(6/1/2003)

Instructions for completing form MAP 109-MWII

The MAP 109-MWII is used by Medicaid providers certified to participate in the Model Waiver II program. The Plan of Care/Prior Authorization For MWII Services (MAP 109-MWII) 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 1:595;
3. Utilized to document the assessed Needs, Goals, Interventions, and Outcomes necessary to maintain the Medicaid MWII recipient in his/her residence;
4. Utilized to document the MWII Services requested, the revenue code, the frequency and duration of the MWII 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 MWII provider's service requests.

General Information Regarding the MAP 109-MWII

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

1. The Plan of Care shall be filled out completely and accurately by the case manager and the appropriate team members;
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 MWII resource member (i.e., case manager, RN) 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;
- Type of application: Check the box corresponding with the appropriate type of application: Whether initial **assessment**, ongoing **reassessment** or adjusted **modification**;
- Recipient Diagnosis(es): Enter all pertinent diagnosis(es);
- 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 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);

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- 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 MWII Services: Enter each MWII service requested;
- 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 MWII service;
- Medicaid Action: **Leave Blank.** The QIO will complete this section.
- Provider Information: Enter the MWII provider name, provider number, telephone number and address;
- Total Estimated MWII Monthly Cost: Enter the total estimated MWII monthly cost;
- Date Plan of Care Developed: Enter the date Plan of Care was developed;
- Certification of accuracy statement: Provide Case Manager's signature and enter date signed;
- Team Members' Signature: Provide the signature of each team member involved in developing 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 signature/title and date.