REQUEST FOR PRIOR AUTHORIZATION OF PLAN OF CARE EXPENDITURES

Case Management Agency: _____ **Medicaid Provider ID#:** _____

Case Manager: _____ **Phone:** _____ **Fax:** _____

Recipient's Medicaid ID #: _____ **Date of Birth:** _____

Provide a brief type written narrative that describes the following:

Recipient's current medical condition. Include functional limitations and opportunistic illnesses.	
Reason and justification for additional expenditures, including anticipated outcomes.	
Please check the documentation included.	☐ Physician's Prescription **Current:** ☐ Level of Care (CARES) ☐ Plan of Care ☐ Social Needs Assessment **Level of Need Score:** ☐ Minimal ☐ Moderate ☐ Intensive Itemized cost list and work orders* for ☐ Environmental Accessibility Adaptations ☐ Specialized Medical Equipment and Supplies * Include a description of the item(s), quantity, manufacturer/model/serial number/parts and special features if applicable, comparable market cost per unit and total cost.
Duration of Request (Max. of 6 months)	**Begin Date:** _____ **End Date:** _____
Comments (Attach additional pages if needed)	

I certify to the best of my knowledge all of the statements contained herein are true, complete and made in good faith.

Signature of Case Manager: _____ **Date:** _____

Medicaid Provider ID# of Case Manager: _____

LEVEL OF NEED SCORES AND PAC WAIVER SERVICES

Request for Prior Authorization of Services in the Plan of Care: Shaded blocks indicate services that are not available under a particular level of need without prior authorization. Prior Authorization Requests may be submitted when a service is needed that is not indicated for that level of need, or is needed more than the maximum limits.

Non-Duplication of Services: PAC Waiver Services may not duplicate services available through other funding sources or Medicaid State Plan programs.

SERVICE	Minimal	Moderate	Intensive
CASE MANAGEMENT	As Required	As Required	As Required
CHORE - PEST CONTROL	When needed.	When needed.	When needed.
CHORE - OTHER		When needed.	When needed.
DAY HEALTH CARE		When needed.	When needed.
EDUCATION AND SUPPORT	Available for 3 months from enrollment.	Available for 6 months from enrollment or in crisis.	Available for on-going needs.
ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS		Available to promote greater independence.	Available to promote greater independence.
HOME DELIVERED MEALS		Prescribed by physician and when no in-home support is present for up to 2 months after discharge from institution.	Prescribed by physician and when no in-home support is present for up to 3 months after discharge from institution.
HOMEMAKER			Available when no in-home support is present, for up to 2 months after discharge from institution.
PERSONAL CARE			Available when prescribed by physician for up to two months after discharge from institution.
SKILLED NURSING (RN OR LPN)			Available when prescribed by physician for up to two months after discharge from institution.
SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES	Available when needed.	Available when needed.	Available when needed.
SPECIALIZED PERSONAL CARE FOR CHILDREN IN FOSTER CARE WITH AIDS	Payment per day does not equate to acuity levels.	Payment per day does not equate to acuity levels.	Payment per day does not equate to acuity levels.
THERAPEUTIC MANAGEMENT OF SUBSTANCE ABUSE	Available when needed. Requires physician order.	Available when needed. Requires physician order.	Available when needed. Requires physician order.
RESTORATIVE MASSAGE		By prescription for specific symptoms noted in handbook.	By prescription for specific symptoms noted in handbook.

APPENDIX A
PAC WAIVER SERVICES PROCEDURE CODES, REIMBURSEMENT AND MAXIMUM LIMITS

Non-Duplication of Services: PAC waiver services may not duplicate services available through other funding sources or other Medicaid programs.

Prior Authorization Requests: A prior authorization request must be submitted when a service is needed and is not indicated under a level of need score or is needed in excess of the maximum limits.

SERVICE	PROCEDURE CODE	MODIFIER	REIMBURSEMENT PER UNIT	MAXIMUM LIMIT
Case Management	G9012	U8	$100 per month	1 Unit ($100) per consumer per month
Chore–Other	S5120	U8	$25 per job	Not to exceed $150 per year
Chore–Pest Control	G9005*	U8	$25 per job	Not to exceed $150 per year
Day Health Care	S5100	U8	$2.50 per 15-minute unit	40 units (10 hours) per day
Education and Support	96152	U8	$10 per 15-minute unit	8 units (2 hours) per month
Environmental Accessibility Adaptations	S5165	U8	$250 per unit	8 units or $2000 per year whichever is lower
Home Delivered Meals	S5170	U8	$5 per Home Delivered Meal unit	62 meals per month or two meals per day
Homemaker	S5130	U8	$2.50 per 15-minute unit	32 units (8 hours) per day
Personal Care	99509	U8	$2.75 per 15-minute unit	16 units (4 hours) per day
Skilled Nursing-LPN	T1003	U8	$7 per 15-minute unit	32 units (8 hours) per day
Skilled Nursing-RN	T1002	U8	$10 per 15-minute unit	32 units (8 hours) per day
Restorative Massage	97124	U8	$8.75 per 15-minute unit	8 units (2 hours) per month
Specialized Medical Equipment and Supplies	E1399	U8	$250 per purchase	$250 per purchase per month
Specialized Personal Care for Children in Foster Care	S5145	U8	$37 per day	$37 per day
Therapeutic Management of Substance Abuse	T1007	U8	$8.75 15-minute unit	16 units (4 hours) per day

*Disposable incontinence supplies must be billed in accordance with the PAC Disposable Incontinence Medical Supplies Procedures Code and Fee Schedule. These supplies are counted toward the total allowable reimbursement for specialized medical equipment and supplies.