CCP Prior Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services (3 Pages)

Prior Authorization Request Submitter Certification Statement
I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request. The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made. The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM). The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment. The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid. The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant *Texas Medicaid Provider Procedures Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions. ☐ We Agree

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Client Information	
First name:	Last name:
Medicaid number (PCN):	Date of birth:
Address, city, and ZIP:	
Diagnoses:	

Certification

I attest that this client's health care is medically complex and multidisciplinary.

Medically complex is the health care needed by a Medicaid beneficiary achieves the designation of "medically complex" when the approved plan of care necessitates a clinical professional, practicing within the scope of their license and in the context of a medical home, coordinate ongoing treatment to ensure its safe and effective delivery.

Multidisciplinary Care is the coordination of clinician ordered medically necessary health care that requires the collaboration of two or more medical, educational, social, developmental or other professionals in order to properly devise and implement the clinician-developed plan of medical care. For Medicaid coverage, multidisciplinary health care must include medically necessary services provided by program-enrolled clinical providers. Development and implementation of the plan of medical care may, in addition, need to take into account other related care provided by nonclinical providers as required to address the overall health needs of a client.

DATE of my last Face-to-Face inpatient or outpatient evaluation and management visit with the client: _______________

I request a six-month authorization from ________________ to ________________ for non-face-to-face care coordination services for the client named on this form. I attest that these services are essential to provide quality health care for the identified client. ***I request authorization for the following types of services in the stated six-month period (check all that apply):***

☐ Non-face-to-face prolonged services (authorization and reimbursement are limited to a maximum of 90 minutes once per client per provider*). ☐ 99358 ☐ 99359

** I understand that I may submit a statement of medical necessity or progress note with a claim or with this authorization form for consideration of authorization of services that exceed the Texas Medicaid Program limits indicated above. Documentation must support a significant change in the client's clinical condition.*

☐ Care plan oversight:

Home or other	Home health**	Hospice**	Nursing Facility
☐ 99339	☐ 99374	☐ 99377	☐ 99379
☐ 99340	☐ 99375	☐ 99378	☐ 99380

(Authorization and reimbursement are limited to one service a month per six-month authorization period without exception.)

** I attest that I am the clinician who signed the plan of care for the home health agency or hospice; I do not have a significant financial or contractual relationship with the home health agency or hospice. I am not the medical director or employee of the hospice; and I do not furnish services under any arrangement with the hospice (including volunteering).

☐ Team conferences (authorization and reimbursement are limited to a maximum of one service per six-month authorization period. Authorization of additional team conferences may be considered for a client when there is documentation on this form of a change in the client's medical home provider.) ☐ 99367

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Client Information	
First name:	Last name:
Medicaid number (PCN):	

Certification (continued)

I attest that I am the medical home provider for the client and, as such, in coordination with the family and client, I have generated or updated (within the prior 12 months), a comprehensive care plan for the client which is documented in the client's medical record, has been shared with the family or client, and includes the following components, at a minimum:

- A current medical summary, encompassing all disciplines and all aspects of the client's care, and containing key information about the client's health (e.g., conditions, complexity, medications, allergies, past surgical procedures, etc.).
- A current list of the main concerns, issues, and problems as well as key strengths or assets and the related current clinical information including a list of all diagnoses with diagnosis codes. Planned action steps to improve or enhance health outcomes.
- Planned action steps and interventions to address the concerns and to sustain or build strengths, with the expected outcomes.
- Disciplines involved with the client's care and how the multiple disciplines will work or are working together to meet the client's needs. Explain how the multidisciplinary approach will benefit the client's needs.
- Short-term and long-term goals with timeframes.

Documentation

One of the following forms of documentation must be submitted with this request in order to obtain prior authorization for non-face-to-face care coordination services:

- Formal and written care plan.
- A progress note detailing care coordination planning and activities.
- A letter stating medical necessity for care coordination, including information on the care plan and care coordination services.

Provider Information	
Clinician provider name:	
Medicaid TPI:	NPI:
Taxonomy code:	Benefit code:
Telephone number:	Fax number:
Address, city, and ZIP:	
Clinician provider signature:	Date: