Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
All Provider Bulletin 189
May 2009

To: All Providers Participating in MassHealth

From: Tom Dehner, Medicaid Director TD

RE: **Prior Authorization (PA-1) Form**

Background

MassHealth encourages providers to submit requests for prior authorization (PA) online as part of its efforts to streamline business practices.

For those providers who continue to submit PA requests to MassHealth on paper, and as part of the preparation for NewMMIS implementation on May 26, 2009, the prior authorization (PA-1) form and instructions used to submit PA requests for certain services or equipment have been revised. The new form has been reorganized and reflects changes in terminology. It can now be completed online.

Please Note

- This bulletin applies to all providers, except dental providers who are not oral or maxillofacial surgeons. Dental providers who are not oral or maxillofacial surgeons should contact the MassHealth Dental Customer Service Center at 1-800-207-5019 if they have any questions about MassHealth.
- The rules for requesting prior authorization *have not changed*. Please refer to the administrative and billing regulations at 130 CMR 450.303 and the applicable MassHealth program regulations in Subchapter 4 of your provider manual to determine when PA is required.

Changes to the PA-1 Form

The following is a summary of changes made to fields on the PA-1 form.

- Provider ID is now Provider ID/Service Location or NPI.
- PA type is now called PA Assignment.
- Recipient ID is now called Member ID, and this is 12 characters long instead of 10.
- The free-text field used to explain why the service is necessary has been redesigned for ease of capturing information.

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Changes to the PA-1 Form

(cont.)

- GAN is now the Tracking Number, and this field has been included on the form.
- Fields for height and weight have been added.
- PA numbers generated by NewMMIS will be 10 characters long. The number begins with the letter P, which is preprinted on the form.
- The form is now fillable online. You can complete them on your computer, print, and then mail it. However, we encourage you to submit PA requests electronically using the Provider Online Service Center (POSC), instead of using the mail.
- P.O. boxes to different locations have been established for mailing paper PA requests, and have been listed on the form.
- Instructions for completing the form are provided on the back of the form.

Please Note

- With NewMMIS implementation, electronic PAs must be submitted through POSC instead of the Automated Prior Authorization System (APAS), which is being obsoleted.
- After NewMMIS implementation, if you need to adjust a PA that was originally created using APAS, you can locate the PA on NewMMIS using the member ID, or you may contact the PA Unit at 617- 451-7017 or 1-800-862-8341.

Using the New PA-1 Form

On May 18, 2009, providers may begin submitting PA requests through the POSC. PA requests that are needed between May 8 and May 18 must be requested on paper using the revised PA-1 form. This form will be available on the MassHealth Web site on May 11, 2009. A sample of the revised PA-1 form is attached.

Requesting a Supply of the PA-1 Form

The PA-1 form can be downloaded from the MassHealth Web site, at www.mass.gov/MassHealth. The form can also be accessed from the POSC. Request for paper copies of this form must be submitted in writing and faxed to 617-988-8973 or mailed to the following address.

MassHealth
ATTN: Forms distribution
P.O. Box 9118
Hingham, MA 02043

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

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Prior Authorization Request

MassHealth reviews requests for prior authorization on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Providers must complete items 1-21 or risk delays.

Reset Form

PROVIDER INFORMATION SECTION

MEMBER INFORMATION SECTION

1. Provider's Name, Address, and Tel. No.	4. Member's Name, Address, and Tel. No.	5. Place of Residence
		☐ Home ☐ Nursing facility ☐ Rehab. Hospital ☐ Other: _____
		6. Height: ft in / 7. Weight: lb oz
2. Provider ID/Service Location or NPI	8. Gender: ☐ M ☐ F / 9. Other Insurance: ☐ Yes ☐ No	10. Full Name of Insurance Carrier
3. PA Assignment	11. Date of Birth	12. Member ID

13. Explain why this service is medically necessary. Include the diagnosis, place of service, and a description of the proposed treatment. Attach supporting documentation if required by MassHealth regulations.

Primary Diagnosis: Secondary Diagnosis:

Diagnosis Code(s): Place of Service:

Description of Treatment:

SERVICES REQUESTED

MASSHEALTH USE ONLY (ITEMS 22-38)

	14. Servicing Provider ID/Service Location or NPI	15. Service Code (Use a separate line for each code.) Include modifier if code requires one.	16. No. of Units (Enter at least 1.)	23. Reviewer Decision	24. Revised Service Code (or Range)	25. No. of Units	26. Duration (Days)	27. Unit Fee	28. Denial Reason No.
A				☐ Approved ☐ Modified ☐ Denied					
B				☐ Approved ☐ Modified ☐ Denied					
C				☐ Approved ☐ Modified ☐ Denied					
D				☐ Approved ☐ Modified ☐ Denied					
E				☐ Approved ☐ Modified ☐ Denied					

17. Attachments	18. Date PA Requested	29. Receipt Date	30. Deferral Date	31. Date Info Received
☐ Yes ☐ No				
19. Requested Effective Date	**20. Requested End Date**	**32. Authorized Effective Date**	**33. Authorized End Date**	**34. Decision Date**

21. Provider Signature

I certify that I am the provider identified on this form. I certify that the information provided on this form and on any attachments, including medical necessity information (per 130 CMR 450.204) 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.

22. Comments for reason of denial, modification, or deferral (MASSHEALTH USE ONLY)

35. Consultant Initials	36. Consultant ID

37. Tracking Number

38. PA Number

P

Please see reverse side for instructions.

INSTRUCTIONS FOR COMPLETING THE PA-1 FORM (PLEASE PRINT OR TYPE.)

General Instructions

Complete Items 1 - 21 only. Enter all dates in mm/dd/yyyy format. Below are instructions for specific fields. All other fields are self-explanatory.

(A) Provider Information Section

Item 1	Provider's Name, Address, and Tel. No.	Enter the provider's name, address, and phone number (including area code).
Item 2	Provider ID/Loc or NPI	Enter the nine-digit requesting provider ID followed by the one-character location code. If not available, enter the requesting provider's 10-digit national provider identifier.
Item 3	PA Assignment	Select the type of PA you are requesting from the following list. **Basic Medical** Medical Pharmacy DMR PCA Services PCA Services Pediatric PCA Services PERS Physician-Adult Physician-Pediatric Private Duty Nursing Skilled Nursing Vision Other **Durable Medical Equipment** Absorbent Products DME – Other Enterals Hearing Services Mobility and Repairs Orthotics and Prosthetics Oxygen Standers **Therapy Services** Occupational Therapy Physical Therapy Speech/Language Therapy

(B) Member Information Section

Item 4	Member's Name, Address, and Tel. No.	Enter the member's name, address, and phone number (including area code).
Item 13	Explain why this service is medically necessary Diagnosis Code(s) Place of Service Description of Treatment	Enter a statement explaining why the proposed service is medically necessary. Include the primary diagnosis and secondary diagnosis if there is one. Also include a description of the proposed treatment and prognosis. Refer to your MassHealth provider manual for additional information about this field. Enter the ICD-9-CM diagnosis code(s) for the most relevant diagnoses for the procedure or item being requested. Enter the location of service. Enter a narrative of the proposed treatment.

(C) Services Requested Section

Item 14	Servicing Provider ID/Service Location or NPI	Enter the nine-digit servicing provider ID followed by the one-character service location code. Write "same" if same as requesting provider ID/Service Location. If not available, enter the provider's 10-digit national provider identifier.
Item 15	Service Code	Enter the appropriate CPT or HCPCS code for each service requested. Refer to Subchapter 6 of the applicable MassHealth provider manual to determine payable service codes. You must include a modifier if the service code requires one.
Item 16	No. of Units	Enter the number of times the service for which you are requesting prior authorization will be furnished. At least "1" must be entered.

(D) Attachments and Signature

Item 17	Attachments	Select the "Yes" box if additional information or supporting documentation is attached (refer to your provider manual); otherwise select the "No" box. Be certain that the attached documentation clearly supports the medical necessity for the services and/or equipment you are requesting (for example, X rays, admission notes, photographs, or explicit details).
Item 21	Provider Signature	**The form must be signed by the provider or the individual designated by the provider to certify that the information entered on the form is correct.** Signatures other than handwritten (that is, typewritten, or those by stamp or data processing equipment) are acceptable.

(E) MassHealth Use Only

Items 22 – 38	**Leave these items blank.**	MassHealth completes Items 22 – 38 when it reviews the request for prior authorization. Leave these fields blank.

See Subchapter 5 of your MassHealth provider manual for additional instructions for requesting prior authorization.

INSTRUCTIONS FOR MAILING REQUESTS FOR PRIOR AUTHORIZATION

Mail the Prior Authorization Request form, together with all necessary attachments, to:

MassHealth
ATTN: Customer Service Team
For Boston Region, use: P.O. Box 9154
For CCM, use: P.O. Box 9152
For Western Region, use: P.O. Box 9153
Hingham, MA 02043