Tri-County Office on Aging

METRICS FOR COVERED ITEMS AND SERVICES

To comply with the CMS Interoperability and Prior Authorization Final Rule Tri-County Office on Aging (TCOA) is required to annually report aggregated prior authorization metrics on our website. Specifically, this includes a list of all MI Choice Waiver medical items and services that require prior authorization, as well as data on prior authorization requests for those items and services (e.g., approvals, denials, etc.) over the previous calendar year. Publicly reporting these metrics promotes transparency and accountability, helps individuals understand prior authorization processes, and enables evaluation of payer performance. In addition, metrics can be used to compare plans, programs, and payers. For questions on the data below, contact: Kirsten Laing, LMSW, Home and Community Based Services Director at TCOA, 517.887.1361 or laingk@tcoa.org

This form is adapted from the template developed by the Centers for Medicare & Medicaid Services (CMS).

Report Date: 11/09/2026

Reporting Period: Calendar Year 2025

Items and Services Requiring Prior Authorization

MI Choice Waiver Services	HCPCS Code(s)
Adult day health (adult day care)	S5100, S5101, S5102
Assistive Technology	E0745, T1999, T2028, T2029, V5267, V5268, V5269, V5270, V5271, V5272, V5273, V5274, V5281, V5282, V5283, V5284, V5285, V5286, V5287, V5288, V5289, V5290,
Chore services	S5120, S5121
Community Health worker	G9012
Community Living supports	H2015

Community transportation	A0080, A0090, A0100, A0110, A0120, A0130, A0140, A0160, A0170, A0180, A0190, A0200, A0210, S0209, S0215, T2001, T2002, T2003, T2004, T2005, T2007
Counseling	99510
Environmental accessibility adaptions	S5165
Fiscal intermediary	T2025
Goods and services	T5999
Home delivered meals	S5170, T2025
MI Choice Nursing services	T1002, T1003
Personal emergency response systems (PERS)	S5160, S5161,
Private duty nursing/respiratory care	G0237, G0238, G0239, T1000
Residential Services	T2032, T2033
Respite services	H0045, S5150, S5151
Specialized medical equipment and supplies	A4931, A4932, A9300, B4100, B4150, E0160, E0161, E0210, E0215, E0242, E0315, E0627, E0629, E1639, S5162, S5199, T1999, T2028, T2029, T4537, T4540,
Support Brokerage	T2041
Support Coordination	T2022
Training in a variety of independent living skills	S5110, S5115
Vehicle Modification	T2039

Federal law and the MI Choice contract with MDHHS require MI Choice waiver agencies to send authorization decisions to enrollees within the following time frames:

Before January 1, 2026:

- Standard authorization decisions to be made no more than **10** calendar days from the day the waiver agency receives the request for a service.
- Standard authorizations may be extended up to an additional 14 calendar days, if:
    - Enrollee or provider requests an extension; or
    - Waiver agency justifies (to MDHHS upon request) the need for more information and how the extension is in the individual's interest
- Fast/urgent authorization decisions
    - May be requested when a standard authorization decision time frame could be bad for the individual's life, health, or ability to achieve, keep, or regain maximum function as indicated by a provider or the waiver agency
    - Must be made no later than 72 hours after the waiver agency receives the request for services.
    - May be extended up to 14 calendar days if participant requests an extension, or if the waiver agency thinks there is a need for the extension if it is in the individual's interest.

Beginning January 1, 2026 and after:

- Standard authorization decisions to be made no more than **7** calendar days from the day the waiver agency receives the request for a service.
- Standard authorizations may be extended up to an additional 14 calendar days, if:
    - Enrollee or provider requests an extension; or
    - Waiver agency justifies (to MDHHS upon request) the need for more information and how the extension is in the individual's interest
- Fast/urgent authorization decisions
    - May be requested when a standard authorization decision time frame could be bad for the individual's life, health, or ability to achieve, keep, or regain maximum function as indicated by a provider or the waiver agency
    - Must be made no later than 72 hours after the waiver agency receives the request for services.
    - May be extended up to 14 calendar days if participant requests an extension, or if the waiver agency thinks there is a need for the extension if it is in the individual's interest.

Standard Prior Authorization Decisions

(Aggregated for all items and services)

	How many times this happened	Total Requests	Percentage
Request approved	**1511**	**1530**	**99%**
Request denied	**17**	**1530**	**0.01%**

	How many times this happened	Total Requests	Percentage
Request approved **only after** time for review was extended	**0**	**0**	**0**

	How many times this happened	Total Requests	Percentage
Request approved **only after** appeal	**2**	**1530**	**0.001%**

Expedited (fast/urgent) Prior Authorization Decisions

(Aggregated for all items and services)

	How many times this happened	Total Requests	Percentage
Request approved	**0**	**0**	**0**
Request denied	**0**	**0**	**0**

	How many times this happened	Total Requests	Percentage
Request approved **only after** time for review was extended	**0**	**0**	**0**

Time Between Receiving Prior Authorization Requests and Sending Decisions

(Aggregated for all items and services)

	Mean (Average) Time (number of days)	Median (Middle) Time (number of days)
Standard Prior Authorization response within 10 days (before January 1, 2026)	**13.83**	**2**
Standard Prior Authorization response within 7 days (starting January 1, 2026 and after)	**13.83**	**2**
Expedited (fast/urgent) Prior Authorization Decision	**0**	**0**
Standard Authorization Decision Extensions	**0**	**0**
Expedited (fast/urgent) Authorization Decision Extensions	**0**	**0**