

Each additional 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.

99439 is not a standalone code, it **must** be billed 99490.

- If 99439 is billed without 99490 it will be denied.
- 99439 is billed for an additional 20 minutes per unit.
- Medical Necessity may be reviewed if units billed are deemed excessive.

Procedure code 99491:

Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified healthcare professional time, per calendar month.

- Greater to or equal to 30 minutes of personal non-face to face care that is coordinated by the billing provider, this cannot be delegated.
- If this is less than 30 minutes, then 99491 cannot be billed.
- 99491 is mutually exclusive with the following codes.
    - 99490 (CCM by staff)
    - 99439 (additional time code for 99490)
    - 99487/99489 (Complex CCM)
    - 99484 (Behavioral Health Integration)
    - 99492–99494 (Collaborative Care)
    - 99091 (data review) – overlapping time cannot be counted
- Only one practitioner may bill per month.
- Patient consent is required.

Procedure code 99437

Each additional 30 minutes of chronic care management services provided personally by a physician or other qualified health care professional, per calendar month.

- Must be billed with 99491 on the same claim.
- Additional 30 minutes of documented personal time by a physician
    - If the total personal time is only 30 minutes, DO NOT bill 99437.
- Cannot be billed by Clinical Staff
- Cannot be combined with other billed services to meet the time requirements.

Procedure code 99495

Transitional care management services with moderate medical decision complexity, face-to-face visit within 14 calendar days of discharge.

- Patient must be seen in person within 14 calendar days post-discharge.
- If outside of the 14-day window you cannot bill 99495
- Moderate Medical Decision Complexity is required to bill 99495.
- Only one provider can bill 99495 per discharge.
- Services include communication within 2 business days of discharge, non-face-to-face coordination, and a face-to-face evaluation, *This has to happen to bill 99495.*

Procedure Code 99496

Transitional care management services with high medical decision complexity, face-to-face visit within 7 calendar days of discharge.

- Patient must be seen within 7 days of discharge.
- High Medical Decision Complexity is required to bill 99496.
- Only one provider can bill 99496 per discharge.
- To bill 99496 The provider must initiate contact with the patient within 2 business days of discharge, provider non face to face coordination of care and have an in person visit within 7 days,
- The following discharge facilities does not APPLY to be able to be 99496.
    - Emergency Departments
    - Observation Admissions
    - Same-day procedures

Procedure Code 99424

Greater than 30 minutes per calendar month of non-face-to-face care management performed by the physician or qualified health provider. NOT Clinical staff.

- Greater than 30 minutes per calendar month of non-face-to-face care management personally performed by the physician and not Clinical staff.
- 99424 is condition specific with the following criteria.
    - Patient has a significant risk of hospitalization.
    - Requires a disease-specific care plan.
    - Requires frequent med adjustment and/or treatment.
    - Can only be billed by one physician per month.

Procedure Code 99425

Principal care management services, for a single high-risk chronic condition, each additional 30 minutes of physician or other qualified health care professional time, per calendar month (List separately in addition to code for primary procedure)

- Add-on code for 99424
- Physician spends more than 30 minutes on PCM in a calendar month.
    - 99424 is billed for the initial 30 minutes and then 99425 is for each additional 30 minutes.
- Clinical staff cannot bill this code.
- Must be billed for a high-risk chronic condition.
- Only one provider per month can bill this code.

Procedure Code 99426

Principal care management services, for a single high-risk chronic condition, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

- At least 30 minutes of non-face-to-face time from clinical staff
- This was for PCM.
- This is for a single high-risk condition.
- Billed by a single provider per patient per month.
- Dates and time length **must** be documented in relation to the care plan for the patient for the disease.

Procedure Code 99427

Principal Care Management (PCM) services, for a single high-risk chronic condition, provided personally by a physician or other qualified health care professional; each additional 30 minutes in a calendar month.

- Add-on code for 99426
- Reimbursement occurs after the initial 30 minutes, billed with 99426.
- One unit represents 30 minutes.
- Only Physician or a qualified health professional's time counts for 99427.
- Can only be billed for a single high-risk chronic condition.

Procedure Code T1016

Case management, each 15 minutes.

- Must be billed in 15-minute units.
- Must be provided by a qualified case manager.
- Direct patient related activities qualify.
- Limited to eligible members
- Cannot be billed with other case management services or care coordination procedure codes.
- Cannot be billed independently of bundled payments where case management is included.

Procedure Code T1017

For individuals with specific, high-need conditions or within population groups (e.g., behavioral health, developmental disabilities, chronic illness, high-risk youth).

- T1017 is billable in 15-minute units.
- Partial units cannot be billed.
- Non-care coordination tasks are not covered.
- Must be billed by a qualified case manager.
- Individualized Care Plan is required.
- Eligibility is based on member diagnosis.

Procedure Code T2017

Used to bill for residential habilitation services provided under a Medicaid Home and Community-Based Services (HCBS) waiver program.

- T2017 is billed in 15-minute units.
- Partial units cannot be billed.

- Eligibility is based on member diagnosis.
- An individualized Care Plan is required.

Procedure Code T2023

Targeted Case Management (TCM) services that assist eligible beneficiaries in gaining access to necessary medical, social, education, and other services. TCM Services must be comprehensive, individualized, and documented to support a unit of service representing a monthly case management episode.

- T2023 may only be billed **ONCE per calendar month per eligible member.**
- One provider may bill per month for TCM.
- Services that duplicate care coordination will not be covered.

NOTE: Modifier 95 may also apply depending on how services are rendered.

Procedure Code H0032

H0032 is used to bill for mental health service plan development performed by a qualified non-physician mental health professional.

- H0032 is reimbursable in accordance with any applicable state fee schedule. If a state is silent then a restriction of once per 90 days will be applied without prior authorization.
- Services must be provided in a clinical setting unless authorized to be changed.
- Must reflect the individualized service plan that is active, and goal directed.
- If the service is bundled under another procedure code, it cannot be billed under H0032.

Procedure Code H0031

H0031 is used to bill for a Mental Health Assessment by Non-Physician

- H0031 is allowed annually unless prior authorization is obtained.
- The assessment must include a member history with problems and diagnoses from the DSM-5 and clinical recommendations and rationale for requiring services.
- H0031 cannot be billed on the same day as another diagnostic or evaluation service such as procedure code 90791.
- Evaluation must be for medical purposes and not for custody, education, employment, forensic purposes, or legal services.

Procedure Code H0034

Procedure Code H0034 is used to bill for medication training and support, per 15 minutes.

- Performed by a clinician.
- Can be performed in any setting to include telehealth.
- Can be limited based on local fee schedule.

Procedure Code H2011

Procedure Code H2011 is used to bill Crisis intervention service, per 15 minutes.

- Typically delivered by mental health specialist
- Modifiers can denote clinician modifiers.
- Can potentially be billed for a group setting but capped at 8 adults or 6 pediatric patients.
- Telehealth only used in emergent situations.

Procedure Code H2014

Procedure Code H2014 is used to bill Skills training and development, per 15 minutes.

- Billed in 15-minute increments and can be rounded up to the nearest 15 minutes.
- Cannot bill for under 8 minutes.
- Must be clearly documented in medical record to not be denied after Med Rec review.
- Limited based on local fee schedule
- Training focuses on skills for daily living and community integration for patients with functional limitations due to psychiatric disorders.

Procedure Code H2017

Procedure H2017 bills for psychosocial rehabilitation services

- Must be rendered by qualified professional staff.
- Services must be goal-directed and based on an individual's treatment plan.
- Must be delivered in approved settings.
- Billed in 15-minute increments.
- Can be limited based on fee schedule.
- Cannot be billed with H2014, H2015, or T1017

Procedure Code H2012

Behavioral health day treatment, billed per hour—structured programming for individuals needing more intensive care than outpatient therapy but less than inpatient hospitalization.

- Must be rendered by qualified professional staff.
- Services cannot be delivered at home or in an inpatient environment.
- Requires Prior Authorization
- Billed in hour units.
- Typically billed for intensive outpatient setting

Procedure Code H2021

Procedure Code H2021 Used for billing community-based wrap-around services, specifically per 15 minutes.

- Limited to members with complex behavioral health needs who meet medical necessity criteria and are enrolled in an MCO-approved wraparound program.
- Must be based on members care plan.
- Billed in 15-minute increments and capped at 32 units per month unless prior authorization is obtained.

Procedure Code H2022

Procedure Code H2022 is used to bill per diem for intensive, individualized wraparound services delivered by a physician or licensed practitioner as part of a structured, family-driven, community-based model of care.

- Must be performed by a licensed behavioral health clinician.
- Member must be high risk behavioral health.
- Must include daily intensive care coordination for wraparound services.
- Services are billed on a per-diem basis, one unit per member per day.

- Cannot be billed on the same day as H2015, H2021, T1017 or other case management/community support codes.

Procedure Code H2023

Procedure Code H2023 used for billing Supported employment, per 15 minutes.

- Member must be actively enrolled in a supported employment or vocational rehabilitation program.
- Can only be billed by Employment Specialists, Vocational Counselors, or job coach.
- Cannot be billed in an institutional, inpatient, or facility setting.
- Billable in 15 units with a cap of 240 units per year per member*****
- Prior Authorization and an Individualized Employment Plan

Procedure Code H2024

Procedure Code H2024 used for billing Supported Employment, per diem.

- Community based settings
- Institutional or inpatient settings are excluded.
- Prior Authorization is required with an individualized employment plan or service plan.
- Cannot be billed during inpatient stays.
- All services must be provided by a credentialed provider.

Procedure Code G9001

Coordinated care fee, initial setup, and education.

- 30 minutes of a face-to-face encounter
- One assessment per patient per care manager
- Must be performed by a qualified care manager.
- Must create a care plan.
- Must include a comprehensive assessment.

Procedure Code G9002

Coordinated care fee, maintenance/ongoing.

- Required face to face encounter.
- Must be furnished by a licensed care team member.
- Discussion on existing care plan
- Unit based but once per encounter 45 minutes per unit.
- All services must be documented and time stamped.

Procedure Code G9007

Coordinated care fee, team conference (physician and nonphysician).

- Must be billed by a physician.
- Must include at minimum the primary care physician and a qualified care manager.
- NOT include the patient
- This meeting is scheduled and focused on the patient’s care plan triggered by clinical changes.
- Minimum of 10 minutes
- Billed one per day per patient.

All Procedure Codes *must* have supported documentation in the patients' medical record.

Supplemental Information

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
CPT	Used by outpatient hospital facilities, inpatient and outpatient dialysis centers, ambulatory surgery centers, physician offices and physicians and clinicians in all settings. CPT codes are utilized to report most procedures on claims that are submitted.
DSM-5	
HCPCS	Used by outpatient hospital facilities, inpatient and outpatient dialysis centers, ambulatory surgery centers and physician offices. Alphanumeric HCPCS codes are used to report various biologicals, drugs, devices, supplies, and certain services.
TCM	Targeted Case Management

State Exceptions

State	Exception
CA	Claims must be submitted **NO LATER THAN** 6 months after DOS.

NY	Eligibility for Case Management requires:
	To be eligible for Health Home services, the individual must be enrolled in Medicaid and must have:
	• Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes*) **OR**
	• One single qualifying chronic condition:
	  ○ HIV/AIDS or
	  ○ Serious Mental Illness (SMI) (Adults) or
	  ○ Sickle Cell Disease (both Adults and Children) or
	  ○ Serious Emotional Disturbance (SED) or Complex Trauma (Children)
	If an individual has HIV or SMI, they do not have to be determined to be at risk of another condition to be eligible for Health Home services. Substance use disorders (SUDS) are considered chronic conditions and do not by themselves qualify an individual for Health Home services. Individuals with SUDS must have another chronic condition to qualify. Chronic Condition Criteria is **not** population specific (e.g., being in foster care, under 21, in juvenile justice, etc.) and does not automatically make a child eligible for Health Home. In addition, the Medicaid member must be appropriate for the intensive level of care management services provided by the Health Home (i.e., satisfy the appropriate criteria). The Health Home Chronic Conditions document outlines guidance for the Health Home Serving Children eligibility, appropriateness, enrollment prioritization, and Health Home Six Core Services.

GA	Georgia Medicaid reimburses code T2023 for Targeted Case Management (modifiers where applicable) for Adult Protective Services and Adults with AIDS

<table>
<tr><td></td><td>programs. Only one service procedure code may be billed each calendar month. Since services must be completed prior to billing and services may span several days during the month, the last day of the calendar month must be submitted as the billing date on claims in the event of multiple types of targeted case management, only one type will be reimbursed during the calendar month for each member. System edits provide that the first claim submitted will be paid, and later claims for a different type of targeted case management during the same month of service will be denied.

T2022 is reimbursed for At Risk of Incarceration Targeted Case Management. These codes are to be billed once per month. Only one procedure code or unit of service may be billed each calendar month per member. Since services must be completed prior to billing and services may span several days during the month, services should be billed from the first (1st) day of the month to the last day of the month.</td></tr>
<tr><td>MI</td><td>Reimburses codes T1017 and T2023 for Target Case Management</td></tr>
<tr><td>SC</td><td>Reimburses codes T1016 and T1017 for Target Case Management</td></tr>
<tr><td>TX</td><td>Case Management for Children and Pregnant Women services are limited to one contact per day per person. Additional provider contacts on the same day are denied as part of another service rendered on the same day. Prior authorization is not required for case management services.
Procedure code G9012, with required modifiers, may be reimbursed for Case Management for Children and Pregnant Women (CPW) services. Modifiers are used to identify which service component is provided.
<table>
<tr><th>Procedure Code</th><th>Procedure Description</th><th>Additional Information</th></tr>
<tr><td>G9012</td><td>Comprehensive visit (in-person)</td><td>Combination Modifier U2 and U5 (both required)</td></tr>
<tr><td>G9012</td><td>Comprehensive visit (synchronous audiovisual)</td><td>Combination Modifier U2, U5 and 95(all required)</td></tr>
<tr><td>G9012</td><td>Follow-up visit (in-person)</td><td>Combination Modifier U5 and TS (both required)</td></tr>
<tr><td>G9012</td><td>Follow-up visit (synchronous audiovisual)</td><td>Combination Modifier U5, TS and 95 (all required)</td></tr>
<tr><td>G9012</td><td>Follow-up visit telephone (audio only)</td><td>Combination Modifier TS and 93 (both required)</td></tr>
</table>
<table>
<tr><th>Modifier</th><th>Description</th></tr>
<tr><td>93</td><td>Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System</td></tr>
<tr><td>95</td><td>Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System</td></tr>
<tr><td>TS</td><td>Follow-up service</td></tr>
<tr><td>U2</td><td>Comprehensive visit</td></tr>
<tr><td>U5</td><td>Face to face visit</td></tr>
</table>
Comprehensive visits are limited to one service per client per provider in 12 consecutive months from the intake date.</td></tr>
</table>

Documentation History

Type	Date	Action
Initial Creation Date	06/24/2025	New Policy
Revised Date	07/31/2025	Added Procedure Codes H2012, H0034, H2011, H2014, H2017, T2017
Revised Date	08/10/2025	Updated template
Revised Date	08/20/2025	Added Initial Creation Date; Added PI number

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link
Medicaid Definition of Covered Case Management Services Clarified	MEDICAID DEFINITION OF COVERED CASE MANAGEMENT SERVICES CLARIFIED | CMS
Arizona Care Cost Containment System- Covered Behavioral Heath Services Guide-	AMPM Policy 1640
California- Local Educational Agency (LEA) Service: Target Case Management	Local Educational Agency (LEA) Service: Targeted Case Management (loc ed serv targ)
California- Every Woman Counts	Every Woman Counts (ev woman)
California-JI Pre-Release Services	Justice-Involved (JI) Pre-Release Services (just inv)
Targeted Case Management CA	Targeted Case Management (TCM)
Florida- Child Health Services Targeted Case Management Coverage and Limitations	CHS Targeted Case Management Coverage and Limitations Handbook June 2012.pdf
Georgia Medicaid Management Information System- Provider Manual- Part 2: Policies and Procedures for Adult Protective Services Targeted Case Management	Adult Protective Services Target Case Management -Q1-Jan 2025 20250103114552.pdf
Georgia Medicaid Management Information System- Provider Manual- Part 2: Policies and Procedures for Adults with AIDS Targeted Case Management	Adults with AIDS Targeted Case Management- Q1- January 2025 20250103114924.pdf

Georgia Medicaid Management Information System- Provider Manual-Part 2: Policies and Procedures for At Risk of Incarceration Targeted Case Management	At Risk of Incarceration Targeted Case Management- Q1-Jan 2025 20250103114637.pdf
Iowa Department of Human Services-Provider Manual-Targeted Case Management, Case Management, and Care Coordination	CaseMgm (1).pdf
Kentucky Administrative Regulations-Title 907-Chapter 015-Regulation 040	Title 907 Chapter 15 Regulation 040 • Kentucky Administrative Regulations • Legislative Research Commission
Kentucky Administrative Regulations-Title 907-Chapter 015-Regulation 045	Title 907 Chapter 15 Regulation 045 • Kentucky Administrative Regulations • Legislative Research Commission
Massachusetts-MassHealth-Administrative Bulletin 23-16- Addition of a Certain Targeted Case Management Code	Administrative Bulletin 23-16
Michigan Department of Human and Health Services-Medicaid Provider Manual-Section 2.10-Targeted Case Management (TCM)-Pupils with an IEP or ISFP Only	MedicaidProviderManual.pdf
Nevada Medicaid-Provider Type 54 Billing Guide-Targeted Case Management	NV_BillingGuide_PT54
Medicaid Health Home NY	Medicaid Health Homes - Comprehensive Care Management
Ohio Department of Medicaid	Targeted Case Management | Medicaid
South Carolina Department of Health and Human Services-Healthy Connections Medicaid-Medicaid Targeted Case Management (MTCM) Provider Manual	Report (Vertical)
Texas Medicaid Provider Procedures Manual	2_02_Behavioral_Health

Utah Medicaid Provider Manual-Targeted Case Management for Early Childhood	Utah Medicaid Official Publications - Medicaid: Utah Department of Health and Human Services - Integrated Healthcare
Utah Medicaid Provider Manual- Targeted Case Management for Individuals with Serious Mental Illness	Utah Medicaid Official Publications - Medicaid: Utah Department of Health and Human Services - Integrated Healthcare
Virginia Medicaid-Provider Manual: Mental Health Services	MHS - Chapter 4 (updated 11.15.24)_Final.pdf
Virginia Medicaid-Provider Manual: Mental Health Services	MHS - Appendix I (updated 8.28.24)_Final.pdf
Wisconsin-Forward Heath-	Online Handbook Display

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*