MassHealth PCA Prior Authorization

PCA Evaluation Time-for-Task Tool

Clear

Section 1: General Information

Evaluation Information:

Evaluation Type:	☐ Initial Evaluation ☐ Reevaluation
Site of Evaluation:	☐ Home ☐ Nursing Facility (specify): _____ ☐ Hospital (specify): _____ ☐ Other (specify): _____
Site of Evaluation Address:	
Date of Evaluation:	

Requesting Provider Information:

Requesting Provider ID/SL:	
Requesting Provider Name:	

Consumer Information:

Consumer Name:		Consumer DOB:	
Consumer MassHealth ID Number:		Consumer Telephone:	
Consumer Address:			

Has the Consumer had a change in their demographic information? ☐ Yes ☐ No

If Yes, please instruct the consumer to update their information through the **Massachusetts Health Connector Online Portal** or by calling **1-800-841-2900 (TTY: 1-800-497-4648)**

Consumer Details:

List any Consumer Communication Difficulties:	
List of Medications (a list can also be attached and uploaded to the provider portal):	

Print Clear

Consumer Name: _____ Date Of Evaluation: _____

Diagnosis (Primary diagnosis affecting functional status and warranting PCA services):

Primary Diagnosis:	Date of Onset:
Weight (lbs.):	Height (inches):

Medical History

List consumer's medical history relevant to the chronic condition that prevents the consumer from performing his/her/their ADLs/IADLs, such as changes in the consumer's medical condition from previous year's evaluation, diagnosis, hospitalizations, and surgical procedures and further describes the consumer's functional abilities and limitations. Attach a separate sheet if necessary.

Medical History: _____

_____

_____

_____

_____

IMPORTANT DISCLAIMER – MUST READ:

Evaluators should consult 130 CMR 422.422(A) for a definition of the ADLs and IADLs described below and the Time-for-Tasks Guidelines for the MassHealth PCA Program.

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Consumer Name: _____ Date Of Evaluation: _____

Section 2: ADLs

If the consumer requires a different level of assist during the day/evening and night hours, please select the highest Level of Assist you need to request time for, and provide explanatory comments.

A. Mobility

☐ ADL requires a flexible schedule?

Mobility Activities

Level of Assist (select one): ☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A

☐ Independent, no device

☐ Independent, with device:
☐ Cane ☐ Walker ☐ Wheel Chair ☐ Other

	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ 1 person physical assist with mobility							
☐ 1 person physical assist with stairs							

☐ Nonambulatory / Bedbound

Mobility Transfers
**excludes bathing and toileting transfers*

Level of Assist (select one): ☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A

☐ Independent, no device

☐ Independent, with device:
☐ Slideboard ☐ Trapeze ☐ Grab bar ☐ Other _____

	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ 1 person physical assist with transfers							
☐ 2 person physical assist with transfer							
☐ Mechanical / manual lift							

Mobility Repositioning

Level of Assist (select one): ☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A

	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ Physical assist with repositioning							

MOBILITY TOTAL CALCULATIONS

	Day/Evening Total Mins/Wk (6AM-Midnight)		**Night Total Mins** (Midnight - 6AM)

Comments:

Print Clear

Consumer Name: _____ Date Of Evaluation:_____

B. Passive Range of Motion (PROM)

☐ ADL requires a flexible schedule?

PROM		Day/Evening				Night		
		Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
	☐ Upper Extremities Left							
	☐ Upper Extremities Right							
	☐ Lower Extremities Left							
	☐ Lower Extremities Right							

PROM TOTAL CALCULATIONS				
	Day/Evening Total Mins/Wk (6AM-Midnight)		**Night Total Mins** (Midnight - 6AM)	
Comments:				

Print Clear

Consumer Name: _____ Date Of Evaluation: _____

C. Bathing

☐ ADL requires a flexible schedule?

Bathing Activities **excludes washing hair/shampooing*

Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A						
	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ Physical assist required (select tasks below)							

☐ Physical assist with showering activity; *including routine transfers*

☐ Physical assist w/sponge/bed bath and drying, *including routine transfers*

☐ Physical assist w/tub bathing & drying, *including routine transfers*

Washing Hair

Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A						
	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ Physical assist with washing hair							

Bathing Special Transfer

	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ Special bathing transfer required (select special transfers below)							

☐ Requires 2 person assist with transfer

☐ Mechanical / manual lift

BATHING TOTAL CALCULATIONS

	Day/Evening Total Mins/Wk (6AM-Midnight)		**Night Total Mins** (Midnight - 6AM)	

Comments:

Print Clear

Consumer Name: _____ Date Of Evaluation:_____

D. Grooming

☐ ADL requires a flexible schedule?

Grooming Activities		Day/Evening				Night		
		Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
	Nail Care ☐ N/A ☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence							
	Oral Care ☐ N/A ☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence							
	Hair ☐ N/A ☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence							
	Shaving ☐ N/A ☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence							
	Other N/A ☐ ☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence							

GROOMING TOTAL CALCULATIONS				
	Day/Evening Total Mins/Wk (6AM-Midnight)		**Night Total Mins** (Midnight - 6AM)	
	Comments:			

Print Clear

Consumer Name: _____ Date Of Evaluation:_____

E. Dressing / Undressing

☐ ADL requires a flexible schedule?

Dressing Activities
**excludes incontinence management, which is under Toileting*

Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A						
☐ Independent, no device							
☐ Independent, with device							
	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ Physical assist required (select tasks below)							
☐ Physical assist upper extremity dressing							
☐ Physical assist lower extremity dressing							
☐ Physical assist with donning footwear							
☐ Physical assist with prosthetics and orthotics/braces							

Undressing Activities
**excludes incontinence management, which is under Toileting*

Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A						
☐ Independent, no device							
☐ Independent, with device							
	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ Physical assist required (select tasks below)							
☐ Physical assist upper extremity dressing							
☐ Physical assist lower extremity dressing							
☐ Physical assist with removing footwear							
☐ Physical assist with prosthetics and orthotics/braces							

DRESSING / UNDRESSING TOTAL CALCULATIONS

	Day/Evening Total Mins/Wk (6AM-Midnight)		**Night Total Mins** (Midnight - 6AM)	

Comments:

Print Clear

Consumer Name: _____ Date Of Evaluation:_____

F. Eating

☐ ADL requires a flexible schedule?

Eating Activities
**excludes supervision and monitoring*

Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ Tube feeding / Special Needs ☐ N/A						
☐ Independent, no device							
☐ Independent, with device							
	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ Physical assist required (select tasks below)							
☐ Physical assist with eating							
☐ Physical assist with drinking							
☐ Assist with utensils/adaptive devices intermittently (1-5) per times per meal							
☐ Enteral Tube feeding							

EATING ACTIVTIES TOTAL CALCULATIONS

	Day/Evening Total Mins/Wk (6AM-Midnight)		**Night Total Mins** (Midnight - 6AM)	
Comments:				

Print Clear

Consumer Name: _____ Date Of Evaluation: _____

G. Toileting

☐ ADL requires a flexible schedule?

Toileting (Bowel / Bladder Care) Activities

Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A						
☐ Independent, no device							
☐ Independent, with device							
	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ Physical assist required: **Bladder**							
☐ Physical assist required: **Bowel**							

- ☐ Physical assist with toilet hygiene
- ☐ Physical assist clothing with management
- ☐ Physical assist with changing absorbent product
- ☐ Physical assist with the use of urinal
- ☐ Physical assist with emptying foley / urostomy bag
- ☐ Physical assist with straight catheter
- ☐ Physical assist with emptying colostomy pouch
- ☐ Physical assist with changing colostomy / urostomy
- ☐ Physical assist with regular transfer
- ☐ Bowel regimen (digital stimulation)

Toileting Special Transfer

	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ Special toileting transfer required (select special transfers below)							

- ☐ Requires 2 person assist with transfer
- ☐ Mechanical / manual lift

TOILETING TOTAL CALCULATIONS

	Day/Evening Total Mins/Wk (6AM-Midnight)		**Night Total Mins** (Midnight - 6AM)	

Comments:

Print Clear

Consumer Name: _____ Date Of Evaluation: _____

H. Assistance with Medications

☐ ADL requires a flexible schedule?

Assistance with Medications

Level of Assist, avg. min/episode (select one)	☐ Independent ☐ Independent, with prefilled / pre-packaged medications ☐ Physical assist required ☐ N/A

	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ Physical assist with prefilling med box							
☐ Physical assist with medications (PO, PR, GTTS, Inhalers, topical)							
☐ Physical assist with Nebulizer treatment							
☐ Physical assist to administer meds via G-tube							
☐ Physical assist to administer subcutaneous injections							
☐ Glucometer check							

MEDICATION TOTAL CALCULATIONS

	Day/Evening Total Mins/Wk (6AM-Midnight)		**Night Total Mins** (Midnight - 6AM)	

Comments:

Print Clear

Consumer Name: _____ Date Of Evaluation: _____

I. Other Healthcare Needs

☐ ADL requires a flexible schedule?

Menses Care

Level of Assist	☐ Not applicable ☐ Assist required	
	Day/Evening	
	Mins/Month	**Total Mins/Wk** *(Divide Mins/Month by 4)*
☐ Menses care		

Other Healthcare Needs

	Day/Evening				Night		
	Mins/Ep	Eps/Day	Days/Wk	**Total Mins/Wk**	Mins/Ep	Eps/Ngt	**Total Mins/Ngt**
☐ Suctioning Oral Secretions							
☐ Ostomy Care *(different from bowel/bladder category)*							
☐ Tracheostomy Care							
☐ Oxygen							
☐ BiPap/Cpap							
☐ Vent							
☐ Cough Assist							
☐ Other (specify)							
☐ Other (specify)							
☐ Other (specify)							

OTHER HEALTHCARE NEEDS TOTAL CALCULATIONS

	Day/Evening Total Mins/Wk (6AM-Midnight)		**Night Total Mins** (Midnight - 6AM)	

Comments:

Print Clear

Consumer Name: _____ Date Of Evaluation:_____

Section 3: IADLs

Background Information

Legally Responsible Person	**1. Does a legally responsible person live with the member?** ☐ No ☐ Yes ☐ Yes, but there are special circumstances requiring IADL assistance from a PCA
	If yes, skip Section 3 and move on to Section 4, "Summary of Requested Hours". **Note**: *If "Yes, but there are special circumstances requiring IADL assistance from a PCA" was selected, fill-out Section 3 and provide explanatory comments.*

Living Arrangement	**2. Does the member live with one or more other people who receive PCA services?** ☐ No ☐ Yes **If yes, list the names of the other members below:**

Print Clear

Consumer Name: _____ Date Of Evaluation: _____

A. Meal Preparation

Home Delivered Meals

Does member receive home delivered meals?

☐ No
☐ Yes

If yes, select all that apply:

☐ Breakfast	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ Fri ☐ Sat
☐ Lunch	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ Fri ☐ Sat
Dinner	Sun Mon Tues Wed Thu ☐ Fri Sat

Meals Provided Outside Home

Does member attend programs or receive services that provide meals outside the home?

☐ No
☐ Yes

If yes, select all that apply:

☐ Breakfast	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ Fri ☐ Sat
☐ Lunch	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ Fri ☐ Sat
☐ Dinner	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ Fri ☐ Sat

Meal Preparation

	Day/Evening		
	Mins/Day	Days/Wk	**Total Mins/Wk**
Breakfast ☐ Independent ☐ Min ☐ Mod ☐ Max ☐ Total dependence ☐ N/A			
Lunch ☐ Independent ☐ Min ☐ Mod ☐ Max ☐ Total dependence ☐ N/A			
Dinner ☐ Independent ☐ Min ☐ Mod ☐ Max ☐ Total dependence ☐ N/A			
Snacks ☐ Independent ☐ Min ☐ Mod ☐ Max ☐ Total dependence ☐ N/A			

MEAL PREP TOTAL CALCULATIONS

Day/Evening Total Mins/Wk (6AM-Midnight)	

Comments:

Print Clear

Consumer Name: _____ Date Of Evaluation:_____

B. Laundry

Laundry Assistance		
	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A
		Day/Evening **Mins/Week**
	☐ Physical assist required (select tasks below)	
	☐ Physical assist with sorting laundry	
	☐ Physical assist with loading/unloading laundry machine	
	☐ Physical assist folding & putting away clothes	
	☐ Dependent for all laundry tasks- residential	
	☐ Dependent for all laundry tasks- out-of-home laundry	

LAUNDRY TOTAL CALCULATIONS		
	Day/Evening Total Mins/Wk (6AM-Midnight)	
	Comments:	

C. Housekeeping

Housekeeping Assistance		
	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A
		Day/Evening **Mins/Week**
	☐ Physical assist required	

HOUSEKEEPING TOTAL CALCULATIONS		
	Day/Evening Total Mins/Wk (6AM-Midnight)	
	Comments:	

Print Clear

Consumer Name: _____ Date Of Evaluation: _____

D. Shopping

Shopping Assistance	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A	
			Day/Evening **Mins/Week**
	☐ Physical assist required		

SHOPPING TOTAL CALCULATIONS	**Day/Evening Total Mins/Wk** (6AM-Midnight)	
	Comments:	

Print Clear

Consumer Name: _____ Date Of Evaluation:_____

E. Special Needs

Equipment Maintenance	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A	
			Day/Evening **Mins/Week**
	☐ Physical assist required (select tasks below)		
	☐ CPAP		
	☐ Gait Trainer		
	☐ Oxygen		
	☐ Stander		
	☐ Wheelchair		
	☐ Other _____		

Special Needs	Level of Assist, avg. min/episode (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A	
			Day/Evening **Mins/Week**
	☐ Assistance with required paperwork for PCA Program		
	☐ Other (explain in the comments sections)		

SPECIAL NEEDS TOTAL CALCULATIONS	**Day/Evening Total Mins/Wk** (6AM-Midnight)	
	Comments:	

Print Clear

Consumer Name: _____ Date Of Evaluation:_____

F. Medical Transportation

Does member have PT-1 services for medical transportation? ☐ Yes ☐ No ☐ N/A

If "No", explain why & what is being utilized in the comments section.

Are you requesting PCA time for Medical Transportation? ☐ Yes ☐ No ☐ N/A

If you are requesting PCA time for medical transportation, please fill out all Medical Provider, Specialty and appointment details below. Alternatively, you may attach a copy of the transportation documentation used by your particular PCM Agency.

Medical Provider(s) Appointment (list by name and specialty)	**Distance (total miles round trip)**	**Travel Time (mins)**	**Transfer Time In / Out of Home (mins)**	**Transfer Time In / Out of Office (mins)**	**Mins / Appt (Sum of travel & transfer time**	**# Appts / Year**	**Total Mins/Year**	**Total Mins/Wk *(Divide Mins/Year by 52)***

MED TRANSPORTATION TOTAL CALCULATIONS		
	Day/Evening Total Mins/Wk (6AM-Midnight)	
	Comments:	

Print Clear

Consumer Name: _____ Date Of Evaluation: _____

Section 4: Evaluator Signoffs

Requested PCA Activity Time

We confirm that the consumer meets the criteria of the MassHealth PCA Program and requires physical assistance for the following number of hours of PCA activity time.

Day/Evening PCA Requested Mins / Week	
Day/Evening PCA Hours Requested per Week (Divide Mins/Week by 60) (Round up to nearest 15-minute unit. For example, 23.3 = 23.5; 42.7 = 42.75)	
Night PCA Requested Mins / Night	
Night PCA Hours Requested per Night (Divide Mins/Night by 60) (Round up to the nearest hour – enter "2" if less than two hours)	
Nights per week (Specify how many nights per week the consumer will receive PCA services.	
Total Weekly Billable Night PCA Hours	

Consumer Ability to Independently Manage Program (check only one of the two boxes below)

I/we _____, on _____, have reviewed the assessment of the consumer's ability to independently manage the PCA program in accordance with 130 CMR 422.422(A) and have determined that:

☐ Based on our assessment, the consumer appears to have the necessary cognitive and emotional ability and skills to perform all of the tasks of managing PCA services and *does not require a surrogate*

☐ Based on our assessment, the consumer does not have the necessary cognitive or emotional ability and skills to perform some or all of the tasks of managing PCA services and *requires a surrogate* (fill in Surrogate information below)

Surrogate Name:			
Surrogate Relation to Consumer:			
Surrogate Address			
Surrogate Telephone		**Surrogate Email**	

Print Clear

Consumer Name: _____ Date Of Evaluation: _____

Signatures

I evaluated the consumer in person and reviewed this evaluation with the consumer/Legal Guardian:

_____ _____

Evaluator Signature Date

Evaluator Credentials:

☐ Registered Nurse (RN) ☐ Licensed Practical Nurse (LPN) ☐ Occupational Therapist (OT)

I was evaluated in person and I have reviewed this evaluation:

_____ _____

Consumer/Legal Guardian Signature Date

_____ _____

Surrogate Signature (if applicable) Date

Print Clear

Consumer Name: _____ Date Of Evaluation: _____

Section 5: Occupational Therapy Functional Status Report

Required for initial evaluations.

OT Evaluator's Name and Credentials: _____

1. Does the consumer's diagnosis manifest as a chronic disabling condition?

- ☐ No
- ☐ Yes

If yes, please select manifested condition(s) below:

- ☐ AROM deficits
- ☐ Spasticity
- ☐ Flaccidity
- ☐ Rigidity
- ☐ Muscle atrophy
- ☐ Pain
- ☐ Decreased strength
- ☐ Impaired sitting balance
- ☐ Impaired mobility / weight bearing
- ☐ Gross motor coordination deficits
- ☐ Fine motor coordination deficits
- ☐ Sensory loss:
  - ☐ Vision
  - ☐ Hearing
  - ☐ Other, describe: _____
- ☐ Cognition issues
- ☐ Behavior issues
- ☐ Endurance / stamina
- ☐ Other, describe: _____

2. Does the disability impact ADL/IADL performance due to any of the following?

- ☐ No
- ☐ Yes

If yes, please select impacted performance(s):

- ☐ Standing tolerance
- ☐ Balance
- ☐ Bending
- ☐ Grasping
- ☐ Sitting tolerance
- ☐ Coordination
- ☐ Reaching
- ☐ PROM
- ☐ Ability to reposition self
- ☐ AROM
- ☐ Squatting
- ☐ Other, describe: _____

3. What is the Level of Assist required to complete ADL and IADL? Check all that apply.

ADLs:	Ind	Min	Mod	Max	Dep
Mobility					
Bathing					
Toileting					
Grooming					
Dressing					
Eating					
PROM					
Meds					
Other health care needs					
Transfers:					
In/out of bed					
In/out of tub/shower					
On/off toilet					
Mechanical lift needed:	☐ No		☐ Yes		

IADLs:	Ind	Min	Mod	Max	Dep
Meal prep					
Housekeeping					
Laundry					
Shopping					
Equip. maintenance					

Other, describe:

4. Is the consumer able to manage stairs?

- ☐ No
- ☐ Yes

Print Clear

Consumer Name: _____ Date Of Evaluation: _____

5. Is the consumer capable of driving?

☐ No
☐ Yes

If yes, would a vehicle require modifications for the consumer to drive?

☐ No
☐ Yes, describe: _____

6. Does consumer require use of adaptive equipment / assistive devices to manage ADLs?

☐ No
☐ Yes

If yes, please describe below:

7. Would consumer benefit from adaptive equipment / assistive devices not currently in use?

☐ No
☐ Yes

If yes, please describe below:

8. If needed, please provide any additional comments or summary of findings below.

_____ _____
Occupational Therapist Evaluator Signature Date

_____ _____
Consumer/Legal Guardian Signature Date

_____ _____
Surrogate Signature (if applicable) Date

Print Clear