Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Adult Day Health Bulletin 35
April 2023

TO: Adult Day Health Providers Participating in MassHealth

FROM: Mike Levine, Assistant Secretary for MassHealth

RE: **Aging Services Access Point (ASAP) Clinical Assessment Process and Documentation Requirements for Initial Prior Authorization Requests for Adult Day Health Services**

Background

This bulletin provides guidance about the prior-authorization (PA) process for Adult Day Health (ADH) services described in 130 CMR 404.406: *Clinical Assessment and Prior Authorization*. This bulletin provides guidance on requirements for assessing clinical eligibility for MassHealth coverage of ADH services. Assessments are performed by Aging Services Access Points (ASAPs) and are required for initial PA for ADH services.

PA Requirement

Under 130 CMR 404.406 (B)(5), ADH providers seeking PA for ADH services to MassHealth members must submit PA requests

> *in the form and format as required by MassHealth. The ADH provider must include all required information, including, but not limited to, documentation of the completed clinical assessment conducted by the MassHealth agency or its designee; other nursing, medical or psychosocial evaluations or assessments; and any other documentation that the MassHealth agency or its designee requests in order to complete its review and determination of prior authorization.*

Additionally, under 130 CMR 404.406(B)(6), MassHealth may require additional assessments when making a PA decision. This may include a completed Minimum Data Set for Home Care (MDS-HC) or other assessment as designated by MassHealth.

Process for Requesting ASAP Clinical Assessment *for Initial PA Requests*

To comply with the requirements of 130 CMR 404.406(B)(5) and (6), the ADH provider must complete and submit the following MassHealth referral forms to the member's local ASAP.

- A **Request for Services** form that has been completed and signed by the ADH provider's registered nurse (RN). This form is available on the LTSS Provider Portal under ADH Prior Authorization.

- An **Adult Day Health Primary Care Provider (PCP) Order Form** that has been completed and signed by the member's PCP. This form is also available on the LTSS Provider Portal under ADH Prior Authorization.

Once an ADH provider has submitted completed versions of these forms to the member's local ASAP, the ASAP will complete an assessment of the member within five days. Note that only completed forms, signed and dated within 90 days of submission, will initiate an ASAP assessment.

Within 48 hours of completing a member assessment, the ASAP will issue a MassHealth Payment of Adult Day Health Services eligibility form to the member and the ADH provider. This form indicates the ASAP's assessment of the member's clinical eligibility for MassHealth coverage of ADH services.

When submitting initial PA requests on the MassHealth LTSS Provider Portal at www.masshealthltss.com, the ADH provider must upload the MassHealth Payment of Adult Day Health Service's eligibility form, along with the MassHealth ADH PCP Order Form. **The process of obtaining the ASAP Clinical Assessment and submitting the eligibility form is needed only for initial PA requests.**

For additional guidance on PA for ADH services, refer to the Guidelines for Medical Necessity Determination for Adult Day Health and the ADH PA Provider Portal Training Guide. All materials, including all required PA forms and documentation, can be accessed through the LTSS Provider Portal at www.masshealthltss.com.

MassHealth Website

This bulletin is available on the MassHealth Provider Bulletins web page.

Sign up to receive email alerts when MassHealth issues new bulletins and transmittal letters.

Questions

If you have any questions about the information in this bulletin, please contact the LTSS Provider Service Center.

Contact Information for MassHealth LTSS Provider Service Center

Phone: Toll-free (844) 368-5184
Email: support@masshealthltss.com
Portal: www.MassHealthLTSS.com
Mail: MassHealth LTSS
PO Box 159108
Boston, MA 02215
Fax: (888) 832-3006

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MASSHEALTH ADULT DAY HEALTH

Primary Care Provider (PCP) Order Form

This form must be completed in its entirety and signed by the member's primary care provider (PCP) to receive prior authorization (PA) for ADH services.

MassHealth Member and Provider Information	
Member's Name:	
MassHealth ID:	Date of Birth:
Member's Address:	
Member's Telephone Number:	
Adult Day Health Provider:	
ADH Address:	
ADH Telephone Number:	

Prescribing Provider (PCP): Please complete the following information, or indicate that this information and any supporting documentation are attached.

Diagnoses:

_____ _____

_____ _____

_____ _____

Medications: (Please include dosage and amount.)

_____ _____

_____ _____

_____ _____

Known Allergies:

_____ _____

_____ _____

_____ _____

Dietary Needs/Restrictions:

_____ _____

_____ _____

_____ _____

Member's Name: _____ MassHealth ID: _____

Treatments/Rehab Services/Assistance Required with ADLs:

_____ _____

_____ _____

_____ _____

PCP Visit History:

Date of Last Physical Exam: _____ Date of Last Office Visit: _____

Pertinent Findings of Physical Exam (includes vital signs and current weight, cognitive assessment/status, physical capabilities):

_____ _____

_____ _____

_____ _____

Current Rehabilitative Services:

_____ _____

_____ _____

_____ _____

Tuberculosis Screening Results (if warranted by ADH TB Risk Assessment): ☐ **Yes** ☐ **No**

Test Planted Date: _____ **Test Read Date:** _____ ☐ **Positive** ☐ **Negative**

PCP Information
MassHealth requires that services be ordered, referred, or prescribed (ORP). ACA Section 6401(b) requires that 1) the billing provider include the ORP provider's NPI on the claim; and 2) the ORP provider be actively enrolled with MassHealth as a fully participating provider or as a non-billing provider.
Prescribing Provider's Name:
Prescribing Provider's Address:
Prescribing Provider's Telephone:
Prescribing Provider's MassHealth Provider ID/Service Location:
Prescribing Provider's NPI:
Prescribing Provider Attestation
I certify that I am the prescribing provider and recommend this patient for Adult Day Health. I certify that the above on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein. _____ _____ **Prescribing Provider's Signature** **Date** **Credentials**: ☐ **MD** ☐ **PA** ☐ **NP** ☐ **DO** Attach additional narration or documentation as necessary.

Clear form **Print**