PROVIDER ALERT
December 4, 2009

AUTHORIZATION REQUESTS FOR CASE MANAGEMENT
for
Uninsured, PAC and Dually Eligible Medicare/Uninsured Eligible Consumers

Effective January 1, 2010

Requesting an initial review for a consumer who has an open Uninsured Eligibility span, is a Primary Adult Care (PAC) or dually eligible Medicare/Uninsured Eligible consumer:

- The Provider must use the "Maryland Uninsured Registration Process for CSA Review" form to request Case Management services.
    - "Request for Case Management Services" must be documented on the form.
    - The provider may call, or fax the request using the designated form, to the CSA of the consumer's county of residence.

- The CSA will determine Uninsured Eligibility **and** establish urgency for case management, such as discharge from a state hospital or diversion from inpatient psychiatric care.
    - If the CSA denies the request, the CSA notifies the provider
    - If the CSA approves the request, the CSA will obtain funding approval from MHA telephonically, or via fax using the "Form for Review of Uninsured for Case Management". (Phone: 410-402-8476, Fax: 410-402-8304).

- The MHA will determine funding availability:
    - If MHA denies:
        - The CSA will be notified, telephonically, or via fax using the "Form for Review of Uninsured for Case Management".
        - The CSA notifies the provider.
    - If MHA approves:
        - The CSA will be notified, telephonically, or via fax using the "Form for Review of Uninsured for Case Management".
        - The CSA forwards the decision to ValueOptions® Maryland, using the "Request for Reimbursement for Non-Medicaid Outpatient Services" form.
        - "Case Management Services approved" must be documented on the form.

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- ValueOptions® will “flag” the consumer, indicating that the consumer has been approved for Case Management Services

- ValueOptions® Maryland will notify the provider that Uninsured Eligibility for Case Management has been approved. The notice will be sent in a secure email to the provider’s email address that was entered on the “Request for Reimbursement for Non-Medicaid Outpatient Services” form.

- When notified of approval of Uninsured Eligibility for Case Management, the Provider submits a request for Case Management Services to ValueOptions® Maryland in ProviderConnect.

- A ValueOptions® Maryland Clinical Care Manager (CCM) reviews the request for medical necessity:
    - If the consumer meets the medical necessity criteria, the CCM approves the authorization.
    - If medical necessity criteria are not met, the case is forwarded for Physician Advisor review.

- Note: authorization may only be issued for the general level. I.e. A maximum of 6 units (2 per month) for a 3 months span.

Process for uninsured consumers without an open Uninsured Eligibility span or Medicaid benefits:

- The Provider must use the “Maryland Uninsured Registration Process for CSA Review” to request Case Management services.
    - “Request for Case Management Services” must be documented on the form.
    - The provider may call, or fax the request using the designated form, to the CSA of the consumer’s county of residence.

- The CSA will determine Uninsured Eligibility **and** establish urgency for case management, such as discharge from a state hospital or diversion from inpatient psychiatric care.
    - If the CSA denies the request, the CSA notifies the provider.
    - If the CSA approves the request, the CSA will obtain funding approval from MHA telephonically, or via fax using the “Form for Review of Uninsured for Case Management”. (Phone: 410-402-8476, Fax: 410-402-8304).

- The MHA will determine funding availability:
    - If MHA denies:

        - The CSA will be notified telephonically, or via fax using the "Form for Review of Uninsured for Case Management".
        - The CSA notifies the provider.
    - If MHA approves:
        - The CSA will be notified, telephonically, or via fax using the "Form for Review of Uninsured for Case Management".
        - The CSA forwards the decision to ValueOptions® Maryland, using the "Request for Reimbursement for Non-Medicaid Outpatient Services" form
        - "Case Management Services approved" must be documented on the form.

- ValueOptions® Maryland will "flag" the consumer and open an Uninsured Eligibility span.

- ValueOptions® Maryland will notify the provider that Uninsured Eligibility for Case Management has been approved. The notice will be sent in a secure email to the provider's email address that was entered on the "Request for Reimbursement for Non-Medicaid Outpatient Services" form.

- When notified of approval of Uninsured Eligibility for Case Management, the Provider submits a request for Case Management Services in ProviderConnect.

- A ValueOptions® Maryland Clinical Care Manager (CCM) reviews request for medical necessity:
    - If consumer meets the medical necessity criteria, the CCM approves the authorization.
    - If medical necessity criteria are not met, the case is forwarded for Physician Advisor review.

- Note: authorization may only be issued for the general level. I.e. A maximum of 6 units (2 per month) for 3 month span.

Process for consumers who become retroactively PAC eligible while receiving Case Management Services under Uninsured Eligibility:

- The Uninsured Eligibility span will terminate on the day prior to the effective date of PAC coverage.
- The Case Management authorization on file will remain in effect until the end date of the authorization span.
- To continue Case Management services beyond the end-date of the current authorization span, the provider must follow the exception process documented above.

Claims denied for Case Management Services for consumers, who received retroactive PAC eligibility during an open authorization span, will be corrected and reprocessed by ValueOptions® Maryland beginning December 16, 2009.

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