PROVIDER ALERT
June 25, 2010

Case Management Q&A

Q: **Can the administrative burden by lightened by expanding the authorization span for Uninsured Eligible Consumers, including uninsured Shelter+Care consumers, from three months to six months?**

A: Not at this time. Due to the current fiscal situation, MHA must closely monitor services provided to the uninsured. When the budget improves and cuts to services decrease, MHA will reconsider.

Q. **Must Medicaid Eligible Shelter+Care consumers meet the Priority Population Diagnosis for continued authorization?**

A. Not necessarily. However, consumers must meet the PMHS Specialty Diagnoses (http://maryland.valueoptions.com/provider/clin_ut/PMHS_Diagnosis.pdf) The diagnostic criteria for Case Management is stated in COMAR 10.09.45: "…that the individual is Adult age 18 or over, who has a serious mental disorder, diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary as; (i) Schizophrenic disorder; (ii) Major affective disorder; (iii) other psychotic disorder; or…" These are general categories of disorders for individuals. There are other diagnostic categories for individuals under age 18.

Q. **Can the diagnostic code 799.9 (diagnosis deferred) be used to bill for the initial assessment since case management will not have a diagnosis until the assessment and service plan are completed?**

A. A diagnostic code must stipulate an approved diagnosis in order to be reimbursed 799.9 is not an acceptable code for billing

Q. **Are Medicaid and Uninsured Eligible consumers leaving case management services for several months required to have an initial assessment if their case was closed by the Case Management agency?**

A. The consumers should have a new assessment if the consumer enters treatment with a new agency and the case was closed by the previous agency.

Q. **Are children in RTC, Foster Care and Extended Services authorized to receive Case Management Transitional services?**

A. When children are referred to case management services and are in RTCs or IMDs, they may be eligible for Transitional Case Management services. The case management service is not to supplant the hospital or RTC's discharge planning process. Claims for the transition service are to be submitted after the individual is discharged.

Q. Can authorization of Case Management services begin at the start of the month?

A. Case Management is not a monthly rate, as services are paid per diem and can begin anytime during the month, as long as the general level offers two visits per month and three - five visits per month for the intensive level.

Q. If a client had active Medicaid at the time of the authorization and was approved for 30 units for six months and Medicaid coverage will expire during the time span of the authorization, must the agency apply for an Uninsured Eligibility span and request a new authorization?

A. Services should continue to be provided under the original authorization, after which the agency should begin the Uninsured Eligibility process if continued services are needed.