MAP 109-HCBW

PLAN OF CARE/ PRIOR AUTHORIZATION FOR HCB WAIVER SERVICES

Recipient Name: _____ **SSN/MAID:** _____
(Last) (First) (MI)

☐ Assessment
☐ Reassessment
☐ Modification

Diagnosis (es): _____

This Plan of Care covers the following period _____ to _____.

NEED(S)	GOAL(S)	INTERVENTION(S)	OUTCOME(S)

REQUESTED HCBW SERVICES:	REVENUE CODE:	FREQUENCY/DURATION:	UNITS OF SERVICE:	DOLLAR AMOUNT:	QIO To Complete MEDICAID ACTION:
					☐ Approved ☐ Denied
					☐ Approved ☐ Denied
					☐ Approved ☐ Denied
					☐ Approved ☐ Denied

HCBW Provider Name: _____ Provider #: _____ Phone # (____) _____

HCBW Provider Address (Street, City, Zip) _____

REQUESTED ADHC SERVICES:	PROCEDURE CODE:	FREQUENCY/DURATION:	UNITS OF SERVICE:	DOLLAR AMOUNT:	QIO To Complete MEDICAID ACTION:
					☐ Approved ☐ Denied
					☐ Approved ☐ Denied
					☐ Approved ☐ Denied

ADHC Provider Name: _____ Provider #: _____ Phone # (____) _____

ADHC Provider Address (Street, City, Zip) _____

Total Estimated HCBW Monthly Cost: $ _____ Date Plan of Care Developed: _____

➢ ***I certify the information entered on the MAP-351A and contained above is accurate:***

HCBW Case Manager's Signature _____ **Date:** _____

HCBW Team Members' Signature: _____ **ADHC RN's Signature**: _____

Recipient's/Representative's Signature: _____ Date: _____

PHYSICIAN, PA OR ARNP STATEMENT: "I certify this individual, who is under my care, meets nursing facility level of care in accordance with 907 KAR 1:022. If home and community based waiver services were not available nursing facility placement would be imminent. I have reviewed this Plan of Care in accordance with 907 KAR 1:160."

Full Name (Print) _____ **License #** _____ Address: _____

Signature _____ **M.D., P.A., A.R.N.P. Date:** _____

QIO Signature/Title: _____ **Date**: _____

Instructions for completing form MAP 109-HCBW

The MAP 109-HCBW is used by Medicaid providers certified to participate in the Home and Community Based (HCB) Waiver program. The Plan of Care/Prior Authorization For HCB Waiver Services (MAP 109-HCBW) is designed to be a complete and thorough instrument that is:

1. Utilized for the recipient's attending physician, physician's assistant (PA) or advanced registered nurse practitioner (ARNP) to certify the recipient meets nursing facility level of care;
2. Utilized to document the physician, PA or ARNP has reviewed the Plan of Care in accordance with 907 KAR 1:160;
3. Utilized to document the assessed Needs, Goals, Interventions, and Outcomes necessary to maintain the Medicaid HCB Waiver recipient in his/her residence;
4. Utilized to document the HCB Waiver Services requested, the revenue code, the frequency and duration of the HCB Waiver Service; the number of units of service requested, the dollar amount requested by the provider as it relates to the units of service requested; and
5. Utilized by the Quality Improvement Organization (QIO) to **Approve** or **Deny** the Medicaid HCB Waiver provider's service requests.

General Information Regarding the MAP 109-HCBW

For the Plan of Care/Prior Authorization for Home and Community Based Waiver Services form (MAP 109-HCBW) to be useful and meaningful to the process of service provision to Medicaid HCB Waiver recipients, the following points must be addressed:

1. The Plan of Care shall be filled out completely and accurately by the case manager, the appropriate HCBW team member and the Adult Day Health Care Center Registered Nurse;
2. The Plan of Care shall recognize each and every assessed need and the goal, intervention and outcome related to that need;
3. The Plan of Care shall recognize who will be addressing the applicant's need. For example, the Medicaid HCB Waiver resource member (i.e., case manager, RN, ADHC) or, if not provided under the waiver; the individual, a family member or other person/method/resource that will be used to adequately address the applicant's assessed need.

The Document:

- Recipient Name: Enter last name, first name and middle initial;
- SSN/MAID: Enter either the Kentucky Medical Assistance Identification (MAID) number found on the Medicaid card or the social security number, if the MAID number has not yet been issued;
- Recipient Diagnosis(es): Enter all pertinent diagnosis(es);
- Type of application: Check the box corresponding with the appropriate type of application: Whether initial **assessment**, ongoing **reassessment** or adjusted **modification**;
- This Plan of Care covers the following period: Enter the begin date and the end date of the plan of care;
- Needs: Using the MAP 351A as a guide, enter **all** the identified need(s);
- Goals: Involving the recipient/caregiver(s) in the goal development, document the goal in relation to the assessed need;
- Interventions: Recognizing applicable waiver services, family members, friends, relatives, neighbors, and other community resources, document the method by which the need will be addressed in order to achieve the recipient's documented goal(s);
- Outcomes: Document the status of each need, goal and intervention every 60 days **AND** as needed. Documented status should indicate whether need, goal and intervention is being met or not and what changes (if any) will be required;
- Requested HCBW Services: Enter each HCB Waiver service requested;

(Continued)

- Revenue Code: Enter each applicable revenue code;
- Frequency/Duration: Enter the amount of time and number of days per week each service is being requested;
- Units of Service: Enter the number of units requested for each service;
- Dollar Amount: Enter the estimated dollar amount of each HCB Waiver service;
- Medicaid Action: **Leave Blank.** The QIO (PRO) will complete this section.
- Provider Information: Enter the HCBW provider name, provider number, telephone number and address;
- Requested ADHC Services: Enter the name of each Medicaid ADHC Waiver service requested, in relation to the applicant's assessed need;
- Procedure Code: Enter each applicable procedure code;
- Frequency/Duration: Enter the amount of time and number of days per week each service is being requested;
- Units of Service: Enter the number of units requested for each service;
- Dollar Amount: Enter the estimated dollar amount of each ADHC service;
- Medicaid Action: **Leave Blank.** The QIO (PRO) will complete this section;
- Provider Information: Enter the ADHC provider name, provider number, telephone number and address;
- Total Estimated HCBW Monthly Cost: Enter the total estimated HCBW monthly cost;
- Date Plan of Care Developed: Enter the date Plan of Care was developed;
- Certification of accuracy statement: Provide HCBW Case Manager's signature and enter date signed;
- HCBW Team Member's Signature: Provide the signature of the HCBW team member who worked in collaboration with the Case Manager, the ADHC Registered Nurse and Recipient to develop the Plan of Care;
- ADHC RN's Signature: Provide the signature of the ADHC Registered Nurse who worked in collaboration with the Case Manager, the HCBW Team Member and Recipient to develop the Plan of Care;
- Recipient's/Representative's Signature and Date: Provide the signature of the recipient or representative and the date signed;
- Physician, PA or ARNP information: Enter the full printed name; enter the license number and enter the address;
- To be completed by Physician, PA or ARNP: After reviewing the Plan of Care and reading Physician, PA or ARNP statement; the Physician, PA or ARNP is to provide his/her signature, circle appropriate title and enter the date of signature;
- To be completed by QIO: QIO (a.k.a. PRO) signature/title and date.