INDEPENDENT CARE HEALTH PLAN
*i*Care is a wholly-owned subsidiary of Humana

# Personal Care Workers (PCW)
# Prior Authorization Request Form

Please fill out this form completely and fax to 414-231-1026
For PA status call Customer Service at 414-223-4847
*i*Care Prior Authorization Department 414-299-5539 or 855-839-1032
Requests submitted with incomplete forms or missing documentation will be returned

| **Member Information** | | |
|---|---|---|
| **Lines of Business:** | □ *i*Care Medicaid SSI | □ *i*Care BadgerCare Plus |
| Member Name: | | DOB: |
| Member ID#: | | Phone: |
| **Service Type:** | □ Court Ordered Service (72-hr. turnaround time) | □ Clinical Trial (72-hr. turnaround time) |
| | □ Elective/Routine (7-day turnaround time) | □ Expedited/Urgent* (72-hr. turnaround time) |

**Definition of Urgent/Expedited:** when the treatment requested is required to prevent imminent, serious deterioration in the member's health or threatens to jeopardize the member's ability to regain maximum function.
***i*Care reserves the right to deny the request for urgent review for all requests outside of this definition.**

| **Servicing Provider Information** (facility/supplier who will perform service) | | |
|---|---|---|
| Provider/ Supplier Name: | | NPI: |
| Contact Name: | Tax ID Number: | Phone: |
| Address: | | Fax: |
| Contact Email: | | |
| **Ordering Practitioner Information** (practitioner who ordered service) | | |
| Practitioner Name: | | NPI: |
| Contact Name: | Tax ID Number: | Phone: |
| Address: | | Fax: |

| **PCW Request Type** | |
|---|---|
| □ Initial Request<br>□ Authorization Renewal/ Extension<br>□ Continuity of Care<br>□ Updates/ Corrections to the authorization | **Temporary increase in service due to change in condition:**<br>☐ _____ units requested per day<br>☐ _____ days the increased units are needed |

| **Services** | **CPT/HCPCS Code** | **Units per week requested** |
|---|---|---|
| PCW Services | T1019 | |
| Travel Time | T1019-U3<br>□ Map included | |
| RN Visits | 99509 | |
| PRN Visits | T1019 | |
| **ICD 10 Diagnosis Code** | **Description** | |
| | | |
| | | |
| | | |

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| **Dates of Service:** | **From:** **To:** |
|---|---|
| **Comments** (please do not mark level of urgency here): | |

**Required documentation:**

- The PCW Agency must submit to *i*Care, by fax, the following required documentation for any new request.
- The request **must include** the number of PCW units per week, supervisory visits, and travel time being requested.
- **Plan of Care (POC) with Provider order**, written according to Wis. Admin. Code § DHS 107.112(3)(b) ,that is signed and dated within 30 days of the authorization request.
    - The POC is developed by a registered nurse based on physician orders
- **Supporting clinical documentation:**
    - For **Initial requests**: comprehensive clinical documentation from the ordering provider who has seen and evaluated the member, in person, within 3 months prior to requesting PCW services.
    - For authorization **Renewal/Extension:** clinicals may be up to 6 months old; members are required to see Provider annually unless there is an increase in units requested.
    - If there is a request for increase in services member must be seen in person for an examination and assessment within 30 days of increase.
- Providers documentation must describe the member's physical limitations, related it to an active diagnosis, and describe what the PCW need is.
- Documentation from visits to any specialist must be included. Examples of specialists include physical therapy, occupational therapy, respiratory therapy, speech therapy, cardiology, orthopedics, rheumatology, neurology, pain management and behavioral health (BH).
- If a member has a BH diagnosis and any of the PCW needs are related to that diagnosis, or if an extra time multiplier is requested, the documentation must specifically show how the BH diagnosis relates to the need. Current BH clinicals should be submitted.
    - A list of current medications.
    - All clinical documentation must directly support the POC/order and PCST.
    - *i*Care will not authorize personal care services for dates before the date on the POC/Provider order.

**Clinical Notes, Supporting Documentation, and Physician Order are Required to Review for Medical Necessity**

*Receipt of an approved prior authorization does not guarantee coverage or payment by*
*iCare Benefits are determined based on the dates that the services are rendered.*
*An incomplete form may delay processing and/or claims payment*

INDEPENDENT CARE HEALTH PLAN (*i*Care)
1555 N RiverCenter Dr. Suite 206 Milwaukee, WI 53212
www.iCareHealthPlan.org