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 190
May 2009

To: All Providers Participating in MassHealth

From: Tom Dehner, Medicaid Director TD

RE: **Preadmission Screening (PAS-A and PAS-CR) Forms**

Background

MassHealth encourages providers to submit preadmission screening (PAS) requests online as part of its efforts to streamline business practices.

As part of the preparation for NewMMIS implementation on May 26, 2009, the acute and chronic/rehab preadmission screening (PAS) forms and instructions used to submit requests for elective admissions to acute hospitals, all admissions to rehabilitation units in acute hospitals, and all admissions to chronic disease and rehabilitation hospitals have been revised. The new forms have been reorganized and reflect changes in terminology. They 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 preadmission screening *have not changed*. For acute hospital elective admissions please refer to the administrative and billing regulations at 130 CMR 450.208. For chronic disease and rehabilitation hospital admissions, concurrent screenings, and conversion reviews, and for rehabilitation units in acute hospitals, refer to 130 CMR 435.408 through 410 in the *Chronic Disease and Rehabilitation Inpatient Hospital Manual*.

Changes to the PAS Forms

The following is a summary of the changes made to the forms.

- Although longer, the forms have been simplified for ease of use.

(continued on next page)

Changes to the PAS Forms

(cont.)

- Depending on your request, only certain pages need to be completed. There are separate sections for new admission, concurrent screening, conversion review, and rereview requests.
- There are now separate sections for requesting provider, admitting facility, and attending physician.
- Recipient ID is now called Member ID, and is 12 characters long instead of 10.
- Provider ID is now Provider ID/Service Location or NPI.
- Admission type is now called Assignment.
- The forms are now fillable online. You can complete them on your computer, print, and then fax or mail them. However, we encourage you to submit your PAS requests electronically using the Provider Online Service Center (POSC), instead of using the telephone, fax, or mail.

Using the New PAS Forms

You can start using the revised PAS forms *immediately*. Samples of the PAS forms are attached.

Using the Old PAS Forms

You can submit your PAS requests using the old PAS forms until close of business Friday, May 15, 2009.

Requesting a Supply of PAS Forms

The PAS forms can be downloaded from the MassHealth Web site at www.mass.gov/masshealth. These forms 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.

MassHealth/Masspro
Telephone: **1-800-732-7337**
Fax: **1-800-752-6334**

Acute

Preadmission Screening for Elective Admissions

Requested Screening:

- ☐ **Admission** — Submit pgs. 1, 2, & 6.
- ☐ **Concurrent/Rehab** — Submit pgs. 3 & 6.
- ☐ **Conversion/Rehab** — Submit pgs. 1, 4, & 6.
- ☐ **Rereview** — Submit pg. 5.

Member (Patient) Information

Member ID:	Member name:
DOB:	Gender: ☐ M ☐ F
Address:	
Guardian:	
Guardian address:	

Requesting Provider Information

Provider ID/Service Location:	or NPI:
Specialty:	
Address:	
Contact name:	
Tel. no.:	Fax:
Name of physician contact for peer-to-peer discussion:	
Tel. no.:	Availability:

Admitting Facility Information

Provider ID/Service Location:	or NPI:
Name:	
Tel. no.:	Fax:
Address:	

Attending Physician Information (at the admitting facility)

Provider ID/Service Location:	or NPI:
Specialty:	
Attention (contact person for the attending):	
Name:	Tel. no.:
Address:	

Admission Screening

(Be sure to complete pages 1, 2, and 6.)

Assignment (Admission type): ☐ Acute ☐ Acute rehab

Requested admission date: _____ Requested length of stay: _____

Accident? ☐ Yes ☐ No Date of accident: _____

Type of accident: ☐ MV-Driver ☐ MV-Passenger ☐ MV-Pedestrian ☐ Work ☐ Fall

☐ Other: _____

Out of state? ☐ Yes ☐ No If yes, reason: _____

Late submission? ☐ Yes ☐ No If yes, reason: _____

Hospital patient account number (if available): _____

	Diagnosis Code	Diagnosis Description
Primary Diagnosis		
Diagnosis 2		
Diagnosis 3		
Diagnosis 4		
Diagnosis 5		

	Service Code	Service Description	Service Date
Primary Service Code			
Service Code 2			
Service Code 3			
Service Code 4			
Service Code 5			

Please describe any clinical indications for admission and/or procedures (e.g., signs, symptoms, or test results) that may assist us in our review:

For REHAB, please include the following information:

Current medical status: _____

Plan of care/goals: _____

PT and OT (Please complete page 6 and submit with this form.): _____

_____

Cognition/SLP: _____

Discharge plan: _____

Concurrent Screening (FOR REHAB ONLY)

(Be sure to complete pages 3 and 6.)

Current PAS#: _____

Hospital name: _____

Member name: _____

Requested level of care (LOC): ☐ Acute w/rehab administrative days (AD)
☐ Acute w/rehab hospital level of care (HLOC)

Requested from date: _____ Requested additional length of stay (LOS): _____

Late request? ☐ Yes ☐ No If yes, reason: _____

Physician contact for peer-to-peer discussion:

Name: _____ Tel. no.: _____

Availability: _____

Clinical Information

Discharge plan: _____

Barriers to discharge: _____

Weekly team meeting results: _____

Estimated discharge date: _____

Assistance with discharge planning requested from MassHealth: _____

_____

Please describe any additional clinical indications (e.g., signs, symptoms, or test results) and/or procedures (treatments, wound measurements and descriptions, etc.) for extending the stay that may assist us in our review:

Please include information on the continued plan of care/goals for the following:

PT and OT (Please complete page 6 and submit with this form.): _____

_____

Cognition/SLP: _____

Conversion Review (FOR REHAB ONLY)

(Be sure to complete pages 1, 4, and 6)

Reason for conversion: _____

Admission date: _____ Date of conversion: _____ Requested length of stay (LOS): _____

Assignment/Requested level of care (LOC): ☐ Acute w/Rehab administrative days (AD)

☐ Acute w/Rehab hospital level of care (HLOC)

Accident? ☐ Yes ☐ No Date of accident: _____

Type of accident: ☐ MV-Driver ☐ MV-Passenger ☐ MV-Pedestrian ☐ Work ☐ Fall

☐ Other: _____

Out of state? ☐ Yes ☐ No If yes, reason: _____

Late submission? ☐ Yes ☐ No If yes, reason: _____

Hospital patient account number (if available): _____

	Diagnosis Code	Diagnosis Description
Primary Diagnosis		
Diagnosis 2		
Diagnosis 3		
Diagnosis 4		
Diagnosis 5		

	Service Code	Service Description	Service Date
Primary Service Code			
Service Code 2			
Service Code 3			
Service Code 4			
Service Code 5			

Clinical Information

Please describe any clinical indications for admission and/or procedures (e.g., signs, symptoms, or test results) that may assist us in our review. Include past medical history and plan of care:

Please include the following information:

PT and OT (Please complete page 6 and submit with this form.): _____

_____

Cognition/SLP: _____

Goals: _____

Discharge plan: _____

Rereview

Current PAS#: _____

Hospital name: _____

Member name: _____

Requested level of care: ☐ Acute admit ☐ Rehab admit ☐ Extension of rehab admit

Requested from date: _____

Requested additional length of stay (LOS): _____

Late request? ☐ Yes ☐ No If yes, reason: _____

Please identify and address all decisions in the Admission Determination Notice with which you disagree, and submit all additional information and documentation to support the medical necessity of the admission.

To facilitate physician-to-physician conversation:

I certify that I am the Requesting Provider/Attending Physician/Authorized Representative of the Admitting Facility (circle one) 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.

Name of physician the Masspro physician should contact: _____

Tel no.: _____

Availability: _____

PT and OT Information

Physical Therapy

	Current Status	Treatment Plan (also specify hours per day)	Goals
Assistive devices: (e.g., cane/crutches/walker/ rolling walker/wheelchair)			
Bed mobility			
Sitting/standing balance			
Transfers: • Bed to chair • Bathroom			
Ambulation–Distance			

Occupational Therapy

	Current Status	Treatment Plan (also specify hours per day)	Goals
Cognitive skills			
Activities of daily living			
Fine motor skills			
Gross motor skills			
Sensory processing			
Social skills			

Please include any additional information in the space below:

I certify that I am the Requesting Provider/Attending Physician/Authorized Representative of the Admitting Facility (circle one) 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.

MassHealth/Masspro
Telephone: **1-800-554-5127**
Fax: **1-800-752-6334**

Chronic/Rehab
Preadmission Screening

Requested Screening:

☐ **Admission** Submit pgs. 1, 2, & 6.
☐ **Concurrent** Submit pgs. 3 & 6.
☐ **Conversion** Submit pgs. 1, 4, & 6.
☐ **Rereview (Reconsideration)** Submit pg. 5.

Member (Patient) Information

Member ID:	Member name:
DOB:	Gender: ☐ M ☐ F
Address:	
Guardian:	
Guardian address:	

Requesting Provider Information

Provider ID/Service Location:	or NPI:
Specialty:	
Address:	
Contact name:	
Tel. no.:	Fax:
Name of physician contact for peer-to-peer discussion:	
Tel. no.:	Availability:

Admitting Facility Information

Provider ID/Service Location:	or NPI:
Name:	
Tel. no.:	Fax:
Address:	

Attending Physician Information (at the admitting facility)

Provider ID/Service Location:	or NPI:
Specialty:	
Attention (contact person for the attending):	
Name:	Tel. no.:
Address:	

Admission Screening

(Be sure to complete pages 1, 2, and 6.)

Assignment (admission type): ☐ Chronic ☐ Rehab

Requested admission date: _____ Requested length of stay (LOS): _____

Accident? ☐ Yes ☐ No Date of accident: _____

Type of accident: ☐ MV-Driver ☐ MV-Passenger ☐ MV-Pedestrian ☐ Work ☐ Fall

☐ Other: _____

Out of state? ☐ Yes ☐ No If yes, reason: _____

Late submission? ☐ Yes ☐ No If yes, reason: _____

Hospital patient account number (if available): _____

	Diagnosis Code	Diagnosis Description
Primary Diagnosis		
Diagnosis 2		
Diagnosis 3		
Diagnosis 4		
Diagnosis 5		

	Service Code	Service Description	Service Date
Primary Service Code			
Service Code 2			
Service Code 3			
Service Code 4			
Service Code 5			

Clinical Information

Ventilator dependent? ☐ Yes ☐ No TBI? ☐ Yes ☐ No Tracheotomy? ☐ Yes ☐ No

Please describe any clinical indications for admission and/or procedures (e.g., signs, symptoms, or test results) that may assist us in our review. Include past medical history and treatment/course of care at the acute facility:

For REHAB, please include the following information:

Current medical status: _____

Plan of care/goals: _____

PT and OT (Please complete page 6 and submit with this form.): _____

_____

Cognition/SLP: _____

Discharge plan: _____

Concurrent Screening

(Be sure to complete pages 3 and 6.)

Current PAS#: _____

Hospital name: _____

Member name: _____

Requested level of care (LOC): ☐ Chronic hospital level of care (HLOC) ☐ Rehab hospital level of care (HLOC)
☐ Chronic/Rehab administrative days (AD)

Requested from date: _____ Requested additional lengh of stay (LOS): _____

Late request? ☐ Yes ☐ No If yes, reason: _____

Physician contact for peer-to-peer discussion:

Name: _____ Tel. no.: _____

Availability: _____

Clinical Information

Ventilator dependent? ☐ Yes ☐ No TBI? ☐ Yes ☐ No Tracheotomy? ☐ Yes ☐ No

Discharge plan: _____

Barriers to discharge: _____

Weekly team meeting results: _____

Estimated discharge date: _____

Assistance with discharge planning requested from MassHealth: _____

_____

Please describe any additional clinical indications (e.g., signs, symptoms, or test results) and/or procedures (treatments, wound measurements and descriptions, etc.) for extending the stay that may assist us in our review:

For REHAB, please include information on the continued plan of care/goals for the following:

PT and OT (Please complete page 6 and submit with this form.): _____

_____

Cognition/SLP: _____

Goals: _____

Conversion Review

(Be sure to complete pages 1, 4, and 6.)

Reason for conversion: _____

Admission date: _____ Date of conversion: _____ Requested length of stay (LOS): _____

Assignment/Requested level of care (LOC): ☐ Chronic hospital level of care (HLOC)

☐ Rehab hospital level of care (HLOC) ☐ Chronic/Rehab administrative days (AD)

Accident? ☐ Yes ☐ No Date of accident: _____

Type of accident: ☐ MV-Driver ☐ MV-Passenger ☐ MV-Pedestrian ☐ Work ☐ Fall

☐ Other: _____

Out of state? ☐ Yes ☐ No If yes, reason: _____

Late submission? ☐ Yes ☐ No If yes, reason: _____

Hospital patient account number (if available): _____

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Primary Diagnosis		
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Diagnosis 5		

	Service Code	Service Description	Service Date
Primary Service Code			
Service Code 2			
Service Code 3			
Service Code 4			
Service Code 5			

Clinical Information

Ventilator dependent? ☐ Yes ☐ No TBI? ☐ Yes ☐ No Tracheotomy? ☐ Yes ☐ No

Please describe any clinical indications for admission and/or procedures (e.g., signs, symptoms, or test results) that may assist us in our review. Include past medical history and plan of care:

For REHAB, please include the following information:

PT and OT (Please complete page 6 and submit with this form.): _____

_____

Cognition/SLP: _____

Goals: _____

Discharge plan: _____

Current PAS#: _____

Hospital name: _____

Member name: _____

Requested level of care: ☐ Chronic ☐ Rehab ☐ Administrative days (AD)

Requested from date: _____

Requested additional length of stay (LOS): _____

Late request? ☐ Yes ☐ No If yes, reason: _____

Please identify and address all decisions in the Admission Determination Notice with which you disagree, and submit all additional information and documentation to support the medical necessity of the admission.

To facilitate physician-to-physician conversation:

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Name of physician the Masspro physician should contact: _____

Tel no.: _____

Availability: _____

PT and OT Information

Physical Therapy

	Current Status	Treatment Plan (also specify hours per day)	Goals
Assistive devices: (e.g., cane/crutches/walker/ rolling walker/wheelchair)			
Bed mobility			
Sitting/standing balance			
Transfers: • Bed to chair • Bathroom			
Ambulation–Distance			

Occupational Therapy

	Current Status	Treatment Plan (also specify hours per day)	Goals
Cognitive skills			
Activities of daily living			
Fine motor skills			
Gross motor skills			
Sensory processing			
Social skills			

Please include any additional information in the space below:

I certify that I am the Requesting Provider/Attending Physician/Authorized Representative of the Admitting Facility (circle one) 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.