CASE MANAGEMENT Q&A
September 2009

The following are questions submitted during the September 9, 2009 Case Management training webinar. Case Management Providers are reminded to refer to COMAR 10.09.45 and to the MHA memo, titled "Case Management Transition Update", dated August 12, 2009 and distributed by their CSA.

1. **If a client is transferred to a Nursing Home or Hospital, can we continue to provide case management services?**
   No – a consumer must be discharged from Case Management upon an inpatient admission or nursing home placement, but services may be requested upon discharge

2. **Can a client self-refer?**
   Yes, a consumer may contact the CSA, the Case Management Provider or ValueOptions® Maryland to request Case Management Services

3. **How should Shelter + clients be entered since some do not have MA?**
   An Uninsured Eligibility span should be requested.

4. **Do we have to fill out the ValueOptions® Maryland Care Plan in ProviderConnect, or may we attach our COMAR compliant Care Plan?**
   You may use the "attachment" option in ProviderConnect to submit your COMAR compliant Care Plan in lieu of completing the online Care Plan.

5. **What time span will be authorized for Uninsured Eligible consumers?**
   Three months of Case Management services for Uninsured Eligible consumers may be authorized.

6. **Can the assessment be completed before requesting an authorization?**
   No, an authorization must be requested prior to performing the assessment.

7. **Will the Case Management information in APS CareConnection® transfer to ProviderConnect?**
   No, the information in APS CareConnection® was tracking, not authorization, information.

8. **What is the required number of cases on a caseload for child and adolescent case managers? Adult case managers?**
   MHA does not specify case load requirements.

9. **Will Uninsured Eligibility status still be available after October 1?**
   Yes, if the consumer meets the Uninsured Eligibility Criteria. However, new uninsured eligibility requests must be authorized by both the MHA and the CSA.

10. **Per the requirement that new uninsured clients will require joint authorization from CSA and MHA – how will this work for individuals coming out of jail?**
    Per MHA: At this time new Uninsured Eligibility requests will be restricted to State Hospital or other hospital discharges. The request must be sent to the CSA, and the CSA will forward to Penny Scrivens or James Chambers at MHA for review and approval.

11. **What constitutes a unit? What is the required time length of a visit?**
    60 minutes is the required length of the visit

12. **Should an assessment be completed every six months or annually?**
    The assessment is required every six months.

13. **If a Case Management provider plans to bill on October 1 for September services, will ValueOptions® Maryland need a list of clients who crossed over from grant-funded services to fee-for-service from the CSA?**
    No. Medicaid consumers can be seen for up to 5 unmanaged sessions, and Uninsured consumers can be seen for up to 2 unmanaged sessions per month in September and October.

14. **Do telephone contacts count as units?**
    Contacts must be face-to-face, or combined with same day telephone or collateral contacts.

15. **Once authorizations are submitted, can changes be made to the requests?**
    No. If changes are required, you must contact a ValueOptions® Maryland Case Manager.

16. **Do the authorizations start at the beginning of the month or from the date the authorization is requested?**
    Authorizations will be issued from the date they are requested.

17. **Can a face-to- face encounter with a school counselor be counted as a visit if the child is not present?**
    No. Only an encounter with the monor's guardian or parent can be counted as a visit.

18. **Is it possible to get an authorization for a consumer who does not have a diagnosis, considering the consumer may need to be linked with a mental health provider?**
    A diagnosis is not required for the initial authorization request. "Diagnosis Deferred" (ICD-9 Code 799.9) may be used for the initial request and updated on subsequent requests.

19. Can consumers in detention centers be authorized before their release?
No.

20. What is a courtesy review?
A courtesy review is a request for a ValueOptions® Care Manager to review a service for Medical Necessity for a consumer who does not currently have PMHS benefit eligibility, but is reasonably expected to become eligible for PMHS benefits.
Courtesy reviews are accepted for Case Management. If there is a reasonable expectation that the consumer is eligible for Medicaid benefits, the Case Manager should request a Courtesy Review and assist the consumer with the Medicaid application.

21. If I did an assessment a month or so ago, can I bill for it as an unmanaged visit?
No, Case Management did not transition from contractual to fee-for-service until September 1, 2009. You may not be reimbursed twice for the same service.

22. Are all 5 Axes required fields?
Yes, all 5 axes are required upon concurrent review.

23. Do we have to enter into ProviderConnect each time we visit a client?
No. ProviderConnect is an authorization system, not a tracking system as was APS CareConnection®.

24. How do we get the client ID number needed?
You must get the consumer's identification number from the consumer, or by contacting ValueOptions® Maryland Customer Service (1-800-888-1965).

25. Can the five unmanaged visits all be used in September if necessary?
Yes, if the consumer meets medical necessity criteria for intensive services.

26. If my last visit is 9/30, may I request an authorization that day for additional visits?
Yes

27. If so, will the authorization begin in October or will it not start until November?
Authorization will begin on the first date of services beyond the unmanaged sessions.

28. For the Medicaid Consumers, are the unmanaged visits five per month, or five within two months?
This is based on the criteria met: intensive are allowed to have up to 5 per month; general are allowed to have up to 2 per month.

29. Do we register all consumers or just the Uninsured Eligible consumers?
Authorizations are required for both Medicaid and Uninsured Eligible consumers.

30. How will we know if the units have been authorized?
You will receive notice of authorization determinations via ProviderConnect.

31. Do unused, authorized case management units carry over into the next month?
No.

32. Is travel time reimbursable?
Travel time is not reimbursable unless it includes an intervention.

33. Must Case Management Services be approved by the CSA?
No, beginning 9/1/2009, the CSAs are not involved in Case Management authorizations, except for the Uninsured Eligibility approval process.

34. Can information on the request be saved or does the request need to completed in one setting?
Currently, the request must be completed and submitted in one sitting. A "save" function will be added to ProviderConnect at a later date.

35. Can authorization requests be submitted online (via ProviderConnect) or must we call them in to a ValueOptions® Maryland Care Manager?
The preferred method of obtaining an authorization is online via ProviderConnect.

36. Is backdating of authorizations allowed?
No, backdating is not allowed. Can information on the request be saved or does the request need to completed in one setting.

37. Must start and end times be documented?
Per MHA, the 60 minute duration must be documented, and should include start and end times.

38. What are the diagnostic criteria for admission to CM services for adults?
The Medical Necessity Criteria is under review by MHA and will be released and distributed in the near future.

39. What if a client has Medicare and Medicaid, with Medicare being primary? Would they be considered uninsured?
In most cases, no – Case Management would be covered under the secondary

Medicaid eligibility. However, if the consumer is QMG or SLMB, an uninsured eligibility span must be requested.

40. **Is the assessment rate the same as the visit rate?**
    Yes, the reimbursement is $105 for both the assessment and the visit.
    Billing reminder: Do not inadvertently bill for services reimbursed by contract for services provided in July and August.

41. **Can you pare down the problem list on the service plan to three or so instead of 10?**
    Yes, you are only required to enter the information pertinent to the consumer.

42. **What about consumers who may not meet all of the medical necessity criteria but who are entitled to case management services per program protocol, e.g., Shelter+Care?**
    MHA is incorporating this into the MNC criteria so that Shelter+Care consumers will now meet the criteria. Shelter+Care will be authorized for Case Management if the service is needed. Other types of mental health services may also be authorized for these consumers.

43. **Can transitional youth be served for a few months if they don't meet adult mental health diagnostic criteria?**
    This will be decided on a case-by-case basis depending on the consumer's need for the service.

44. **What do we put in on claims for authorization numbers for the TCM clients initial visits that are transferring from MAPS. We have no auth numbers since they transferred from a grant system.**
    Authorization numbers are not required on claims.

45. **For intensive Case Management, are 5 visits required or any number of visits up to 5?**
    Any number of visits up to 5 as appropriate.

46. **Is one visit with a child's parents still reimbursable?**
    Yes. The contact may be with the minor's parent(s) or guardian(s).

47. **If I see a child in school for 20 minutes and then make phone calls to the parent, therapist, or school officials, etc. regarding the child, does that count as the rest of my hour?**
    A combination of phone contact and face-to-face contact, for a minimum of 60 minutes, on the same day, constitutes a billable service.

48. **If you do a phone contact and a face to face in the same day can you bill twice?**

No.

49. **When someone is the intensive level are these all face to face visits or can they be over the phone?**
Each visit must contain face to face contact.

50. **Can more than 2 visits per month be authorized/reimbursed for Uninsured Eligible consumers?**
No, the benefit for Uninsured Eligible consumers is limited to 2 visits per month. Funding for Uninsured Eligible consumer services is very limited and will be closely monitored by MHA.

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