

LIMITED DIAGNOSIS

When a health care provider suspects an eligible medical condition exists, but a definitive diagnosis has not been established, the participant may meet medical eligibility criteria with a limited diagnosis. If the participant meets financial eligibility guidelines, limited funding will be considered for medically necessary diagnostic services. Eligible services include inpatient and outpatient diagnostic testing, professional fees, inpatient hospitalizations, surgical diagnostic services, and medications directly related to the eligible limited diagnosis.

All limited diagnoses require clinical review by the Program Manager prior to enrollment for the limited condition. The Service Coordinator must obtain and send medical records or a letter from the physician indicating there is a concern regarding a suspected condition that has not been clearly identified to the Program Manager. Upon approval, the Program Manager will enter the limited diagnosis into the SHS Information System and notify the Service Coordinator. Limited diagnosis enrollment extends for one (1) year with Service Coordinator review taking place every six (6) months. Extensions beyond one (1) year may be granted on a case by case basis pending clinical review by the Program Manager.

When a definitive diagnosis has been established, the limited diagnosis is closed and the defined diagnosis is entered in the SHS Information System. The Service Coordinator will need to evaluate continued medical eligibility based on the newly defined diagnosis (ICD code) entered.

If the diagnosis is eligible, a new eligibility letter must be printed and mailed to the participant/family. A copy must be retained in the participant's file.

If the diagnosis is ineligible, the participant's Program eligibility for that diagnosis must be closed. When applicable, a new eligibility letter must be printed and mailed to the participant/family. A copy must be retained in the participant's file.