

CYSHCN Prior Authorization Request Instruction Form

Request Type: Check the box next to the type of request you are submitting.

- New: A request that was not being considered by CYSHCN in the previous (immediately preceding) authorization period.
- Continued: A request that CYSHCN is currently reimbursing for that needs to be extended into a new fiscal year or authorization period.
- Amended: A request that is currently being reimbursed by CYSHCN but has had a change occur to either units, time, or cost authorized.

Name: Full name as listed in MOHSAIC. Do not use alias or nicknames.

Date of Birth: Month/Day/Year of birth as listed in MOHSAIC.

DCN: Departmental Client Number as listed in MOHSAIC. If the participant is listed with more than one DCN, notify PM so the multiple DCNs may be merged.

Address, City, State/Zip: Participant's complete address as listed in MOHSAIC. If the participant has recently moved or there is a discrepancy, please update MOHSAIC before listing the new address on the PA form.

Primary Diagnosis Code: The ICD code that the requested service is most directly related to. The code must be active and CYSHCN eligible for the participant. Codes that require review and have not been approved in MOHSAIC by the PM are not acceptable to use on the PA form.

Diagnosis Description: Description of the diagnosis code listed in the previous field. This may be obtained from MOHSAIC, the participant's Health Certification Form or an ICD Code Book.

SC Assessment (SCA) Date: The date the SCA was completed with the participant/family as listed in Web MOHSAIC. Not the date it was started (if it was not completed on the same day) or the date it was entered. However, the SCA must be completely entered in Web MOHSAIC prior to the PA request being considered.

Begin Date of Service: The first day CYSHCN will consider reimbursing for the service. Not the first date the service was delivered. This date should not precede the date of the SC Signature authorizing services, unless prior approved by PM.

End Date of Service: The last day of the documented length of need, authorization period or fiscal year for which CYSHCN will consider reimbursing for the service. On-going requests end date on 12/31 or 6/30 depending on type of service. Therapies are typically authorized no longer than six months at a time, then re-evaluated; unless otherwise stated in the letter of medical necessity and prior approved by the PM. A PA may not cross fiscal years.

Service or Equipment Description:

- Service code and description of service or equipment being requested. Provider will be able to supply the service code when submitting their price quote (UCR).
- Also include the calculation for recurrent monthly expenses. $UCR \times \text{quantity per month} = \text{monthly UCR}$
 $\text{monthly UCR} \times \text{reimbursement rate} = \text{CYSHCN monthly reimbursement}$
 $\text{CYSHCN monthly reimbursement} \times \text{no. of months in the authorization period} = \text{total authorized reimbursement amount}$.

Authorized Reimbursement Amount: The total authorized reimbursement amount for the entire authorization period. Not a monthly total for recurrent expenses. For one time reimbursements: UCR x reimbursement rate or the ‘agreed upon rate’, whichever is lower.

Approved/Denied: A check mark must be in the column indicating if each line item on the request was approved or denied. This will be done by the SC on requests that do not require PM approval. PM will place the check mark on all other requests.

Detailed Explanation of Medical Necessity for Services or Equipment:

- Purpose for the request as it relates to the participant’s eligible diagnosis. You may simply reference the letter of medical necessity, if it accompanies the PA.
- Reference private insurance and MO HealthNet status.
- Note if the service/item is excluded from coverage. If so, documentation of the exclusion must accompany the PA request.
- Note any amount that insurance has agreed to pay (i.e. up to \$500 or 80%). This amount is subtracted from the CYSHCN reimbursement amount, not the UCR.

Enrolled Provider: The SHCN provider as listed in Web MOHSAIC.

Contact Name: The person affiliated with the SHCN enrolled provider that supplied you with the PA information.

Address/City/State/Zip: The provider’s complete billing address as listed in Web MOHSAIC (SC Payment Address). Not their physical location.

Denial Reason: For Central Office/PM use only.

Service Coordinator Signature & Date: The date the PA is completed, signed and sent to Central Office.

For Internal Use Only: For Central Office/PM use only.