Adult and Children's Mental Health Targeted Case Management

Policy Number: SC14P0044A2

Effective Date: May 1, 2018

Last Update: September 19, 2022

PAYMENT POLICY HISTORY

DATE	SUMMARY OF CHANGES
September 19, 2022	Information regarding code-specific procedure CPT® or HCPCS was removed.
December 6, 2021	The policy was updated to clarify that a functional assessment for adults and children must focus assessing both the mental and physical of a person and should not focus just on the general health of an individual. In addition, case load limitations for both adults and children were added to the policy.
August 5, 2021	Annual policy review completed. Grammatical corrections were made. These changes did not impact the technical requirements of the document.
September 10, 2020	Annual policy review. No technical changes were made to the policy. Information was moved to the new UCare template, and as a result some information was reformatted.
August 28, 2019	Information regarding comparison to the DHS MH Procedure CPT® or HCPCS Codes and Rates Chart and UCare fee schedules was removed from the document. The UCare Provider Manual contains information regarding how and when UCare updates fee schedules. A link to the UCare Provider Manual continues to be available within the document.
August 1, 2019	Children's Mental Health Targeted Case Management requirements were added to the policy. Internal links within the document and the UCare logo were updated.
May 1, 2018	The AMH-TCM policy implemented by UCare.

APPLICABLE PRODUCTS

This policy applies to the products checked below:

UCARE PRODUCT	APPLIES TO
UCare MinnesotaCare	√

UCARE PRODUCT	APPLIES TO
UCare Minnesota Senior Care Plus (MSC+)	√
UCare Prepaid Medical Assistance (PMAP)	√
UCare Connect	√
UCare Connect +Medicare (When MHCP is the primary payer)	√
UCare Minnesota Senior Health Options (MSHO) (When MHCP is the primary payer)	√

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PAYMENT POLICY INSTRUCTIONS

A payment policy assists in determining provider reimbursement for specific covered services. To receive payment, the provider must be in a contractual relationship with UCare and provide services to a member enrolled in one of UCare's products. This payment policy is intended to provide a foundation for system configuration, work instructions, call scripts, and provider communications. A payment policy describes the rules for payment, which include applicable fee schedules, additional payment rules by regulatory bodies, and contractual terms. This policy is a general guideline and may be superseded by specific provider contract language.

PAYMENT POLICY OVERVIEW

Adult mental health targeted case management (AMH-TCM) and children's mental health targeted case management (CMH-TCM) services assists individuals with serious and persistent mental illness (SPMI) and children with severe emotional disturbance (SED) gain access to needed medical, social, educational, vocational, and other necessary services connected to the person's mental health needs.

Targeted case management) services include development of a functional assessment and individual community support plan) for an adult and an individual family community support plan by referring and linking the person to mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

The billing and payment guideline for adult and children's targeted case management are outlined in this policy.

POLICY DEFINITIONS

TERM	NARRATIVE DESCRIPTION
Adult Mental Health Targeted Case Management Assessment	Means for purposes of this policy an assessment that includes the five (5) parts listed below: 1. Review of the patient's diagnostic assessment; 2. Assess the patient receiving AMCH-TCM for strengths, resources, needs, functioning, health problems and conditions, safety, vulnerability, and injury risk. This assessment should include family members, significant others and providers identified by the patient as being important to their recovery process; 3. Screen for substance use and abuse;

TERM	NARRATIVE DESCRIPTION
	4. Review and update documentation related to the patient's status, cultural considerations, and functional description in all the FA domains specified in Minnesota statute; and Complete LOCUS assessment to determine resources and resource intensity needs.
Case Manager	Means an individual with a bachelor's degree in one of the behavioral sciences or related fields, including but not limited to social work, psychology, or nursing from an accredited college or university; or, if without a degree must: • Have three or four years of experience as a case manager associate; • Be a registered nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or • Be a person who qualified as a case manager under the 1998 DHS waiver provision and meet the continuing education and mentoring requirements.
Case Management Services	Means activities that are coordinated with the community support services program and are designed to help adults with serious and persistent mental illness in gaining access to needed medical, social, educational, vocational, and other necessary services as they relate to the client's mental health needs. Case management. Case management services include developing a functional assessment, an individual community support plan (ICSP), referring and assisting the person to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.
Clinical Supervision	Means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional co-signing individual treatment plans and by entries in the patient's medical record regarding supervisory activities.
Clinical Supervisor	Means the mental health professional who accepts full professional responsibility for the supervisee's actions and decisions, instructs the

TERM	NARRATIVE DESCRIPTION
	supervisee in the supervisee's work, and oversees or directs the work of the supervisee.
Clinical Trainee	Means a mental health practitioner who meets the qualifications specified in Minnesota Rules, part 9505.0371, subpart 5, item C.
Diagnostic Assessment	Means a written report that documents the clinical and functional face-to-face evaluation of an individual's mental health that includes the nature, severity, and impact of behavioral difficulties, including: • Functional impairment • Subjective distress • Strengths and resources
Functional Assessment	Means an assessment that clearly and concisely describes an individual's: • Current status and level of function within each domain, and when applicable and present, making the link to the individual's mental illness and his or her status and level of functioning within that specific domain • Current status and level of functioning within each domain • Identify functional strengths and impairments to: ○ Help the individual articulate his or her recovery life vision or goal, service goals, needs and priorities ○ Prioritize needs based on the individual's preferences and posed risk ○ Formulate service planning based on the individual's recovery vision or goal, service goals, priorities, and best practice interventions ○ Utilize the individual's strengths of functioning and resources in any domain to build, restore and enhance functioning that is currently impaired in that same or another domain ○ Demonstrate medical necessity and establish a that necessity by documenting that necessity throughout the individual's service medical record ○ Inform other assessments (i.e., LOCUS) ○ Guide the documentation for all services and interventions ○ Justify reimbursement or payment for services • Cultural and social mores of the individual must be considered in the assessment of all domains
Individual Community Support Plan (ICSP)	Means a written plan developed by a case manager based on a diagnostic assessment and functional assessment. The plan identifies specific services needed by an adult with serious and persistent mental

TERM	NARRATIVE DESCRIPTION
	illness to develop independence or improved functioning in daily living, health and medication management, social functioning, interpersonal relationships, financial management, housing, transportation, and employment.
Level of Care Utilization System (LOCUS) Assessment	Means a level of care tool to help determine the resource intensity needs of individuals who receive adult mental health services along a continuum of care. The assessment is used to ensure and support that an accurate level of care is being utilized for the considerations of an individual's needs. All LOCUS recording forms must be reviewed and signed by a clinical supervisor unless it is completed by a mental health professional or a Mental Health Rehabilitative Professional. The assessment form is not valid without all necessary signatures.
Mental Health Professional	Means one of the following providers: • Clinical nurse specialist (CNS) • Licensed independent clinical social worker (LICSW) • Licensed marriage and family therapist (LMFT) • Licensed professional clinical counselor (LPCC) • Licensed psychologist (LP) • Mental health rehabilitative professional • Psychiatric nurse practitioner (NP) • Psychiatry or an osteopathic physician
Serious and Persistent Mental Illness (SPMI)	Means a condition with a diagnosis of mental illness that meets at least one of the following and the patient had two or more episodes of inpatient care for mental illness within the past 24 months: • Had continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the past 12 months • Has been treated by a crisis team two or more times within the past 24 months • Has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder; evidences a significant impairment in functioning; and has a written opinion from a mental health professional stating he or she is likely to have future episodes requiring inpatient or residential treatment unless community support program services are provided • Has in the last three years, been committed by a court as a mentally ill person under Minnesota statutes, or the adult's commitment as a mentally ill person has been stayed or continued

TERM	NARRATIVE DESCRIPTION
	• Was eligible under one of the above criteria, but the specified time period has expired • Was eligible as a child with severe emotional disturbance, and the patient has a written opinion from a mental health professional, in the last three years, stating that he or she is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in the above criteria, unless ongoing case management or community support services are provided.
Severe Emotional Disturbance	Means a child with emotional disturbance that meets at least one of the following criteria: • Has been admitted to inpatient or residential treatment within the last three years or is at risk of being admitted • Is a Minnesota resident and receiving inpatient or residential treatment for an emotional disturbance through the interstate compact • Has been determined by a mental health professional to meet one of the following criteria: o Has psychosis or clinical depression o Is at risk of harming self or others because of emotional disturbance o Has psychopathological symptoms because of being a victim of physical or sexual abuse or psychic trauma within the past year Has a significantly impaired home, school, or community functioning lasting at least one year or presents a risk of lasting at least one year, because of emotional disturbance, as determined by a mental health professional.

ENROLLEE ELIGIBILITY CRITERIA

THIS SECTION OF THE POLICY PROVIDES INFORMATION THAT IS SPECIFIC TO THE UCARE MEMBER, INCLUDING INFORMATION ABOUT THE CRITERIA THE MEMBER MUST MEET IN ORDER FOR THE SERVICE(S) IN THE POLICY TO BE ELIGIBLE FOR PAYMENT

Adult Mental Health Targeted Case Management

An UCare adult enrollee must meet one of the following criteria to receive AMH-TCM services:

- Is a person with a serious and persistent mental illness (SPMI) determined by a diagnostic assessment.

- Is determined by a county or tribe to appear to be eligible for case management but due to the person's initial refusal to participate in the diagnostic assessment process, the eligibility determination can't be completed. In these circumstances, eligibility is limited to four months from the day the person first received case management services.
- Is an adolescent who has received children's MH-TCM services within 90 days of turning 18 years old, and upon turning 18 seeks adult MH-TCM services. Transition aged youth maintain eligibility for AMH – TCM for up to 36 months based upon the most recent diagnostic assessment when the youth transitioned to adulthood.

Children's Mental Health Targeted Case Management

An UCare enrolled child must have a severe emotional disturbance (SED) and meet one of the following criteria to CMH-TCM services:

- The child has been admitted within the last three (3) years or is at risk of being admitted to inpatient treatment for an emotional disturbance.
- The child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact.
- The child has one of the following as determined by a mental health professional:
  - Psychosis or clinical depression
  - Risk of harming self or others because of an emotional disturbance
  - Psychopathological symptoms as result of being a victim of physical or sexual abuse or of psychic trauma within the last year
- The child because of emotional disturbance, has significantly impaired home, school or community functioning that has lasted at least one year or that in the written opinion of mental health professional, present substantial risk of lasting at least one year.

ELIGIBLE PROVIDERS OR FACILITIES

OUTLINED BELOW IS THE SPECIFIC CRITERIA A PROVIDER MUST MEET IN ORDER FOR THE SERVICE(S) IN THIS POLICY TO BE ELIGIBLE FOR PAYMENT. THE SERVICE(S) IN THE POLICY TO BE ELIGIBLE FOR PAYMENT

Provider

- AMH-TCM agencies run by or under contract with a county are eligible to provide Minnesota Health Care Programs (MHCP) MH-TCM services.
- Eligible providers are case managers or case manager associates (CMA) employed by an AMH-TCM agency and meet qualifications in Minnesota Statutes.

- UCare requires that professionals be licensed at the independent clinical level and be able to enroll in the MHCP provider system as a licensed mental health professional.

Facility

Not applicable. This policy outlines the billing and payment guidelines for professional services.

Other and/or Additional Information

Not applicable.

EXLUDED PROVIDER TYPES

OUTLINED BELOW IS INFORMATION REGARDING PROVIDERS WHO ARE NOT ELIGIBLE TO FURNISH THE SERVICE(S) LISTED IN THIS POLICY.

Not applicable.

MODIFIERS, CPT, HCPCS, AND REVENUE CODES

General Information

The Current Procedural Terminology (CPT®) HCPCS, and Revenue codes listed in this policy are for reference purposes only. Including information in this policy does not imply that the service described by a code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee of claim payment.

Modifiers

The modifiers listed below are not intended to be a comprehensive list of all modifiers. Instead, the modifiers that are listed are those that must be appended to the CPT® / HCPCS codes listed below. Based on the service(s) provided, and the circumstances surrounding those services it may, based on correct coding, be appropriate to append an additional modifier(s) to the CPT® / HCPCS code.

When a service requires multiple modifiers, the modifiers must be submitted in the order listed below. If it is necessary to add additional modifiers, they should be added after the modifiers listed below.

MODIFIER(S)	NARRATIVE DESCRIPTION
HA	Child or Adolescent
HE	Mental health service

U4	Service provided via non-face-to-face contact (e.g., telephone)

CPT and/or HCPCS Code(s)

CPT AND/OR HCPCS CODE(S)	MODIFIER(S)	NARRATIVE DESCRIPTION
T1017	HE	Face-to-face encounter - age eighteen (18) and over with a SPMI
T1017	HE HA	Face-to-face encounter – age seventeen (17) and under with a SED.
T2023	HE	Face-to-face contact – age 18 and over with a SPMI
T2023	HE, HA	Face-to-face contact between CM and patient – age seventeen (17) and under with SED
T2023	HE, U4	Telephone contact – age eighteen and over with SPMI

CPT® is a registered trademark of the American Medical Association.

Revenue Codes

Not applicable.

PAYMENT INFORMATION

Covered Services

Adult and Children's Mental Health Targeted Case Management includes four core components of care:

Assessment

Adult MH-TCM

- A diagnostic assessment must include the following:
    - Review of the Diagnostic Assessment
    - Assessment of the patient's strengths, resources, supports, needs, functioning, health problems and conditions, safety, vulnerability, and injury risk. The assessment should include family members, significant others and providers identified by the patient as being important to their recovery process
    - Screen for substance use and abuse
    - Review existing documentation and update regarding the patient's status, cultural considerations, and functional description in all the Functional Assessment Domains.
    - Complete the LOCUS assessment to determine resources and resource intensity needs
- A functional assessment must include:
    - The person's health care coverage;

  - Individual participation in recommended physical and mental health care treatment; and wellness issues important to the person. Both the mental and physical health must be assessed and should not focus just on the general health of an individual;
  - Access to preventive and routine care;
  - Individual participation in recommended health care treatment; and
  - Wellness issues that are important to the patient.
- The case manager must complete the functional assessment within thirty (30) days of the first meeting with the patient and at least every 180 days after the development of the IFCSP or ICSP. The functional assessment must be developed with input from the patient, persons from the patient's support network, and service providers.

Children's MH-TCM

- A children's assessment must include the following:
  - Review of the diagnostic assessment, CASII, and SDQ provided by the mental health professional.
  - Complete the functional assessment by assessing with the child and family receiving CMH-TCM for strengths, supports, supports, needs, functioning, health problems and conditions, safety, vulnerability, and injury and risk. The assessment should include family members, significant others and providers identified as important to the patient's recovery process.
  - Review and update of documentation regarding the child's status, cultural considerations, and function description in all functional assessment domains specified in Minnesota statutes.
- A functional assessment must include:
  - Information regarding the patient's health care coverage
  - Individual participation in recommended physical and mental health care treatment; and wellness issues important to the person. Both the mental and physical health must be assessed and should not focus just on the general health of an individual
    - Access to preventive and routine care
    - Individual participation in recommended health care treatment, and
    - Wellness issues that are important to the patient.
- The case manager must complete the functional assessment within thirty (30) days of the first meeting with the patient and at least every 180 days after the development of the ICSP. The functional assessment must be developed with input from the patient, persons from the patient's support network, and service providers.

Planning

- A Case Manager must develop an ICSP n or IFCP with the patient that includes:
    - Goals and the specific services

  - Activities for accomplishing each goal
  - A specific schedule for each activity
  - The frequency of face-to-face contact between case manager and patient
- The ICSP must be developed with the patient, other service providers, and significant members of the patient's support network
- The ICSP must be completed within 30 days of the first meeting with the patient, and at least every 180 days after the development of the ICSP.

Referral and Connection to Appropriate Support and Resources

- Referral and connection to MH-TCM services involves acquiring the resources needed to ensure the patient meets planned goals. Referral and linkage require interactions with the patient to:
  - Connect with informal natural supports;
  - Connect with local community resources and service providers; and
- Refer to available health treatment and rehabilitation services.

Monitoring and Coordination

A significant portion monitoring and coordination activities are done over the phone by the case manager. These activities serve four (4) key purposes:

1. Ensure service coordination by reviewing programs and services for accountability and verify that everyone is addressing the same purposes stated in the ICSP so that the person is not exposed to discontinuous or conflicting interventions and services
2. Determine achievement of the goals and objectives in the ICSP to see if goals are being achieved according to the ICSP's projected timeline(s) and continue to fit the person's needs
3. Determine service and support outcomes through ongoing observations which can trigger reconsideration of the plan and its recommended interventions when the ICSP is not accomplishing its desired effects
4. Identify any new emerging needs by staying in touch with the person to identify problems, modify plans, ensure the person has resources to complete goals, and track emerging needs

Face-to-Face Contact between Patient and Case Manager

Monthly face-to-face contact between the patient and case manager is the standard of care. Care at less than this standard is unacceptable for the vast majority of people receiving case management services. Flexibility of this standard is to be applied in limited circumstances. The monthly rate for MH-TCM will be paid if at least one of the following occurs:

Adult and Child MH-TCM

One case management core service component (assessment, planning, referral, linkage, monitoring, and coordination) is provided consistent with the ICSP or IFCSP in at least one face-to-face contact with the patient during the month.

Adult Only MH-TCM

- Telephone contact with the person within at least one case management core service component is provided consistent with the ICSP, plus at least one qualifying face-tot-face contact has taken place within the preceding two (2) months.
- Case managers may have contact with adults through phone or interactive television (ITV).
- Interactive video may be used instead of a face-to-face contact if an individual resides in a hospital, nursing facility, residential mental health facility, or an intermediate care facility for persons with developmental disabilities. The use of interactive video may substitute for no more than fifty percent (50%) of the required face-to-face contacts.
- Payment for qualifying services should not be interpreted as the service frequency standard for face-to-face contact with the patient. Monthly face-to-face contact remains the standard of care.

Children's MH-TCM

- To receive payment case managers can only have face-to-face contact with the eligible child, their parent, or the child's legal representative to receive payment. It is best practice to see the child every month. The frequency of face-to-face contacts with the child must be appropriate to the client need and the implementation of the individual family community support plan. A monthly face to face continues to be required when the youth is in out-of-home placement.
- Payment for qualifying services should not be interpreted as the service frequency standard for face-to-face contact with the patient. Monthly face-to-face contact remains the standard of care.

Limits on Size of a Case Manager's Caseload

Adult Mental Health

The average caseload size of a full-time equivalent case manager must not exceed a caseload of thirty (30) people to one full-time equivalent case manager. This standard applies to the average caseload size of case managers across the provider agency. This applies to adult MH-TCM services provided by lead agencies (counties, tribes and managed care organizations).

Children's Mental Health

The average caseload size of a full-time equivalent children's MH-TCM case manager must not exceed a caseload of fifteen (15) children to one full-time equivalent case manager. This standard applies to the

average caseload size of case managers across the provider agency. This applies to children's MH-TCM services provided by lead agencies (counties, tribes, and managed care organizations).

Psychotropic Medication

The case manager must arrange for a standardized assessment with a physician of the patient's choice. The assessment must reflect include side effects related to the administration of the patient's psychotropic drugs.

Payment Decreases and Increases

Based on MHCP guidelines when certain mental services are furnished by a Master's level provider a twenty percent (20%) reduction is applied to the allowed amount. Master's level providers are:

- Clinical Nurse Specialist (CNS-MH)
- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Psychologist (LP) Master's Level
- Master's Level enrolled provider

Legislated Changes Affecting Payment

In addition to the Master's level provider reduction, UCare also applies a 23.7% increase to specific mental health services when furnished by the providers listed below:

- Psychiatrists;
- Advance Practice Nurses;
  - Clinical Nurse Specialist
  - Nurse Practitioner
- Community Mental Health Centers;
- Mental health clinics and centers certified under Rule 29 and designated by the Minnesota Department of Mental Health as an essential community provider;
- Hospital outpatient psychiatric departments designated by the Minnesota Department of Mental Health as an essential community provider; and
- Children's Therapeutic Services and Supports (CTSS) providers for services identified as CTSS in the DHS mental health procedure CPT or HCPCs codes and rates chart.

Master's level provider reductions are not applied to mental health services when they are furnished in a Community Mental Health Center (CMHC).

UCare fee schedule updates can be found in the UCare Provider Manual (Section 10-20, Fee Schedule Updates).

Non-Covered Services

The services listed below are not considered MH-TCM services:

- Treatment, therapy, or rehabilitation services
- Other types of case management (e.g., CAC, CADI, TBI, DD)
- Legal advocacy
- A diagnostic assessment
- Eligibility determination for MH-TCM
- Medication administration
- Services that are integral components of another service or direct delivery of an underlying medical, educational, social, or other service
- Transportation services

BILLING REQUIREMENTS AND DIRECTIONS

Outlined below is information regarding billing of Adult and Children's Mental Health Targeted Case Management Services:

- Submit AMH-TCM services using the MN-ITS 837P format or the electronic equivalent.
- Do not enter a treating provider NPI on each service line.
- Use only the HCPCS codes and modifiers as outlined above.
- When submitting services furnished via telehealth, submit the 02 (Telehealth) as the place of service.
- MH-TCM and ACT - UCare will reimburse MHC-TCM and ACT services concurrently only during the month of admission to, or discharge from ACT services. To receive payment for the month of admission, append modifier -99 to the line item and enter the ACT admission date in the "comments" field of the 837P.
- MH-TCM and Institutions of Mental Disease (IMD) – Reimbursement for MH-TCM may be available for individuals covered by major program IM.
- MH-TCM and Diagnostic Assessment – Eligibility is presumptive. MH-TCM is available to patients before a diagnostic assessment is completed when all the conditions outlined below are met:
    - The patient is referred for and accepts case management services;

- At the time of referral, the patient refuses to receive a diagnostic assessment for reasons related to their mental illness or a child's parent refuses to obtain the assessment for the child;
- The case manager determines the patient is eligible for MH-TCM services; and
- The patient obtains a new or updated diagnostic assessment, resulting in SED or SPMI, within four (4) months of the first day MH-TCM services began.

PRIOR AUTHORIZATI0N, NOTIFICATION AND THRESHOLD INFORMATION

Prior Authorization and Notification Requirements

UCare does update its' authorization, notification, and threshold requirements from time-to-time. The most current prior authorization requirements can be found here.

Threshold Information

See link above.

RELATED PAYMENT POLICY INFORMATION

OUTLINED BELOW ARE OTHER POLICIES THAT MAY RELATE TO THIS POLICY AND/OR MAY HAVE AN IMPACT ON THIS POLICY.

POLICY NUMBER	POLICY TITLE
SC14P0021A4	Assertive Community Treatment (ACT)

UCare payment policies are updated from time to time. The most current UCare payment policies can be found here.

SOURCE DOCUMENTS AND REGULATORY REFENCES

LISTED BELOW ARE LINKS TO CMS, MHCP, AND STATUTORY AND REGULATORY REFERENCES USED TO CREATE THIS POLICY

MHCP Provider Manual, Mental Health Services, Adult Mental Health Targeted Case Management, and Children's Mental Health Targeted Case Management

DHS MHCP Procedure CPT® or HCPCS Codes and Rates List

MN Statutes 245.461 to 245.468 Minnesota Comprehensive Adult Mental Health Act
MN Statutes 245.462 subd. 4 Adult Case Manager Qualifications
MN Stats. 245.4871, subd. 4 Children's Case Manager Qualifications
MN Statutes 245.462 Definitions
MN Statutes 256B.0625, subd. 20 Mental Health Case Management
MN Statutes 256G Minnesota Unitary Residence and Financial Responsibility Act
MN Statutes 245.487 to 245.4887 MS 245.487 to 245.4887 Minnesota Comprehensive Children's Mental Health Act
Minnesota Rules 9520.0900 to 9520.0926 Case Management for Children with SED
Minnesota Rules 9505.0322 Mental Health Case Management Services

DISCLAIMER

"Payment Policies assist in administering payment for UCare benefits under UCare's health benefit Plans. Payment Policies are intended to serve only as a general reference resource regarding UCare's administration of health benefits and are not intended to address all issues related to payment for health care services provided to UCare members. When submitting claims, all providers must first identify member eligibility, federal and state legislation, or regulatory guidance regarding claims submission, UCare provider participation agreement contract terms, and the member-specific Evidence of Coverage (EOC) or other benefit document. In the event of a conflict, these sources supersede the Payment Policies. Payment Policies are provided for informational purposes and do not constitute coding or compliance advice. Providers are responsible for submission of accurate and compliant claims. In addition to Payment Policies, UCare also uses tools developed by third parties, such as the Current Procedural Terminology (CPT®*), InterQual guidelines, Centers for Medicare, and Medicaid Services (CMS), the Minnesota Department of Human Services (DHS), or other coding guidelines, to assist in administering health benefits. References to CPT® or other sources in UCare Payment Policies are for definitional purposes only and do not imply any right to payment. Other UCare Policies and Coverage Determination Guidelines may also apply. UCare reserves the right, in its sole discretion, to modify its Policies and

Guidelines as necessary and to administer payments in a manner other than as described by UCare Payment Policies when necessitated by operational considerations.”