PERSONAL CARE ATTENDANT PROGRAM OPERATING STANDARDS

For use by Personal Care Management Agencies and the Prior Authorization Unit

Updated May 2026

Personal Care Attendant Program Operating Standards

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I. Purpose & Scope

The MassHealth Personal Care Attendant (PCA) Program Operating Standards are designed to provide specific action steps to be taken by the contracted Personal Care Management (PCM) Agencies and the Prior Authorization Unit (PAU) to ensure consistent and equitable enactment of existing MassHealth regulations and contractual requirements across the PCA program when submitting a Prior Authorization.

The MassHealth PCA Program Operating Standards are supplementary to the MassHealth Administrative and Billing regulations (130 CMR 450.000), the MassHealth PCA Program regulations (130 CMR 422.000) and the PCM Contract. All parties should, first, review and understand the above-mentioned regulations and contractual requirements to understand the procedures in this document.

II. Eligibility and Submitting a Prior Authorization

MassHealth covers PCA services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in 130 CMR 450.105: *Coverage Types* which specifically states, for each MassHealth coverage type, which services are covered, and which members are eligible to receive those services. MassHealth requires Prior Authorization (PA) as a prerequisite to payment for all PCA services.

Checking MassHealth Eligibility

a. PCM Agencies must verify a Consumer's MassHealth eligibility prior to providing PCM services and prior to submitting a PA. If a Consumer's MassHealth eligibility is not active at the time of PA submission or adjudication, the PA will be denied by the PAU.
b. MassHealth eligibility can change many times during a PA period and payment is subject to all general conditions of MassHealth, including the Consumer's current MassHealth eligibility status, service limitations, and program restrictions.
c. When checking eligibility, if the Consumer's eligibility shows enrollment in a Community Case Management (CCM), Senior Care Options (SCO), One Care, or Program for All Inclusive Care for the Elderly (PACE), the PA request will be denied as personal care services are available and authorized through SCO, CCM, OneCare, or PACE.
d. If a Consumer loses MassHealth eligibility or enrolls in SCO, ICO, CCM or PACE during an active Fee For Service (FFS) PA period, the PA does not need to be terminated, but the PCA services will not be reimbursable through the FFS PA.
e. If the PCM discovers an issue with MassHealth eligibility, the PCM must work with the Consumer to regain eligibility prior to submitting a PA. Once eligibility has been established, the PCM will submit the PA request. Upon receipt of a PA request, and active MassHealth eligibility confirmed, the PAU will adjudicate the PA based on medical necessity.

Submitting Prior Authorization

a. Once a PCM agency determines that a member is a candidate for the program, as outlined at 130 CMR 422.403, the PCM must proceed to submitting PA.
b. PCM Agencies must submit all PA requests in accordance with the PCM Agency Contract requirements and the PCA Regulations at 130 CMR 422.416. Please note that MassHealth reserves the right to impose sanctions in accordance with Section 5.20 A(10) of the PCM Agency Contract if a PCM Agency consistently fails to meet requisite timelines when submitting PAs.

c. All PCA PAs are submitted in the form and format required by MassHealth and are adjudicated by the Prior Authorization Unit (PAU).
d. PCM Agencies are required to maintain an active PA for all Consumers and must not let PAs expire. PCMs must complete the re-evaluation process and PA submission before the expiration of the original PA (See 130 CMR 422.416(C) for specific timing requirements). While MassHealth acknowledges that there are some cases where this is not possible, every effort must be made to ensure that there are no gaps or lapses in PA coverage. If a gap is unavoidable, the reasoning and plan of action should be submitted to MassHealth with the PA request for review and approval.

III. Initial and Re-Evaluation Prior Authorizations

Initial Prior Authorizations

a. The PCM is responsible for the submission of Initial PAs for FFS Consumers and most OneCare Consumers. SCOs and certain OneCare plans may perform their own Initial evaluations.
b. Initial PAs must be submitted within 45 calendar days from the date of receipt of the signed Primary Care Provider (PCP) Summary Form.
c. Nursing evaluations are required for all Initial PAs and must be completed in accordance with the requirements outlined in the PCM Contract, PCA Regulations, and any relevant Provider Bulletins. The initial evaluation must accurately represent the member's need for physical assistance with ADLs and IADLs, and must consider the member's physical and cognitive condition and resulting functional limitations to determine ability to benefit from PCA services. Please see *Helpful Resources and References*, to note which tasks (skilled tasks) may not be considered for PCA time.
d. Occupational Therapist (OT) assessment is required for all Initial PAs and must be completed in accordance with the requirements outlined in the PCM Contract, PCA Regulations, and any relevant Provider Bulletins.
e. A Consumer may only have one Initial PA per lifetime. Consumer's transferring PCMs or transitioning from one Coverage Type to another will require a Re-Evaluation.
f. The effective date for an Initial PA will be authorized on the date the MassHealth agency sends a notice of its decision to the member (See 130 CMR 450.303: (B) (3)).
g. PCA PA has one line-item, line item A, which includes all approved hours with one procedure code: T1019.
h. The PCM agency must include in its prior authorization request the documentation described in 130 CMR 422.416(A) and signatures in accordance with *All Provider Bulletin 385*.
i. Documentation required to be submitted with an Initial PA request :
    - The Time for Task Tool (in the form and format required by MassHealth)
    - PCP Summary Form
    - OT assessment and signature page
    - Nurse evaluation signature page
    - Consumer Assessment Form
    - Any additional documentation per standard documentation requirements. NOTE: It is the responsibility of the PCM agency to inquire with the Consumer regarding other services received to prevent duplication

j. If a Consumer requires complex care tasks, outlined in 130 CMR 422.414(A), the PA request must contain support for those tasks and be documented on the PCP Summary Form. See Section *Complex Care Prior Authorizations.*

Re-Evaluation Prior Authorizations

Re-evaluation is the clinical evaluation of a member's continuing need for PCA services to be provided to a member who requests a continuance of PCA services, because the current authorization is expiring. The PCM is responsible for the tracking of expiring PAs and submission of re-evaluation PA requests for FFS Consumers and most OneCare Consumers. SCOs and certain OneCare plans may perform their own Re-evaluations. PCM Agencies are responsible for submitting re-evaluations PA requests to MassHealth at least 21 days prior to the expiration date of the PA (130 CMR 422.416). If more PCA hours are requested for a PCA re-evaluation, documentation must be provided to support the need for the additional time requested

a. Re-evaluations must be conducted by a registered nurse, or a Licensed Practical Nurse (LPN) or an Occupational Therapist (OT) that is under the supervision of a registered nurse and must include a review of the service agreement and the assessment by qualified PCM agency staff.
b. Except as described in 130 CMR 422.422(D)(2) (Please see Section : *Authorizing PAs Greater Than 1 Year Duration*), re-evaluations must be conducted annually, or more frequently when a significant change in the member's physical condition or living situation has occurred. The re-evaluation must accurately represent the member's need for physical assistance with ADLs and IADLs, and must consider the member's physical and cognitive condition and resulting functional limitations to determine ability to benefit from PCA services. Please see *Helpful Resources and References* which notes tasks (skilled tasks) may not be considered for PCA time.
c. Re-evaluations must be submitted within 90 days of the completed evaluation date. If an Evaluation is submitted that is over 90 days, the PCM must review the evaluation with the Consumer to ensure no changes have occurred. If the Consumer identifies a change, a new evaluation is required. Evaluations submitted that are older than 180 days will result in a denial by the PAU.
d. If a Consumer requires complex care tasks, outlined in 130 CMR 422.414(A), the PA request must contain support for those tasks. (See *Complex Care Prior Authorizations*)
e. Documentation required to be submitted with a re-evaluation PA request:
    - The Time for Task Tool (in the form and format required by MassHealth)
    - PCP Summary Form or Electronic Medical Record clinical documentation that contains the following:
        1.) Chronic disabling condition(s) that require them to need PCA Services
        2.) Medications for chronic disabling condition(s) that require them to need PCA Services
        3.) At least 2 consumer identifiers (ex. Name, date of birth, MassHealth ID, etc.)
        4.) Date of most recent visit with PCP or specialist related to the chronic disabling condition (must be within the last 2 years)

*If the Consumer requires Complex Care tasks, a PCP Summary Form is required.

- The OT-Nurse Evaluation Signature Page
- Consumer Assessment Form
- Any additional documentation per standard documentation requirements. It is the responsibility of the PCM agency to inquire with the Consumer regarding other services received to prevent duplication

Note: The start date of a newly adjudicated PA will be the day after the end date of the old PA . ***Example:*** An existing Initial PA ends on 12/31/2026, the new, re-evaluation PA will begin on 01/01/2027.

Pediatric and Split Pediatric Initials and Re-evaluations

Pediatric PA Types are available for Consumers through the age of 22.

a. Standard Documentation requirements will follow the same as above for adult Initial and Re-eval PA types described in 130 CMR 422.416(A), signatures in accordance with All Provider Bulletin 385, 130 CMR 422.422(C)(2) through (4), and 130 CMR 450.303: (B) (3),
b. Split Pediatric PA types are utilized for both school and vacation weeks when a difference of hours in either week is medically necessary and will be authorized using one line-item A and one PA number. The external message will include the details regarding the authorized hours for school and vacations weeks.
a. Please see *Pediatric PCA Evaluation* for additional information regarding pediatric PA

Complex Care Prior Authorizations

On January 1, 2026, MassHealth began the PCA complex care payment differential (See PCA Bulletin 17). PCAs who work for MassHealth members approved for PCA complex care tasks may receive this complex care payment differential. These complex care tasks are reviewed and authorized by the PAU via the PA process. Eligibility for PCA complex care requires the following:

- Members must have a PCA evaluation in accordance with 130 CMR 422.422(C) and (D) and 130 CMR 422.416(A) and (B).
- In accordance with 130 CMR 422.422(C) and (D), MassHealth or its designee must have determined that the member requires physical assistance with digital rectal stimulation (DRS) or feedings via enteral tube (G & J), and these tasks must be reflected in the member's PCA evaluation.
- Members must have a completed PCP Summary Form showing the clinical need for assistance with these tasks and whether the tasks are appropriate for a PCA provider to perform. PCA complex care tasks cannot be approved when they are considered a skilled service under the following circumstances.
    - Enteral tube (G & J): MassHealth does not approve PCA time for this task, for either children or adults, when there is an aspiration risk
    - Digital Rectal Stimulation (DRS): MassHealth does not approve PCA time for this task for a pediatric consumer
    - If the PCP does not approve of these tasks to be performed by an unskilled worker, the PCM should not submit time on the PA.

- PCA PA has one line-item, line-item A, which includes all approved hours with one procedure code: T1019. Complex Care Prior Authorizations will also contain an approved modifier: TG.
- Please note that anticipatory time will not be approved for any task, inclusive of complex care tasks (for example, where a rectal suppository is the primary service and Digital Rectal Stimulation being a secondary/non-routine need)

To submit a PA with a complex care need, the PCM must:

a. Submit a PA request, either "Initial" or "Re-Eval" in the form and format required by MassHealth.
b. The PCM must select the appropriate complex care tasks on the TTT. Only having comments related to DRS or enteral feeds without the selection of the tasks on the TTT will not be sufficient.
c. The PCM must clearly document that the complex care tasks being requested are to be delegated to a PCA to perform.
d. Upload a signed copy of the PCP Summary Form with one or both complex care needs checked off in Section D. The form must also be signed by the primary care provider.

Once submitted, the PAU will:

a. Defer the PA if all documentation is not submitted or complete. If no additional documentation is submitted at the end of the deferral period and the PA does not demonstrate medical necessity for complex care, but otherwise qualifies for PCA Services, the PAU will adjudicate a standard PA, modifying down any time requested for complex care tasks. External text will be supplied noting the modification due to insufficient evidence submitted for medical necessity.
b. If the PCM is seeking a complex care PA but the PCM evaluator does not select a complex care box on the TTT, the PAU will void the PA.
c. Approve the PA request if all documentation is complete and submitted. A PA letter will be generated to the Consumer, PCM, and FI.

Prior Authorization for Meal Preparation Above 7 Hours per Week

Per MassHealth regulation 130 CMR 422.410(C)(3), a maximum of 7 hours per week (420 mins/week) may be authorized for meal preparation. Authorization of any time beyond 7 hours per week will require a demonstration of medical necessity to support the request. Consumers will need to have the following for the MassHealth PAU to approve greater than 7 hours a week for meal preparation:

1. Active diagnosis of dysphagia AND need for mechanically altered meals
2. Clinical documentation that supports this diagnosis and needs (PCP Summary Form or Speech Language Pathologist Order in the Electronic Medical Record)
    - Clinical documentation must align with timeline requirements for all evaluation/PA requests
    - Clinical documentation should describe functional swallowing limitations and identify any risk factors such as aspiration or choking.
    - Clinical documentation clearly distinguishes meals requiring preparation for oral intake from g-tube feeding tasks.

Meal preparation time applies only to food prepared for oral consumption. For Consumers who get nutrition via g-tube and by mouth, the clinical evaluator must clearly demonstrate in the evaluation the need for regular/scheduled meal prep needs for non-g-tube delivered meals.

G-tube feeding activities, including setup, administration, and cleanup, are considered complex care tasks and are not counted toward meal preparation time.

Duplicate or overlapping time for meal preparation and g-tube feeding tasks will not be authorized.

All clinical evaluators should provide thorough detail around the meals (type of food, necessary modifications, if meal is being prepared fresh or reheated, and number of meals per day) in the evaluation. This will prevent deferrals for clarification around medical necessity.

If a Consumer is eligible for time greater than 7 hours per week based on the above criteria, the PCM will need to request the additional time in the evaluation that aligns with the specific type of mechanical alteration:

1. Purée and Ground/Minced: 10 mins per meal/snack
2. Regular Cut/Chopped: 5 mins per meal/snack
3. Liquid Thickening: 10 mins per day

A Consumer may be authorized time for both purée/ground/minced and liquid thickening.

Adjustment Requests for Meal Prep:

To adjust the current PA to include time for meal preparation greater than 7 hours, the PCM must submit the following:

1. Signed adjustment form by PCM clinical staff
2. Clinical documentation that supports this diagnosis and the need for mechanically altered meals needs (PCP Summary Form or SLP Order in your Electronic Medical Record)

Pediatric PCA Evaluation

At the time of the initial evaluation, re-evaluation, or adjustment for Pediatric PCA services, a PCM Agency Nurse Evaluator is responsible for evaluating the disabling condition, functional ability of the child, and the medical necessity for PCA services (see definition of disability of children per *Office of Social Security*, 130 CMR 450.204, 130 CMR 422.402, 130 CMR 422.412). The PCM Agency Clinical Evaluator must use their assessment skills and clinical judgment and educate the parent or legal guardian regarding what services are appropriate to include in the PCA evaluation request. It is appropriate to request time for PCA services when a child has a chronic, permanent disabling condition resulting in **hands-on** ADL care needs and services due to functional limitations.

Schematics of Age Ranges at which Non-Disabled Children Master Functional Items(50% percentile) is the adopted pediatric developmental tool to assist the PCM Agency Clinical Evaluator and the PAU Clinical Reviewer in determining if the child's functional ability is within the age range for the mastery of functional skills for non-disabled children. The PCM Agency must reference the Schematics tool before

requesting pediatric PCA services to ensure that they are not requesting PCA Services for a task that a non-disabled child within their age range would be expected to complete (i.e. A one year old, regardless of ability will require assistance with toileting. Therefore, PCA Services for toileting should not be requested for a one year old). The PCM Agency must include documentation to support medical necessity in the PCA evaluation. The PAU Clinical Reviewer will review all supporting documentation for medical necessity on an individual basis. If medical necessity is established based on the PCA evaluation documentation, an approval or modification will be considered. If medical necessity is not established, a denial will be considered.

When a PCM Agency initiates a pediatric PCA evaluation request, the PCM Agency must consider the following as part of the evaluation and documentation process:

a. Parent(s), legal guardian(s) or designee(s) are responsible for providing oversight and care for children and directing the PCA services (see MassHealth Regulations 130 CMR 422.412 (A) and 130 CMR 422.412 (G) and 130 CMR 422.412 (J)).
b. The MassHealth Regulations address non-covered services (130 CMR 422.412(A) (C)) which include (A) social services, including, but not limited to, babysitting, respite care, vocational rehabilitation, sheltered workshop, educational services, recreational services, advocacy, and liaison services with other agencies, and (C) assistance provided in the form of cueing, prompting, supervision, guiding, or coaching;
c. A parent or "designee" (i.e. sibling, aunt, uncle, etc.) is required to be the second person when two people are required to perform a task (i.e. if a child has spastic tone due to cerebral palsy, a second person may be required for transfers). If a parent has a documented condition or circumstance that limits their ability or availability to safely provide assistance, MassHealth may authorize a second PCA for the purposes of providing the required two person assist, consistent with the documentation provided. Time may only be authorized under this subsection in circumstances where the child would be expected to be able to perform the task based upon on the developmental spectrum.
d. Special consideration may be given for MD transportation if a second person is required to assist with medical and/or behavioral needs. Documentation must be consistent and clear to support this request.
e. Special consideration may be given to behavioral needs that demonstrate a safety risk for the child or others (i.e. removing a child from a dangerous situation), but documentation must support the request. Please Note: PCA time is not allowed when requested for purposes of restraint.
f. Special consideration may be given for IADL's if the documentation supports the reason(s) the parent(s) or legal guardian(s) cannot perform the task(s) or if the task(s) is/are above and beyond what would be expected of a non-disabled child of the same age. Please refer to non - covered services and schematics age range. Where documentation regarding the parent or guardian's inability to perform a task is provided, the Clinical Evaluator shall document whether the information provided by the parent or guardian impacted the time authorized. The PAU may defer and deny any tasks if inadequate information has been received regarding the reason the parent or guardian is unable to participate in care. (Special considerations do not include time for babysitting due to a parent working, sleeping, being on vacation, etc.). Time may only be authorized under this subsection in circumstances where the child would be expected to be able to perform the task based upon on the developmental spectrum.

g. The PCM Agency Clinical Evaluator evaluates non-skilled care and assesses if the task can be safely performed for the child by the PCA. The following tasks are examples that may be considered non-skilled services and can be requested if assessed to be safely performed for the child by the PCA and directed by the parent or legal guardian or designee.
    - Gastrostomy tube (G-tube) feedings if the child does not have an aspiration risk.
    - G-tube site care (as part of bathing)
    - Oral Suctioning

h. The PCM Agency Clinical Evaluator must identify if skilled care services are required for the consumer. *Skilled care services are not appropriate services to be completed by a PCA and generally should not be requested.* Skilled care services are considered to be high risk and unsafe tasks to be performed by a PCA and therefore, should be performed by a skilled clinician, parent, legal guardian or designee. These services require individuals with training in specialized skills, clinical assessment, and judgment to promote safe and effective care for consumers whose conditions may be complex.

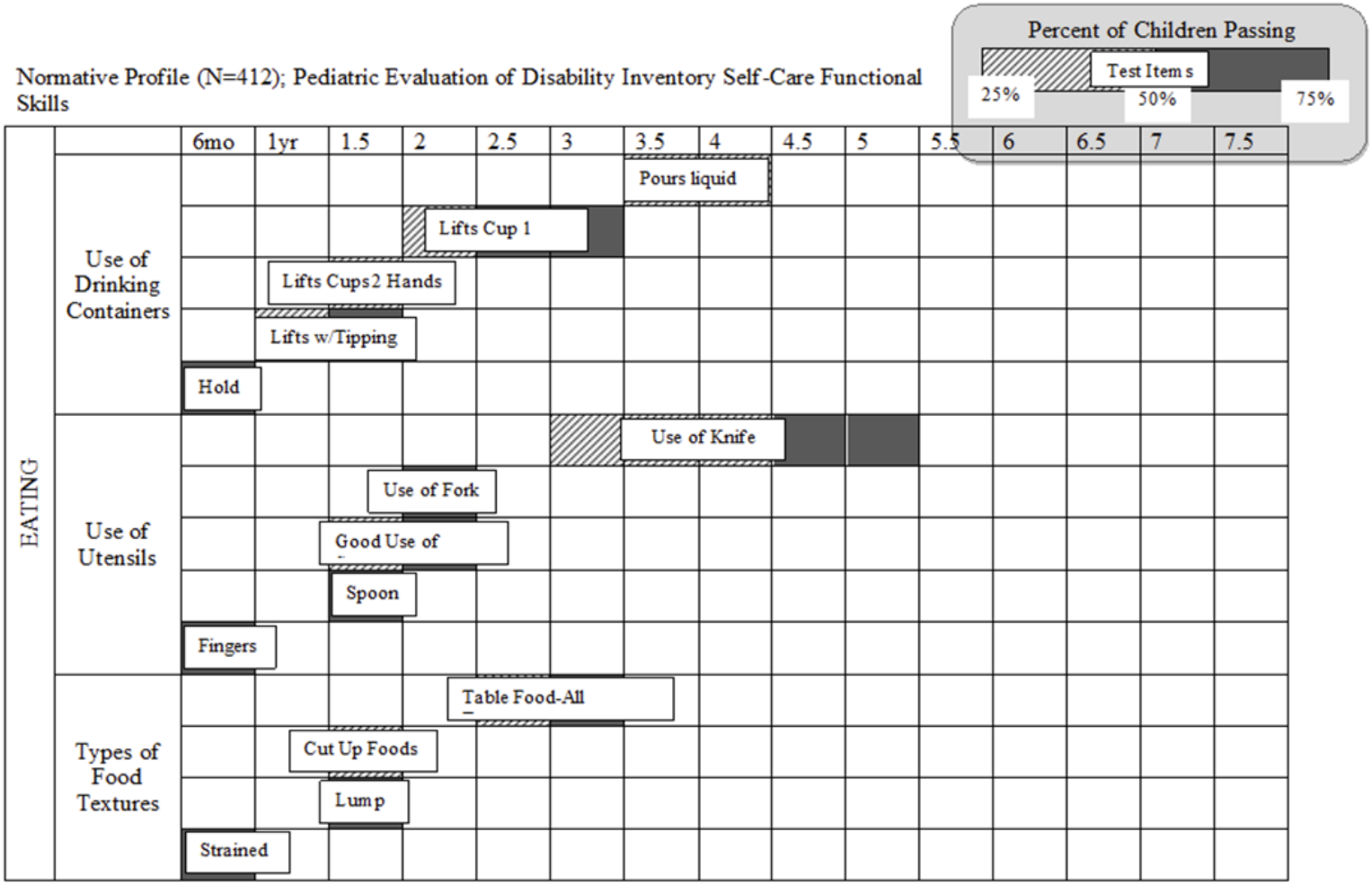
    The following tasks are examples of skilled care services that are generally performed by trained healthcare professionals and should not be requested for pediatric consumers:
    - Feeding a child with a high aspiration risk
    - Medication administration
    - Oxygen administration
    - Tracheal care and suctioning
    - Chest physical therapy (Chest PT)
    - Cough assist therapy
    - Chest vest therapy
    - Nebulizer treatments
    - Complex Wound Care
    - Catheterizations
    - Peripherally Inserted Central Catheter (PICC) line and central line dressing changes
    - Total Parenteral Nutrition (TPN)
    - Intravenous (IV) therapy and IV medication administration
    - Administration of peritoneal dialysis medication and fluids
    - Adjustment of ventilator settings and controls
    - Applied Behavior Analysis (ABA) Behavioral Therapy
    - Wilbarger Brushing Therapy

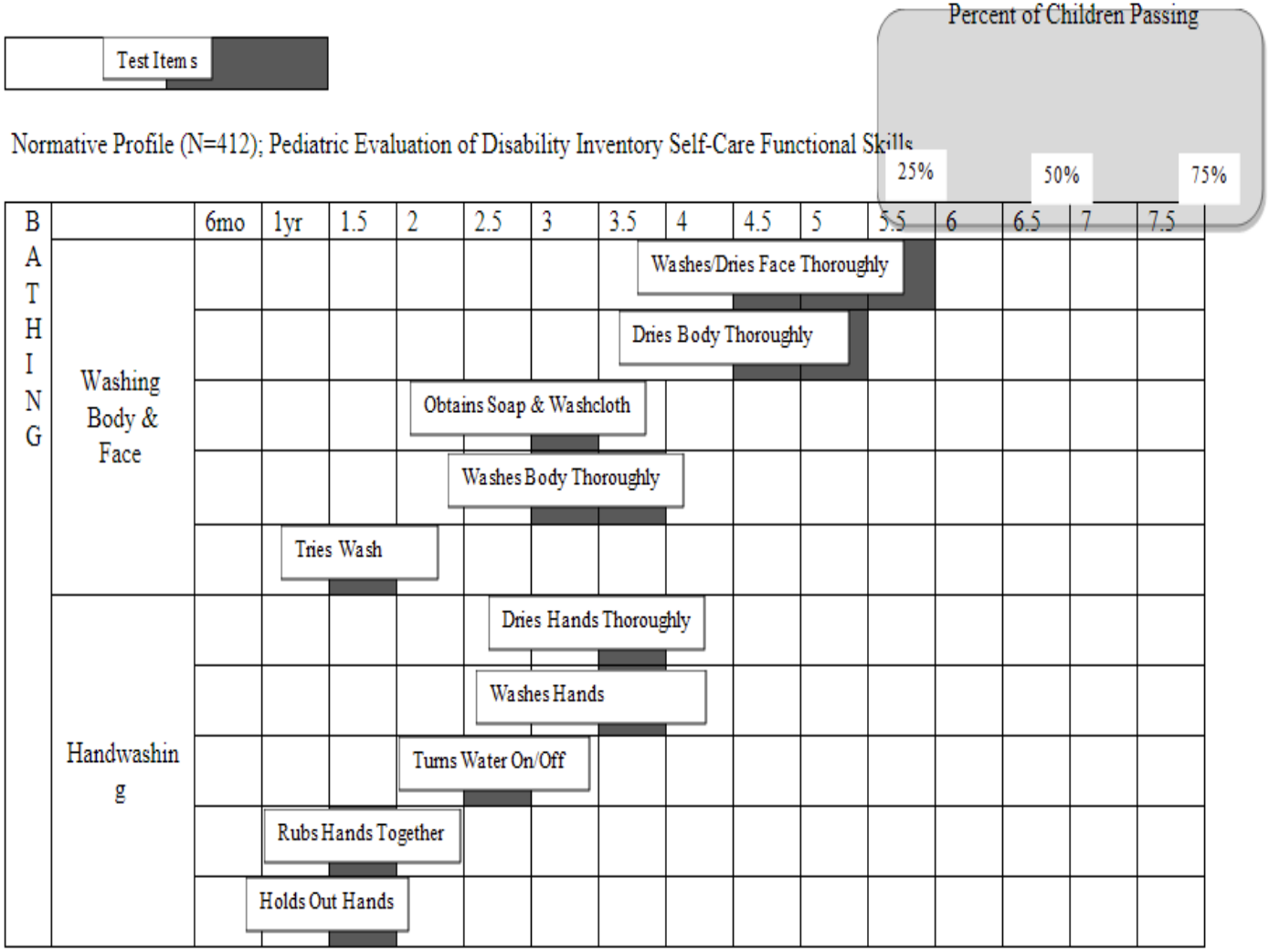
The PCM Agency may include separate evaluations if requesting different hours for school and vacation weeks. The PCM Agency must include separate evaluations as part of the pediatric PCA PA submission request and will be adjudicated as one PA number.

The documentation for ADL service requests must include documentation to support the medical necessity of the request in accordance with 130 CMR 422.416 and the *List of Standard Documentation to Include with a Prior Authorization for PCA Services*. If more PCA hours are requested the following year for a PCA re-evaluation, documentation must be provided to support the need for the additional time requested

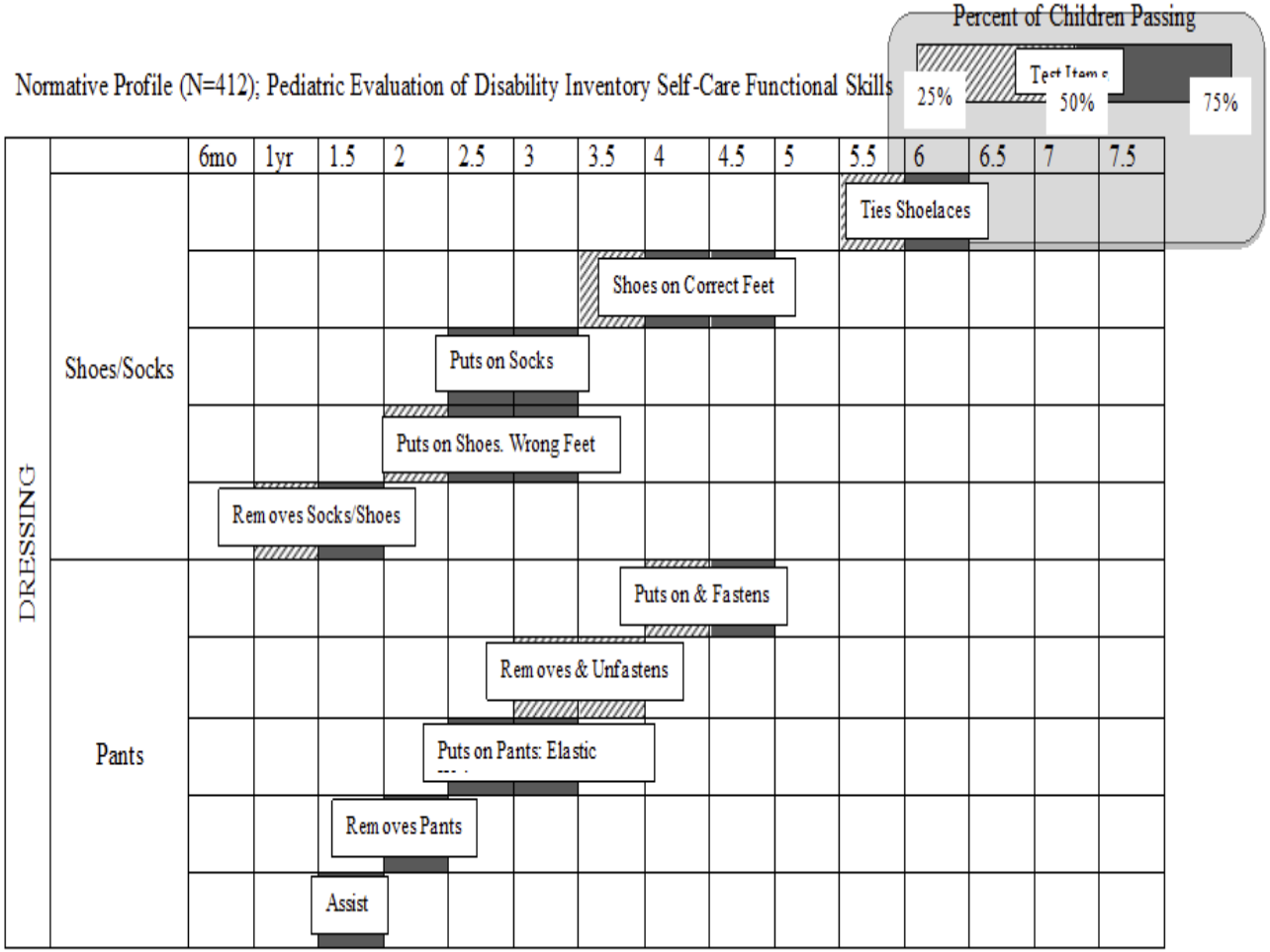
Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

The Schematics of Age Ranges tool below is utilized by MassHealth, the PAU, and can be referenced by the PCM Clinical Evaluator to determine the age ranges for which a non-disabled child would perform a certain task. As of the publishing date of this document, clinical staff at MassHealth have reviewed current publications and found that this tool is still the most accurate and useful for the purposes of determining the age at which children master specific functional tasks.

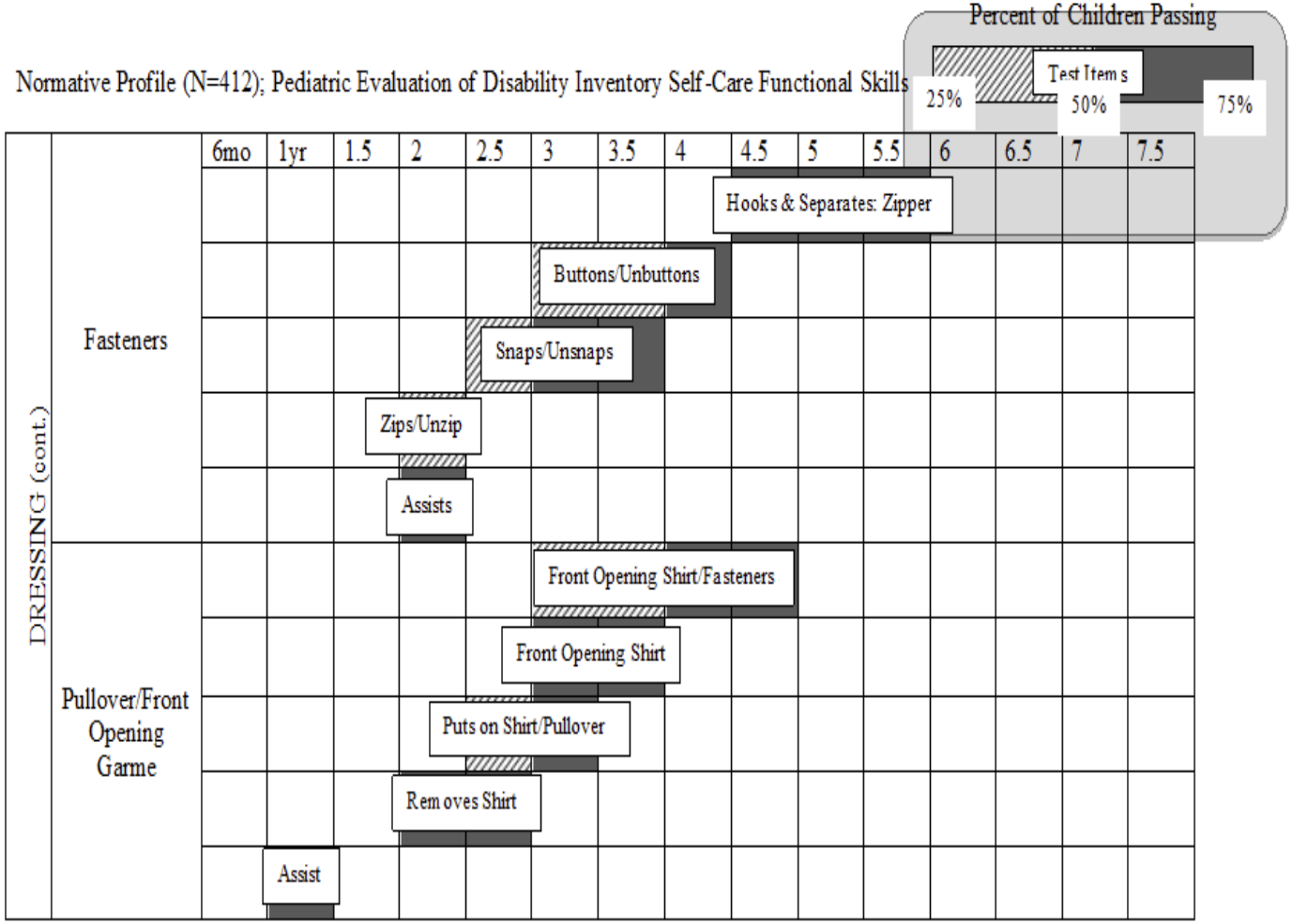



Test Items
Percent of Children Passing
25%
50%
75%
Normative Profile (N=412); Pediatric Evaluation of Disability Inventory Self-Care Functional Skills
BATHING
Washing Body & Face
Handwashing
6mo
1yr
1.5
2
2.5
3
3.5
4
4.5
5
5.5
6
6.5
7
7.5
Washes/Dries Face Thoroughly
Dries Body Thoroughly
Obtains Soap & Washcloth
Washes Body Thoroughly
Tries Wash
Dries Hands Thoroughly
Washes Hands
Turns Water On/Off
Rubs Hands Together
Holds Out Hands

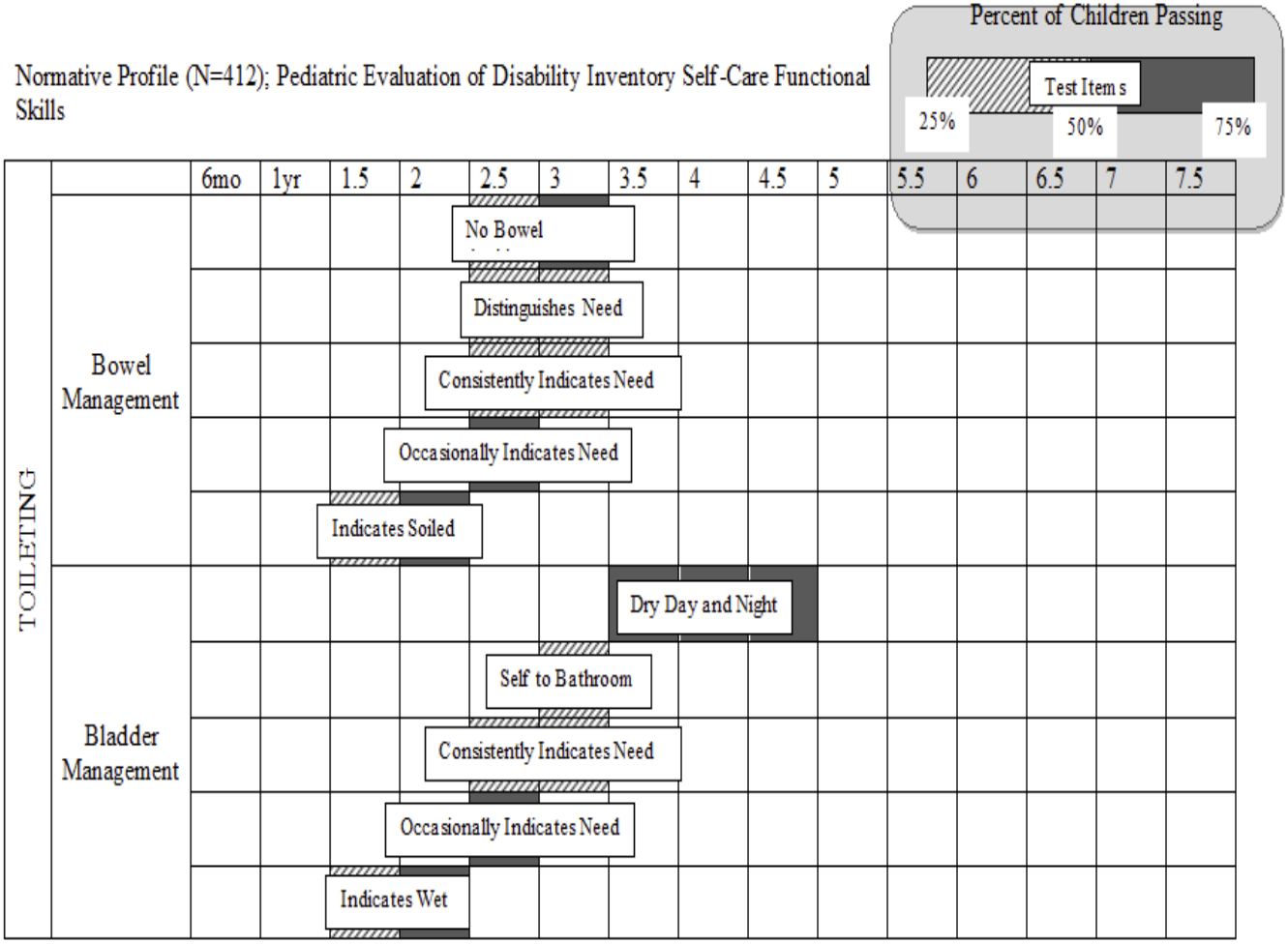
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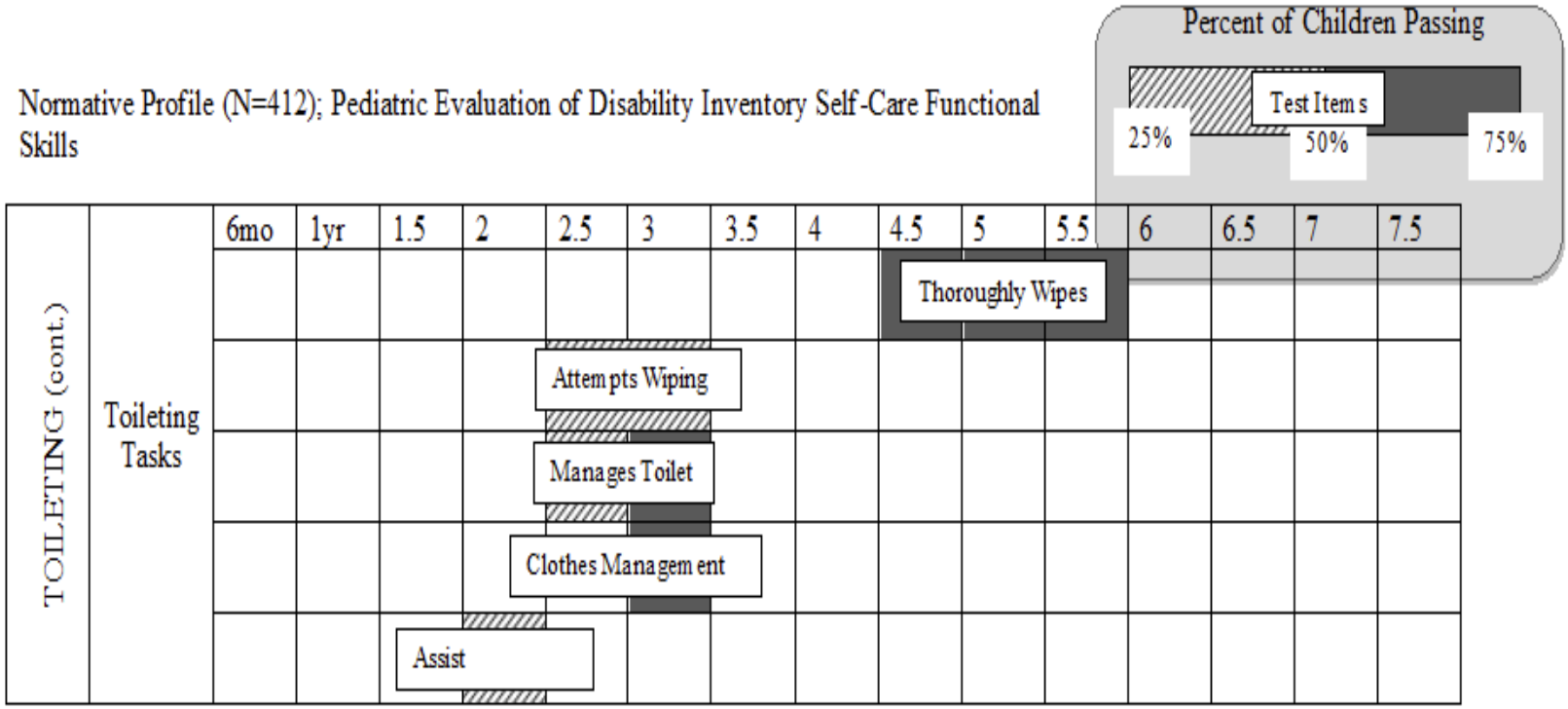
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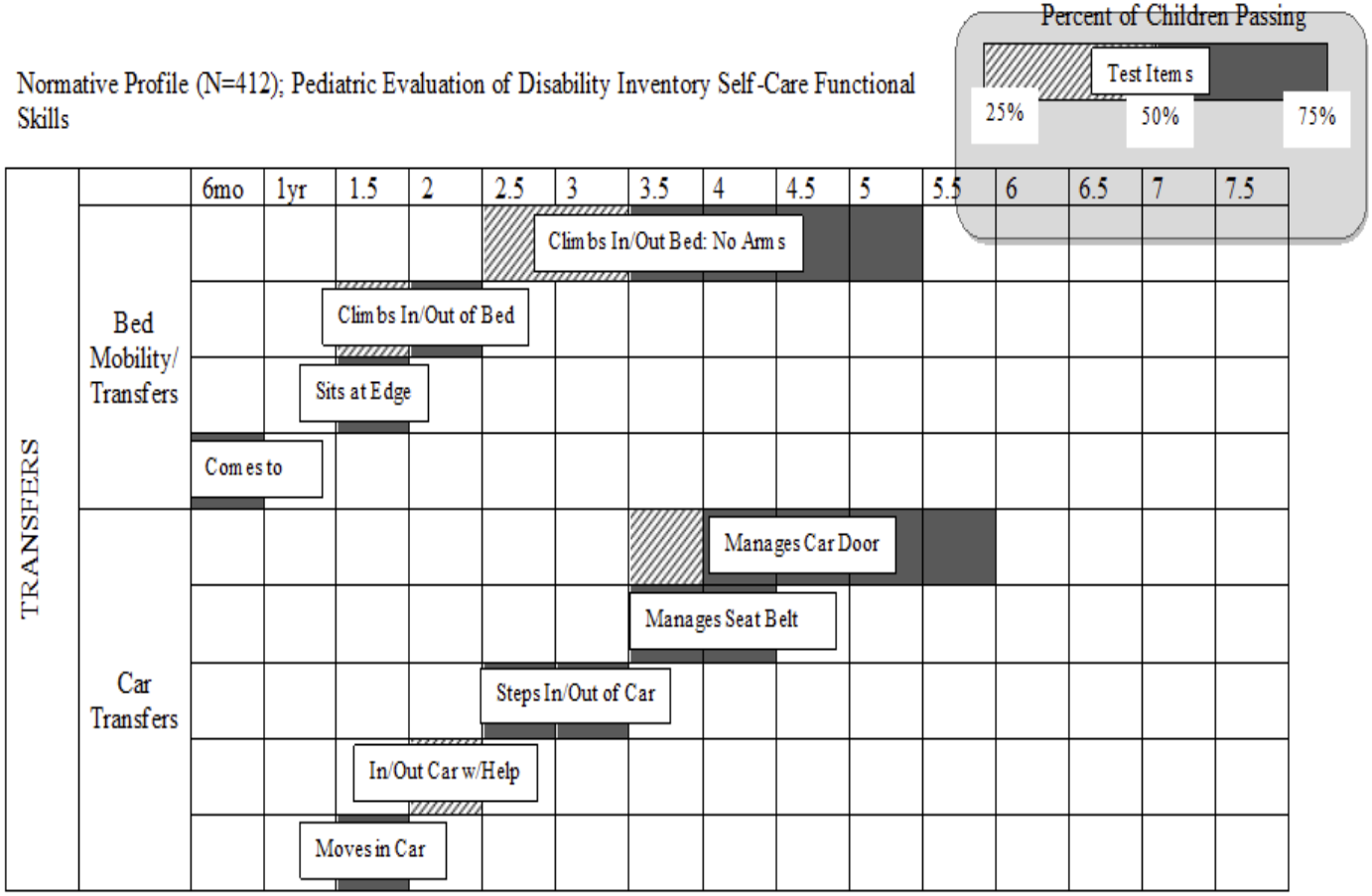
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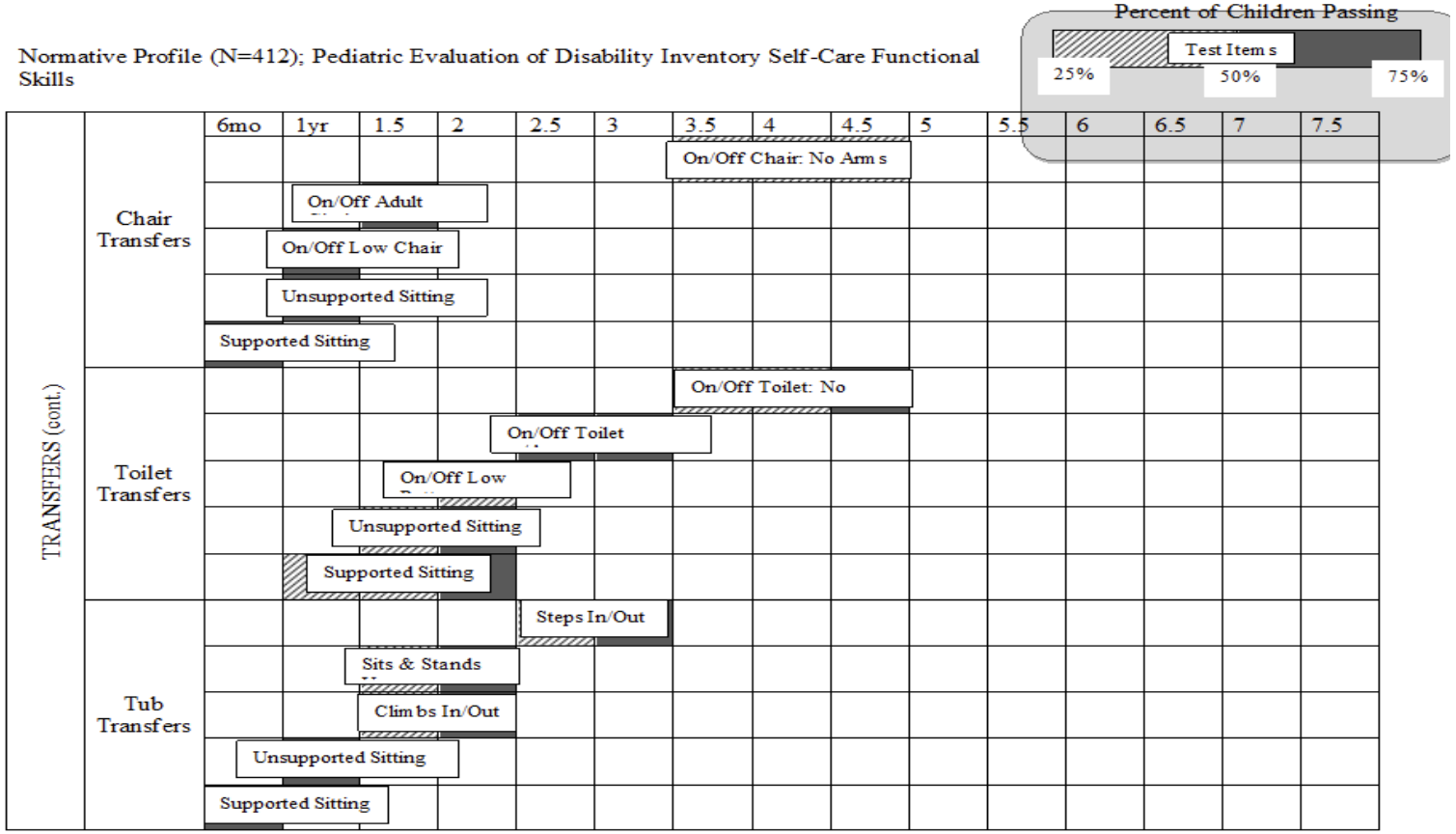
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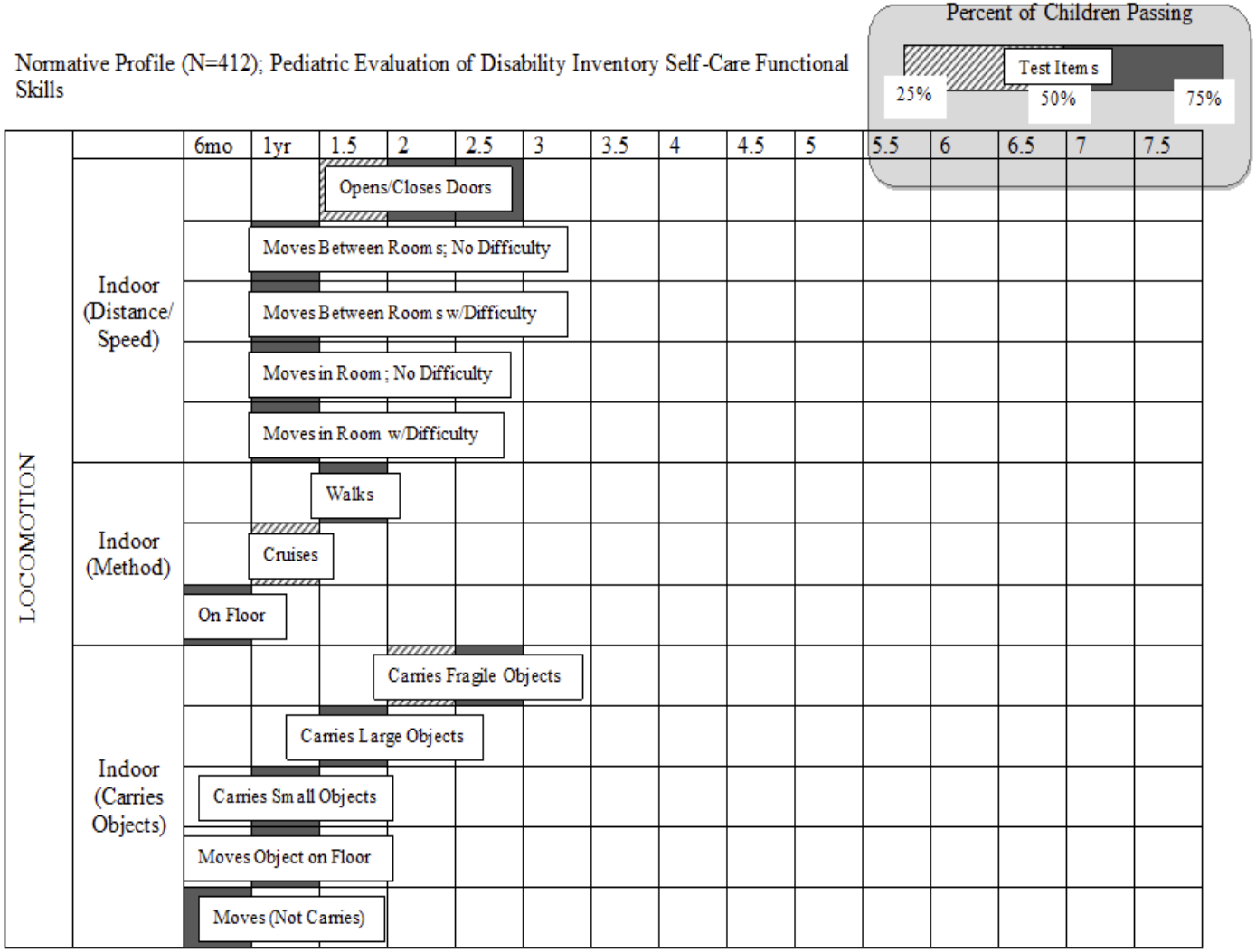
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Schematics of Age Ranges at which Non-Disabled Children Master Functional Items



Schematics of Age Ranges at which Non-Disabled Children Master Functional Items



Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

Age Range (yrs) at Which 10/25/50/75/90 Percent of Children Master Self-care Functional Skills Items

	Eating	>10%	>25%	>50%	>75%	>90%
1	Strained foods	>	>	>	>	0.5-1.0
2	Lumpy foods	0.5-1.0	>	1.0-1.5	>	1.5-2.0
3	Cut-up foods	>	1.0-1.5	>	1.5-2.0	3.0-3.5
4	All textures of table foods	1.5-2.0	2.0-2.5	2.5-3.0	3.0-3.5	3.5-4.0
5	Finger feeds	>	>	>	0.5-1.0	1.0-1.5
6	Spoon use	0.5-1.0	>	1.0-1.5	>	1.5-2.0
7	Good spoon use	1.0-1.5	>	1.5-2.0	>	2.0-2.5
8	Fork use	>	>	1.5-2.0	2.0-2.5	2.5-3.0
9	Use of knife	2.0-2.5	2.5-3.0	4.0-4.5	>	5.0-5.5
10	Holds container	>	>	>	>	0.5-1.0
11	Lifts with tipping	>	0.5-1.0	1.0-1.5	>	1.5-2.0
12	Lifts cup 2 hands	>	1.0-1.5	>	1.5-2.0	2.0-2.5
13	Lifts cup 1 hand	1.0-1.5	1.5-2.0	2.0-2.5	>	3.0-3.5
14	Pours Liquid	2.0-2.5	3.0-3.5	>	4.0-4.5	5.0-5.5

Note: Greater-than signs (>) reflect that a greater percentage of children mastered a given item than represented by that column.

Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

Age Range (yrs) at Which 10/25/50/75/90 Percent of Children Master Self-care Functional Skills Items

	Grooming and Bathing	>10%	>25%	>50%	>75%	>90%
15	Allows toothbrushing	>	0.5-1.0	1.0-1.5	>	1.5-2.0
16	Holds toothbrush	>	>	1.0-1.5	>	1.5-2.0
17	Brushes teeth, not thorough	1.0-1.5	>	1.5-2.0	2.0-2.5	2.5-3.0
18	Thoroughly brushes teeth	2.5-3.0	3.0-3.5	4.0-4.5	4.5-5.0	6.0-6.5
19	Prepares toothbrush	3.0-3.5	3.5-4.0	4.0-4.5	4.5-5.0	6.0-6.5
20	Holds head when brushed	>	>	0.5-1.0	1.0-1.5	1.5-2.0
21	Brings comb to hair	0.5-1.0	>	>	1.0-1.5	1.5-2.0
22	Brushes hair	1.0-1.5	>	1.5-2.0	2.5-3.0	3.5-4.0
23	Manages tangles/parts	4.0-4.5	5.5-6.0	6.5-7.0	>	7.0+
24	Allows nose wiped	>	>	0.5-1.0	>	1.5-2.0
25	Tries to blow nose	>	1.0-1.5	>	>	1.5-2.0
26	Wipes when requested	1.0-1.5	>	1.5-2.0	2.0-2.5	2.5-3.0
27	Wipes nose w/no request	1.5-2.0	>	2.0-2.5	3.0-3.5	4.0-4.5
28	Blows and wipes on own	2.5-3.0	3.0-3.5	3.5-4.0	6.0-6.5	6.5-7.0
29	Holds out hands for wash	>	0.5-1.0	1.0-1.5	>	1.5-2.0
30	Rubs hands together	>	1.0-1.5	>	1.5-2.0	2.0-2.5
31	Turns water on/off	1.5-2.0	>	2.0-2.5	2.5-3.0	3.0-3.5
32	Washes hands thoroughly	2.0-2.5	2.5-3.0	3.0-3.5	3.5-4.0	4.0-4.5
33	Washes/dries hands thoroughly	2.0-2.5	2.5-3.0	3.0-3.5	3.5-4.0	4.0-4.5
34	Tries to wash body	>	>	1.0-1.5	>	1.5-2.0
35	Washes body thoroughly	1.5-2.0	2.0-2.5	2.5-3.0	3.5-4.0	4.0-4.5
36	Obtains soap and washcloth	1.5-2.0	2.0-2.5	2.5-3.0	3.0-3.5	4.5-5.0
37	Dries body thoroughly	2.5-3.0	3.0-3.5	4.0-4.5	5.0-5.5	6.0-6.5
38	Washes/dries face thoroughly	2.5-3.0	3.0-3.5	4.0-4.5	5.5-6.0	6.5-6.5

Note: Greater-than signs (>) reflect that a greater percentage of children mastered a given item than represented by that column.

Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

Age Range (yrs) at Which 10/25/50/75/90 Percent of Children Master Self-care Functional Skills Items

	Dressing	**>10%**	**>25%**	**>50%**	**>75%**	**>90%**
39	Assists pullover	>	>	0.5-1.0	1.0-1.5	1.5-2.0
40	Removes shirt	1.0-1.5	>	1.5-2.0	>	2.5-3.0
41	Puts on shirt	1.5-2.0	2.0-2.5	2.5-3.0	3.0-3.5	3.5-4.0
42	Front opening shirt	2.0-2.5	>	2.5-3.0	3.5-4.0	4.0-4.5
43	Front opening shirt & fasteners	>	2.5-3.0	3.5-4.0	4.5-5.0	5.5-6.0
44	Assists with fasteners	1.0-1.5	>	1.5-2.0	>	2.0-2.5
45	Zips/unzips	1.0-1.5	1.5-2.0	>	2.0-2.5	4.0-4.5
46	Snaps/unsnaps	1.5-2.0	2.0-2.5	2.5-3.0	3.5-4.0	4.5-5.0
47	Buttons/unbuttons	>	2.5-3.0	3.5-4.0	4.0-4.5	5.0-5.5
48	Hooks & separates zipper	2.5-3.0	>	4.0-4.5	5.5-6.0	6.0-6.5
49	Assists with pants	0.5-1.0	>	1.0-1.5	>	1.5-2.0
50	Removes pants	1.0-1.5	>	1.5-2.0	2.0-2.5	2.5-3.0
51	Puts on pants, elastic waist	1.5-2.0	>	2.0-2.5	>	3.0-3.5
52	Removes & unfastens	2.0-2.5	3.5-3.0	>	3.5-4.0	4.5-5.0
53	Puts on & fastens	2.5-3.0	3.5-4.0	4.0-4.5	4.5-5.0	5.5-6.0
54	Removes socks/shoes	>	0.5-1.0	1.0-1.5	1.5-2.0	2.0-2.5
55	Puts on shoes, wrong feet	1.0-1.5	1.5-2.0	2.0-2.5	>	3.0-3.5
56	Puts on socks	1.5-2.0	>	2.0-2.5	3.0-3.5	3.5-4.0
57	Shoes on correct feet	2.0-2.5	3.0-3.5	3.5-4.0	4.5-5.0	5.5-6.0
58	Ties shoelaces	4.0-4.5	5.0-5.5	5.5-6.0	6.0-6.5	6.5-7.0

Note: Greater-than signs (>) reflect that a greater percentage of children mastered a given item than represented by that column.

Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

Age Range (yrs) at Which 10/25/50/75/90 Percent of Children Master Self-care Functional Skills Items

	Toileting	>10%	>25%	>50%	>75%	>90%
59	Assists with clothing	>	1.5-2.0	>	2.0-2.5	3.0-3.5
60	Attempts wiping	>	2.0-2.5	>	3.0-3.5	3.5-4.0
61	Manage toilet	>	2.0-2.5	2.5-3.0	>	3.0-3.5
62	Clothes management	1.5-2.0	>	2.5-3.0	>	3.0-3.5
63	Thoroughly wipes	3.0-3.5	>	4.0-4.5	5.5-6.0	6.0-6.5
64	Indicates when wet	0.5-1.0	1.0-1.5	1.5-2.0	2.0-2.5	2.5-3.0
65	Occasionally indicates need (bladder)	1.5-2.0	>	2.0-2.5	2.5-3.0	3.0-3.5
66	Consistently indicates need (bladder)	>	2.0-2.5	>	>	3.0-3.5
67	Self to bathroom	2.0-2.5	2.5-3.0	>	>	3.0-3.5
68	Dry day & night	2.0-2.5	>	3.0-3.5	>	4.5-5.0
69	Indicates soiled	0.5-1.0	1.0-1.5	1.5-2.0	>	2.0-2.5
70	Occasionally indicates need (bowel)	1.5-2.0	>	2.0-2.5	2.5-3.0	3.0-3.5
71	Consistently indicates need (bowel)	>	2.0-2.5	>	>	3.0-3.5
72	Distinguishes need	>	2.0-2.5	>	>	3.0-3.5
73	No bowel accidents	2.0-2.5	2.5-3.0	>	3.0-3.5	3.5-4.0

Note: Greater-than signs (>) reflect that a greater percentage of children mastered a given item than represented by that column.

Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

Age Range (yrs) at Which 10/25/50/75/90 Percent of Children Master Mobility Functional Skills Items

	Transfers	>10%	>25%	>50%	>75%	>90%
1	Supported sitting: toilet	>	0.5-1.0	1.5-2.0	>	2.0-2.5
2	Unsupported sitting: toilet	>	1.0-1.5	1.5-2.0	>	2.0-2.5
3	On/off low potty	1.0-1.5	1.5-2.0	>	2.0-2.5	3.0-3.5
4	On/off toilet: arms	1.5-2.0	>	2.0-2.5	>	3.0-3.5
5	On/off toilet: no arms	2.5-3.0	3.0-3.5	4.0-4.5	4.5-5.0	6.0-6.5
6	Supported sitting: chair	>	>	>	>	0.5-1.0
7	Unsupported sitting: chair	>	>	0.5-1.0	>	1.0-1.5
8	On/off low chair	>	>	>	1.0-1.5	1.5-2.0
9	On/off adult chair	>	>	1.0-1.5	1.5-2.0	2.0-2.5
10	On/off chair: no arms	2.0-2.5	3.0-3.5	>	4.5-5.0	5.5-6.0
11	Moves in car	>	>	1.0-1.5	1.5-2.0	2.0-2.5
12	In/out car with little help	>	1.5-2.0	>	2.0-2.5	2.5-3.0
13	Steps in/out car	1.3-2.0	>	2.0-2.5	>	3.0-3.5
14	Manages seat belt	2.0-2.5	>	3.0-3.5	4.0-4.5	4.5-5.0
15	Manages car door	>	3.0-3.5	3.5-4.0	>	5.5-6.0
16	Comes to sit in bed	>	>	>	0.5-1.0	1.0-1.5
17	Sits at bed edge	>	>	1.0-1.5	1.5-2.0	2.0-2.5
18	Climbs in/out bed	>	1.0-1.5	1.5-2.0	>	2.0-2.5
19	Climbs in/out bed: no arms	1.5-2.0	2.0-2.5	3.0-3.5	5.0-5.5	5.5-6.0
20	Supported sit: tub	>	>	>	>	0.5-1.0
21	Unsupported sit: tub	>	>	0.5-1.0	1.0-1.5	1.5-2.0
22	Climbs in/out: tub	>	1.0-1.5	1.5-2.0	2.0-2.5	3.0-3.5
23	Sits & stands up: tub	>	1.0-1.5	1.5-2.0	2.0-2.5	2.5-3.0
24	Steps in/out: tub	>	2.0-2.5	2.5-3.0	3.0-3.5	4.0-4.5

Note: Greater-than signs (>) reflect that a greater percentage of children mastered a given item than represented by that column.

Prior Authorization Requests for Adult Consumers Who Receive Residential Supports

PCA services provided to a member while the member is a resident of a nursing facility or other inpatient facility, or a resident of a provider-operated residential facility subject to state licensure, such as a group home, are not covered (Per 130 CMR 422.412 (D**)**; Consumers living in 24/7 residential programs are not eligible for PCA unless the consumer has a specific, regular flex, where they split their living time between a residential program and another setting (i.e. visit and live with family members every weekend); in this instance, they may be eligible for a "Split PA". Please note the following in relation to PA for adults receiving residential supports:

- Adult PAs are for consumers above the age of 22.
- If the consumer requires PCA services in multiple settings, they may obtain a 'Split PA' where the consumer's PA can accommodate different PCA service requirements for different settings. (i.e. vacation weeks vs. work/day program weeks).
- Split PAs are only intended for regular, long-term, split schedules.
- Documentation is required to support schedules on Split PAs, and PA requests will be denied if the supporting documentation is not supplied. Denied PA requests will have an external message.
- If a PCM is submitting a PA for consumers who receive DDS, DMH, or MassAbility, they must refer to the Standard Documentation Form to see which additional documentation may be necessary to submit with the PA request to prevent duplication**.**

Requesting a Split Adult PA via an Adjustment Request

When submitting a request for an adult consumer that requires different schedules of PCA services in multiple settings, the PCM Agency must:

a. Complete separate evaluations (Time for Tasks)to support the PCA services for each setting.
b. Submit a NEW Initial or Reevaluation PA request in the form and format required by MassHealth. Despite having two evaluations, it will be one PA submission and will be for the full PA period (52.14 or 52.28 weeks).
c. Within the PA request, the PCM must include a note stating that there will be an adjustment submitted to accommodate a Split PA between the different settings.
d. The PCM should wait until this PA request has been adjudicated by the PAU and assigned an MMIS PA number.
e. Using that approved MMIS PA number for the Initial/Re-eval PA, the PCM must then submit a request for an adjustment in the online system.
f. The PCM must state the PA# already approved and the reason for the adjustment in the comments. The PCM must clarify how many weeks and hours are being requested per setting in the Comments section. For example: "*Adjustment request for PA xxxxx for adult member who requires a split PA. Member is requesting 5 hours per week for 40 day program weeks and 10 hours per week for 12 vacation weeks."*
g. The PCM must upload an attachment Letter from the Group Home or DDS attesting that the Consumer leaves the 24/7 group home on certain scheduled days. The letter must also attest to their ADL and IADL needs.

Once the Adjustment is submitted, the PAU will:

a. Review the requested Split Time

b. Review the attached documentation supporting the split schedule.
c. If all documentation is in order, the PAU will adjudicate with an external message that specifies the details on the split schedule.
d. If the documentation is not in order, the PAU will defer the PA to allow the PCM more time to submit required supporting documentation for the split schedule. If, by the end of the deferral period, no additional supporting documentation is submitted, the Adjustment Request will be denied.

IV. Authorizing PAs Greater Than 1 Year Duration

A PCM may request a PA for greater than one year, and up to two years, if the Consumer meets the requirements outlined at 130 CMR 422.422(D)(2); Initial prior authorization requests and requests containing Complex Care will not be considered for a span greater than 1 year, only Re-evaluation PAs without Complex Care are eligible. If the PCM determines that the Consumer meets the criteria for a two-year PA, the PCM must submit a Re-evaluation PA and explicitly request a PA period of 2 years.

To request a 2-year PA, the PCM must:

a. Submits a NEW PA request for a "Re-evaluation" PA.
b. Within the PA Request, make a note requesting a 2-year PA.

Once submitted, the PAU will:

a. Review to ensure that the consumer meets the criteria for a 2-year PA (130 CMR 422.422(D)(2)) by ensuring that:
    i. The consumer is 22 years of age or older.
    ii. There have been no significant changes in the Consumer's ADL/IADL needs since the last evaluation. For example: Requested PCA time and ADLs/IADLs have remained unchanged.
    iii. There has been no major change in condition, hospitalization, need for new services, etc.
    iv. If ADL/IADL times have changed, it is due to living situation only, but the member's functional needs have not changed.

b. The PAU will also confirm that the re-evaluation was done in person.
c. The determination will be made by the PA reviewer based on a review of the entire PA request, including, but not limited to, any modifications to the PCM's original request made by the reviewer, any adjustment made to the current prior authorization, etc.
d. If the request does not meet all criteria above for a 2-year PA, the request will be adjudicated for a 1-year time span.

Note: No External Text will be added related to the adjustment from 2-year to 1-year. PCMs must review the PA and monitor adjudicated end dates.

The modification from a 2-year to a 1-year time span is not an appealable action.

All other aspects of PA adjudication will be executed in accordance with the PAU's standard practices outlined in this document and per the regulations at 130 CMR 422.000 & 130 CMR 450.000.

Significant Changes for Consumers With a 2 -Year PA

Should a Consumer with an approved 2-year PA experience a significant, permanent, and unexpected change, the PCM may need to prioritize a Re-evaluation over an Adjustment. If there are greater than 10 months left on the PA, a Re-evaluation must be conducted. If there are less than 10 months left on the PA, an Adjustment may be submitted (see *Adjustments*).

V. Identifying Duplication of Services

MassHealth pays for medically necessary services in accordance with 130 CMR 450.204. When submitting or authorizing PCA prior authorization requests, the PCM Agency and PAU must make every effort to ensure PCA services are medically necessary and are not requested or authorized for times that the member is participating in other MassHealth programs as described in 130 CMR 422.412 (E) (F), or that the PCA services being requested are not otherwise provided through another service provider or payer.

Submitting for PCA PA

When submitting for PCA PA, PCM Agencies must ensure all necessary documentation is completed and submitted with the PA request.

The PCM Agency must submit necessary documentation to allow the PAU to ensure there is no duplication of services. The PCM Agency must ensure that the PA Request is filled out to the best of the PCM's knowledge.

a. If the PA request indicates that **In-Home** Services are being received by the Consumer, additional information must be provided. In-Home Services include services provided via Waivers, VNA/Home Care, other LTSS.
b. The application must denote other services the Consumer is receiving including the service type, agency providing the service and contract information, level of service and frequency of service.
c. It is the PCM Agency responsibility to:
    - Inquire with the Consumer regarding other services received
    - If other services are identified, utilize that information when conducting the PCA evaluation
    - Provide documentation on the PCA evaluation that demonstrates there is no duplication of services for the Consumer
    - Include additional documentation with the PCA prior authorization request, as appropriate. The Standard Documentation to Include with a Prior Authorization Request for Personal Care Attendant (PCA) Services document outlines when additional documentation is required and what documentation must be submitted to support the Consumer's medical necessity for PCA services. The updated list of standard documentation is available at List of Standard Documentation PAU Clinical Reviewers must review evaluations and attached documentation to ensure there are no duplicative services being requested in the PCA PA request.

a. If upon reviewing a PA request, the PAU Clinical Reviewer identifies possible duplication of services due to incomplete or missing information within the evaluation or supporting documentation, the PAU Clinical Reviewer will defer the prior authorization request consistent with Operating Standards Section *Deferrals.*

b. If the documentation submitted by the PCM Agency clearly documents duplication of services, the PAU will modify the prior authorization request and provide the reason code regarding the modification in the message text of the prior authorization notice. If needed, a contingency message will be placed if a duplication such as, but not limited to, AFC/GAFC is active. A contingency message would be seen at the beginning of the external message, i.e. *"NOTE: Approval is contingent upon the discontinuation of xxxx services".*

Contingencies

In certain circumstances, a PA may be approved with a "contingency," meaning that the PCA PA is approved, however, duplicative services must be ended before the consumer can utilize their PCA Services. Circumstances where a PA may be approved with a Contingency include:

a. Adult Foster Care (AFC) and PCA duplication
b. Group Adult Foster Care (GAFC) and PCA duplication.
c. Home Health Aid (HHA) and PCA duplication (Complex member may have both but should not duplicate or overlap. A modification may be used for some cases rather than a contingency message).
d. Consumer Directed Care (CDC) provided by Elder Services.
e. Personal care services like homemaking, laundry, or shopping services provided by other vendors (i.e. Frail Elder Waiver (FEW).

Please note that contingencies will NOT be used for:

a. Adult Day Health (ADH) or Day Hab (DH) and PCA (*If a Consumer attends a day program, the PCM must clarify the frequency that the Consumer attends so that the PAU can review for duplication).
b. Managed Care Plans or Community Case Management: (SCO, ICO, CCM, PACE) The PAU will defer and either void or deny these requests.
c. Services that have already been modified (e.g. Home Delivered Meals, if remains in place, there will be a modification rather than a contingency).

When a contingency is placed on a PA, the Contingency message will be placed into the External Text of the PA directly after the 'DATE.' For example, "*1/1/2026: NOTE: Approval is contingent upon the discontinuation of xxxx services provided by ..... services*."

Once a contingency message is placed on the PA, the PCM must work with the Consumer to determine the preferred services. Upon confirmation from the Consumer that PCA is the preferred service, the PCM must:

a. Obtain a letter from the other provider (e.g. AFC) stating that the services with their agency will be ending on a specific date.
b. Email support@masshealthltss.com requesting that the contingency is lifted. The email should include:
    - The Consumer's name
    - PA number
    - Attachment from the other provider with the end date of those services.

When Support receives this information, the email will be forwarded to the PAU for review. The PAU will review the email and attached supporting documents and instruct support on response:

a. If information supports the lifting of the contingency, the PAU will ask Support to let the provider know that the contingency has been lifted and note the effective date of the lift. .

- The effective date is always the day after the other services are being discontinued. Example: *HHA is being discontinued 6/22/2026 and therefore the contingency will be lifted effective date 6/23/2026*

b. The PAU will also instruct Support to include the following on the cc line of the email:

- If the contingency lift request is coming from the PCM, add the FI email to the reply: InboxBudgetManagement@tempusunlimited.org.
- If the contingency lift request is coming from the FI , add the specific PCM contact email to the reply.

c. The PAU will then attach/upload the letter from the other provider to their PCA PA for record keeping purposes.

d. The External text message will not be updated

Please note that for a contingency to be lifted fully, the other provider type must also end their Prior Authorization. For example, if there was an AFC Contingency on a PCA PA, the AFC Provider must supply the PCM with a letter noting their end of service date AND end their AFC PA with the PAU.

VI. Adjustments

The PCM Agency may submit a request to MassHealth to increase or decrease the number of PCA hours on a Consumer's existing PA as a result of changes in the Consumer's medical condition and/or functional status, or a change in the living condition that affects the Consumer's ability to perform ADLs/IADLs without physical assistance. In addition, the PCM Agency will utilize the Adjustment process to add units to a PA due to a PCA having Jury Duty, or request an "Adult Split PA" for Consumers who qualify (see *Prior Authorization Requests for Adult Consumers Who Receive Residential Supports*).

Adjustment to Increase Hours

When a Consumer requires an increase in hours on their current PA, the PCM must request this adjustment by doing the following:

a. Request an Adjustment and attach the following Documentation (See MassHealth PCA Regulation 130 CMR 422.416 B):

- The completed MassHealth PCA PA Adjustment Form signed by both the evaluating nurse and the Consumer's PCP. If no PCP signature, then the following documentation is also required:
  - A letter from the Consumer's Medical Provider outlining the reason for the adjustment request including the medical condition, functional status or living situation, specific ADLs or IADLs for which an increase or decrease in PCA services being requested, including the number of units, the number of hours, and the duration of time for which the adjustment is being requested. This letter can be substituted for medical Provider signing the adjustment form containing the needed details.

- PCP Summary Form (required if asking for Complex Care tasks)
  OR
  Electronic Medical Record (EMR) clinical documentation for Consumers without Complex Care Needs.

- Any documentation from the list of standard documentation, as appropriate.

If the Adjustment PA request is approved or modified, the PAU will adjust the current PA and a PA notice is forwarded to Consumer, PCM Agency, and FI.

If the determination of medical necessity cannot be made with the information submitted, the PA will be deferred to allow time for the PCM agency to provide additional documentation to support medical necessity. If the PA is denied, it will follow the denial process and a decision notice will be forwarded to Consumer, PCM Agency, and FI. The Consumer will be supplied with appeals rights.

The effective date of an adjustment request for increases, is the date that MassHealth receives the PA adjustment request from the PCM Agency. The effective date of all other PA requests is the date MassHealth sends notice of its decision to the Consumer in accordance with 130 CMR 450.303(B)(3).

Adjustment to Decrease Hours:

When a Consumer requires a decrease in hours on their current PA, the PCM must request this adjustment by doing the following:

a. The PCM Agency must Request an Adjustment.
b. The PCM must attach the following Documentation (See MassHealth PCA Regulation 130 CMR 422.416 B):
   - The completed MassHealth PCA PA Adjustment Form signed by both the evaluating nurse and the Consumer's Medical Provider. If no Medical Provider signature, then the following documentation is also required:
     - A letter from the Consumer's Medical Provider outlining the reason for the adjustment request including the medical condition, functional status or living situation, specific ADLs or IADLs for which an increase or decrease in PCA services being requested, including the number of units, the number of hours, and the duration of time for which the adjustment is being requested. . This letter can be substituted for medical Provider signing the adjustment form containing the needed details.
     - PCP Summary Form (required if asking for Complex Care tasks)
       OR
       Electronic Medical Record (EMR) for Consumers without Complex Care Needs
   - Any documentation from the list of standard documentation, as appropriate.

If the Adjustment PA request is approved or modified, the PAU will adjust the current PA and a PA notice is forwarded to Consumer, PCM Agency and FI.

If the adjustment request for a decrease in hours is authorized, the PAU will add 14 calendar days to the date of adjudication to allow for the Consumer's receipt of the notice and appeal rights. The adjustment PA will be voided and the current Re-eval or Initial PA will be adjusted.

Adjustment to Add Complex Care Tasks:

When a Consumer seeks an adjustment because they have had a change to their needs that now requires their PA to reflect a Complex Care need. The PCM must submit an Adjustment to get the Complex Care tasks added to the PA. The Adjustment request will require a signed and completed PCP Summary Form. Complex Care will begin on the date of adjudication and cannot be backdated.

Adjustment for PCA Jury Duty

MassHealth provides specific reimbursement for personal care attendants who are required to perform juror service during regularly scheduled work hours for a maximum of three days. An increase in PCA hours may be granted to maintain the units on the PA that were needed for Jury Duty. When this type of adjustment is necessary, the PCM must request the adjustment by doing the following:

a. The PCM Agency must Request an Adjustment.
b. Specifically note "JURY DUTY" as the reason for Adjustment..
c. Attach the following required Jury documentation:
    - Copy of the Certificate of Juror Service issued by the Massachusetts Office of the Jury Commissioner (state jury service) or the Attendance Sheet issued by the Federal District Court (federal jury service)
    - Copies of PCA timesheets submitted to the FI to confirm number of hours regularly scheduled to work
    - No MD/NP signature is required for Jury Duty adjustments.

The PAU will review the request and contact the PCM Agency designee if any of the above criteria are missing. If all information is in order, the PAU will adjust the current PA based on the information provided in the PA submission, and VOID the new PA requested by the PCM Agency. Once adjudicated, a PA notice is generated and sent to the Consumer, PCM Agency, and FI.

Adjustment due to Loss of Clinical Eligibility

When a PCM discovers during a re-evaluation that a Consumer no longer qualifies for the PCA Program because they do not meet the requirement for physical hands on assistance with at least 2 ADLs, the PCM will need to adjust the current PA to reflect this clinical change.

The PCM should request an Adjustment in the form and format required by MassHealth and decrease the hours in all ADL/IADL categories down to zero. The PCM will attach their recently completed evaluation that shows the consumer is no longer clinically eligible for the PCA Program. The PCM must also note in the request, that the reason for Adjustment is due to clinical ineligibility.

Administrative Adjustments

In certain circumstances, a PCM may request an Adjustment that is "administrative" in nature. For these instances, a PCP signature or EMR clinical documentation are not required with PA submission. An administrative adjustment may be appropriate for a Consumer electing to change their PCA approved hours because another service will be taking its place (i.e. A Consumer will be electing to have a Home Health Agency come for medication visits rather than having their PCA assist with medications.).

If the PA for the alternative service is not yet submitted, then the Admin Adjustment may be deferred for additional documentation as the PAU will not have access to the new service request information.

VII. Extensions

PCM Agencies are responsible for submitting PA requests (re-evaluations) to MassHealth at least 21 days prior to the expiration date of the PA (***Note:*** This standard applies to Consumers in facilities as well). If a PCM cannot meet the 21-day submission requirement, a PA request may be submitted to extend the expiration . If an extension is needed, the PCM must include justification for the extension in the request. Extensions should be submitted prior to a PA expiring (to prevent gaps in service) and should be submitted in 30-day increments, unless otherwise directed by MassHealth. A PA will not be extended for greater than 90 days, unless otherwise approved by MassHealth.

<u>Extensions for Consumers In a Facility (PA is Active and the expiration date is approaching)</u>

If a Consumer is in a facility, their PA can be extended to ensure that the Consumer is discharged home with PCA services intact and to allow the PCM Agency sufficient time to conduct a re-evaluation. PCMs should only extend the PA the amount of days necessary to complete the re-evaluation. MassHealth expects that the PCM Agency, to the best of their ability, communicates with the facility, tracks the Consumer's discharge, and is involved in the discharge process. Upon the Consumer's discharge, the PCM Agency should conduct a re-eval and submit a Re-evaluation PA request if PCA services need to continue. Re-evaluations for these Consumer discharges can be expedited if appropriate.

The PCM can complete an extension request for Consumers in a facility by doing the following:

a. The PCM Agency creates an Extension Request for a particular Consumer's PA.
b. The type of Extension, "Gap vs. Regular", will be captured based on the dates requested.
c. The PCM must attach any relevant documentation to support the request, if applicable.
d. For pediatric PAs, the PCM Agency must ensure the requested units reflect vacation and/or school weeks, as appropriate
e. The PCM Agency request must include the following in the Comments of the PA Request:
    - The PA number that requires extension
    - The reason for extension
    - The facility admission date
    - Projected facility discharge date
    - The number of days being requested for extension
    - The proposed new expiration date

Once submitted, the PAU will review the extension request and will:

a. Defer the extension PA if any of the above criteria are incomplete.
b. Deny the extension PA if the projected facility discharge date is not included or is greater than 90 days from the date of the facility admission.
    - NOTE: If the request is denied, the PCM must determine if this Consumer's case should be closed.
c. Deny the Extension request if the Consumer's PA is expired.
    - NOTE: If the PAU denies the extension request, the PCM Agency may submit a re-evaluation for review.

d. If all information is in order, the PAU will extend the CURRENT PA based on the information provided and VOID the extension PA request.
    - A PA notice will be generated to the Consumer, PCM Agency, and FI.
    - The effective date (start date) of the extension PA request is the day after the end date of the current PA. (For example:
    - The PAU will automatically extend a PA when the PCM Agency has submitted the extension request prior to the PA expiration date as long as the expiration date is greater than 21 days away.

e. If the PCM submits a re-evaluation for a Consumer who has an extension request submitted, the PAU will attempt to prioritize the adjudication of the re-evaluation in lieu of the extension, however this may not always be possible depending on the timing of the two submissions.

Extensions Covering Gaps in Service

If a new PA request is not submitted to MassHealth prior to the expiration date of a PA, the Consumer will experience a "gap in service". In an instance where there is a gap, due to no fault of the Consumer, the PCM Agency may request an extension of an expired PA.

An extension to cover the gap in service will not be granted if the Consumer was not using PCA services during the period in question, or if the Consumer failed to cooperate with the PCM Agency in having the PCA evaluation conducted.

MassHealth encourages PCM Agencies to submit all PA requests in accordance with the PCM Agency contract requirements and the regulations. Please note that MassHealth has the authority to impose sanctions in accordance with Section 5.20.A(11) of the PCM Agency Contract if a PCM Agency consistently fails to meet requisite timelines when submitting PAs to MassHealth.

If an extension is required and a gap is present, the PCM can complete an extension request to fill the gap by doing the following:

a. The PCM Agency creates an Extension Request on a Consumer's last PA..
b. Supply the reason for the extension request.
c. Enter the number of days being requested for extension (30-day increments). The new expiration date will auto populate.
d. For pediatric PAs, the PCM Agency must ensure the requested units reflect vacation and/or school weeks, as appropriate

Once submitted, the PAU will review the extension request and will:

a. Defer the extension PA if any of the above criteria are incomplete. I.e. If the "Reason for extension" is incomplete, the request will be deferred, and the PAU will request that the PCM Agency submit the required information
b. Seek OLTSS direction on gap extensions greater than 60 days. The PAU may deny the request based on the direction given from OLTSS.
    - Note: If Optum denies the request, the PCM Agency may submit the re-evaluation for review.
c. If all information is in order, the PAU will extend the EXPIRED PA based on information provided in the PA submission and will VOID the extension PA requested by the PCM Agency.

- A PA notice is generated to the Consumer, PCM Agency, and FI.
- The effective date (start date) of the extended PA is the day after the end date of the expired PA.

If the Consumer intends to continue services, the PCM Agency must submit a new Re-evaluation PA request before the end date of the extended PA. Optum will process the re-evaluation PA, and the effective date will be the date the new PA request was adjudicated.

VIII. Short Term PAs for Unknown Facility Discharges and Reinstatements

Short Term PAs may be used to cover a span of time shorter than a year, at the same hours/units as the directly preceding expired or ended PA, and for two specific reasons; when a Consumer is discharged from a facility and the PA has expired, and when a terminated Consumer is returning to the PCA Program.

Discharges from Facilities

PCM Agencies must make every effort to communicate with facilities regarding discharge planning for Consumers. However, in the event a Consumer is discharged from a facility without any notice to the PCM Agency, and the Consumer's PA had expired while they were in the facility, the PCM may utilize a Short Term PA. MassHealth will not extend an expired PA in this instance, so the short-term PA can be requested to allow the PCM time to conduct a re-evaluation and ensure that MassHealth does not pay for PCA services while the Consumer was in a facility. An approved short-term PA will begin on the date the Consumer is discharged from a facility and will be granted for no more than 90 days. Previous extension requests will be considered in the 90-day short -term PA timeframe (I.e. If an expired PA was already extended 30 days, only a 60-day short term PA will be granted, equal to a total of 90 days).

If a short-term PA is required for an unknown facility discharge, the PCM can complete the request by doing the following:

a. The PCM Agency creates an Extension request.
b. In the Comments of the PA request, include the following:
    - Typed text that states "EXPIRED PA, DISCHARGED WITHOUT NOTICE"
    - The facility Admission Date
    - The facility Discharge Date
    - The number of days being requested for PA
    - The dates of service, ensuring the new PA starts on the date of facility discharge.

Note: If applicable, for pediatric PAs, the PCM Agency must ensure the requested units reflect vacation and/or school weeks, as appropriate.

Once submitted, the PAU will review the extension request and will:

a. Defer the extension PA if any of the above criteria are incomplete. I.e. the "Facility Admission Date" or "Facility Discharge Date" is not included in the request, it will be deferred and the PAU will request that the PCM Agency submit the required information
    - If the required information is not received, Optum will deny the request.
b. Seek OLTSS direction if a PA was extended 90 days or greater prior to the short-term PA request. The PAU may deny the request based on the direction given from OLTSS.
    - Note: If Optum denies the request, the PCM Agency may submit the re-evaluation for review.

c. If all information is in order, the PAU will authorize the new Short Term PA based on information provided in the PA submission.
    - A PA notice is generated to the Consumer, PCM Agency, and FI for the new PA.
    - The effective date (start date) of the extended PA is the day after the end date of the expired PA.

Note: In the event that a short-term PA needs to be extended, extensions will only be granted up to 90 days and will follow the same expectations for extensions noted in *Extensions*.

Requests to Reinstate a Terminated Consumer

If a Consumer is terminated from the PCA program for failing to comply with the program rules outlined at 130 CMR 422.420(A) (i.e. Unable to Contact, Failure to Participate, Failure to Identify a Surrogate, Failure to Utilize EVV), and later can demonstrate compliance with the rules, the PCM will submit a reinstatement PA request to resume the Consumer's PCA services. A reinstatement will utilize an administrative, short-term PA to cover the date of compliance with the rules, through the original end date (inclusive of extensions) prior to the Consumer's termination.

Since the reinstatement will start on the day of compliance and go through the original end date of the PA, there will likely be a gap in PA coverage. PCMs must not request to fill a gap on a reinstated PA unless specifically directed by OLTSS. Consumers should not schedule PCAs to work if they were terminated from the program.

MassHealth will not reinstate a Consumer whose PA end date has passed (is expired). Consumers who want to return to the program after termination and are outside of their annual PA cycle will need to be reassessed and have a re-evaluation PA submitted on their behalf.

MassHealth will not reinstate a Consumer if the original PA end date prior to termination (inclusive of approved extensions) is within 30 calendar days. The 30 calendar days are inclusive of the reinstatement request date. These Consumers should be prioritized by PCM agencies for reassessment and have a re-evaluation PA submitted on their behalf. I.e. *A Consumer's PCA PA was approved for 2/1/24 – 1/31/25. This PA was terminated on 12/2/24 and a request for reinstatement was submitted by the PCM on 1/22/25. This reinstatement PA request will be denied as the original end date (1/31/25) is less than 30 calendar days from 1/22/25*.

Reinstated PAs can be adjusted, but they cannot be extended. The PAU will automatically deny an extension request for a reinstated PA.

Before PCMs request a reinstatement for a terminated Consumer they must:

a. Speak with the Consumer/Surrogate to ensure compliance with the program rules. PCMs must ensure that Functional Skills Training is completed related to the task(s) that the Consumer was originally terminated for.
b. Determine how long the Consumer has been terminated for and email OLTSS with the Consumer and PA information. OLTSS may ask for contact notes and additional information to support a reinstatement PA request. OLTSS will send the PCMs an email confirming whether a reinstatement is appropriate. For reinstatements requests sent to OLTSS within 5 days after the termination date, OLTSS may reinstate without the need for PCMs to complete a Short Term PA submission.

c. PCMs must save the email communication and if directed by OLTSS to submit a reinstatement PA request in the form and format established by MassHealth.

To submit a Reinstatement request, the PCM must:

a. Create and Extension request
b. Note the reason for extension to be "Reinstatement Per OLTSS"
c. The PCM Agency must include the following required documentation with the PA request:
    - Attach a copy of the email from OLTSS confirming that the Consumer may be reinstated; the email should include
        i. PA number
        ii. Dates of approval by OLTSS
        iii. The approving OLTSS Staff person
    - Contact notes that contain the following information:
        i. The reason that the Consumer was originally terminated.
        ii. The action that the Consumer took to come back into compliance
        iii. The date that the Consumer came back into compliance

Once submitted, the PAU will review the reinstatement request and will:

a. Defer the request if any of the above criteria are missing. I.e. the email correspondence from OLTSS is not attached. If the information is not submitted during the deferral period, the PA request will be denied.
b. If all information is in order, the PAU will authorize a NEW PA (Short-Term & Administrative) from the date of compliance through the original PA's end date (inclusive of any approved extensions).
c. PA notice is generated to the Consumer, PCM Agency, and FI for the NEW Short Term PA
d. External text on the new PA will note that this is a short-term authorization and is not an appealable action.

Note: Short Term PAs are not to be extended unless specifically directed by OLTSS.

IX. Transition of Care

When a Consumer transitions from an ICO or SCO plan to FFS, a Transition Of Care (TOC) Initial PA must be requested by the receiving PCM to allow a continuation in the Consumer's PCA services during the change in health plan coverage. A TOC is a **90-day short term PA** that is based on the hours/units previously approved while they were with the ICO/SCO plan and will not require a medical necessity review for adjudication. Authorization of hours documented from the SCO/ICO program must be attached and dates and hours must align with request. PCMs must complete and submit an evaluation for the Consumer in the 90 days allotted by the initial TOC request. In circumstances where the 90 days does not allow for the evaluation to be completed, one 90-day TOC extension may be requested (allowing 180 days total). SCO/ICO enrollment cannot be active for TOC dates requested, but the TOC PA may only be adjudicated for dates the consumer has already been clinically authorized for, if their ICO/SCO enrollment had continued; For example: *A SCO PA was approved for dates 1/2/25 - 1/1/26. Consumer disenrolled from SCO effective 3/31/25. A FFS TOC may be requested by the PCM for dates 4/1/25 - 6/30/25 as that date range is still within the dates already approved as clinically necessary by the SCO.*

Authorizations cannot be based on future MassHealth and Managed Care eligibility, but on the enrollment status on the date of adjudication. Dates requested must be within 60 days of submission. Anything with more than a 60-day gap will require OLTSS review.

Requesting an Initial TOC

To request a TOC, the PCM must:

a. Create a PA request for "Initial – One Care/SCO Transition of Care".
b. Note the program that the Consumer is transitioning from, "One Care" or "SCO"
c. Enter the One Care/SCO Date of Disenrollment
d. Attach the "Authorization of Hours" document from the SCO or One Care.
    - The requested dates of the TOC PA request must be within the previously authorized dates on the SCO/One Care Authorization of hours document.
    - The requested hours of the TOC PA request must be the same as the hours authorized on the SCO/One Care Authorization of hours document.

Once submitted, the PAU will review the extension request and will:

a. Defer the request if any of the above criteria are missing. I.e. the Authorization of Hours is not attached.
b. If all information is in order, the PAU will authorize a TOC PA from the date of SCO/One Care disenrollment and the expiration date will be granted out to 90 days.
c. PA notice is generated to the Consumer, PCM Agency, and FI for the NEW Short Term PA

Additional notes on TOC PAs

If a Consumer has an active TOC authorization in place and their PCM agency submits a Re-evaluation PA, the new PA will begin on the date of adjudication if the hours are equal or more than what was previously approved (regardless of the PCM's requested start date). This new PA must be submitted as a Re-evaluation PA. In any case where the Consumer will see a decrease in hours from the TOC authorization to the new Initial or Re-evaluation PA, the new PA will begin two weeks (14 days) from the date of the new PA's adjudication. Optum will terminate the TOC authorization, accordingly, based on the new PA start date (i.e. if the new PA starts on 4/1/27, the TOC's end date would be 6/30/27).

Extension Requests on a Transition of Care

PCM's must make every attempt to complete the evaluation within the 90 days allotted by the Initial TOC In the event that the PCM cannot complete the evaluation within the 90 days on the Initial TOC, a total of 90 days in TOC extension may be requested (total of 180 days).

To request a TOC Extension, the PCM must:

a. Create a PA request for "Extension – One Care/SCO Transition of Care".
b. Note the PA Number for which the extension is being requested.
c. PCM Agency request must include the reason for extension in the PA request in the comments of the PA request.

Once submitted, the PAU will review the extension request and will:

a. Defer the request if any of the above criteria are missing.
b. Deny the request if the TOC Extension is greater than 180 days in total.

c. Extend the TOC PA if all information is in order.
d. A new external message will be created and sent to the PCM Agency, Consumer and the FI.

Additional Notes on TOC Extensions:

- TOC extensions will not be extended more than 90 days.
- TOC extensions submitted outside of the 90 days will be denied.

X. Agency Transfers

When a consumer must transfer from one PCM agency to another, the transferring PCM shall facilitate the transfer in accordance with guidelines established or provided by EOHHS, including the regulations at 130 CMR 422.405 and the PCM Management Functions Contract, both agencies must work together to ensure a smooth transition. The agency that initiates the transfer (the transferring agency) must ensure that the consumer's PA is transferred to the new agency (receiving agency) so that there is no interruption in service or billing.

Transferring a Consumer to another PCM Agency

Should a Consumer need to transfer to another PCM agency (under MassHealth direction, moving out of the catchment area, etc.), the current (transferring) PCM Agency must notify the PAU at support@masshealthltss.com of the transfer of a consumer's PA to a new (receiving) PCM agency and ensure both the FI and the receiving PCM are aware and cc'd on the email. If the transfer is due to a consumer moving outside of the PCM catchment area, the PCM must supply the consumer with a list of agencies in their new catchment area and must initiate a transfer to another PCM agency of consumer choice within the new service area within 10 business days of notification of the new address.

All PCM Transfer requests emailed, securely, to the PAU must include the following information:

- MMIS PA number:
- Member's Name:
- MassHealth Member ID:
- Current PCM:
- New PCM:
- Effective date

***NOTE:** PCM Agencies cannot submit this information through MMIS, it must be via the support@masshealthltss.com email address.

Using the information supplied in the email, the PAU will update the Provider ID/Service Location (PID/SL) to the new (receiving) PCM on the PA.

PCMs must also be prepared to securely share a complete transfer packet with the receiving PCM agency. The transfer packet should contain the following:

- The Service Agreement
- The most recent Consumer Assessment
- A copy of the Surrogate/AP Assessment, if applicable
- A copy of the last evaluation
- Any additional supporting information that will be useful to the receiving PCM

Extensions for Transferring PAs

If a consumer needs to transfer PCMs and the expiration date of their PA is approaching, the PA can be extended to allow the new (receiving) PCM Agency sufficient time to conduct the re-evaluation once transferred. The transferring agency is responsible for extending the PA prior to the transfer request.

To request a PA extension for a consumer who is transferring, the PCM can follow the steps noted above in *Extensions* and select "Other (specify below)" as the 'Reason for Extension'. The PCM must write in the comment section that the request is due to a consumer transferring to another PCM Agency.

XI. Overtime

MassHealth requires an overtime prior authorization for consumers to schedule an individual PCA over the allowance of 50 hours in a single week. Hours worked are aggregated, which means that PCAs working for more than one consumer are required to obtain prior authorization to work overtime for each of their consumers. There are no changes to the rules for overtime between 40 and 50 hours; this means that PCAs can work for up to 50 hours without an overtime authorization.

Consumers must request authorization to schedule a PCA to work more than 50 hours and up to the maximum weekly hour limit in a single week in accordance with program regulations at 130 CMR 422.418(A), 130 CMR 422.412(K), and the PCA Overtime Policy. MassHealth will review the request and, if approved, will provide a time-limited authorization. MassHealth will use program regulations and health and safety guidelines to make approval determinations.

Scheduling a PCA to work overtime without prior authorization is a violation of the PCA program regulations. The Consumer and/or the PCA may be terminated from the PCA program after the third violation.

MassHealth and the PAU will approve prior authorizations for overtime if they have a temporary or long-term need for a PCA to work over 50 hours a week, but no more than the maximum weekly hour limit , and meet the criteria specified below in either Temporary Authorization or Continuity of Care Authorization.

Requests for all overtime authorizations must

- Include the specific reason(s) for such request; and
- Include required documentation to support the reasons for the overtime request**.**

Temporary Authorization

Temporary Authorizations are time-limited and can be requested for up to 12 weeks. Temporary authorizations are approved when at least one of the following conditions is present and the appropriate documentation is submitted with the PA request:

DURATION	ACCEPTABLE REASONS FOR THE REQUEST OF A TEMPORARY AUTH	TYPE OF DOCUMENTATION REQUIRED
Up to 12 weeks	The consumer needs time to hire additional PCAs	At least one of the following: - Printed ads offering PCA jobs or posted on any web or social media resource, including the PCA Directory - PCA termination forms with a specific reason provided
	The consumer has planned travel within the United States, including its territories, and it would not be possible to bring multiple PCAs to provide the consumer's PCA services.	Travel dates relevant to the request
	The PCA(s) left employment suddenly	When available, proof that the PCA left employment suddenly (resignation letters or other documentation)
	The consumer's PCA(s) is/are temporarily unavailable	Statement from the PCA explaining the reason for being temporarily unavailable, or for taking a short leave, and the dates when the leave will take place
	The consumer is receiving hospice care	At least one of the following: - Post-hospitalization and discharge summaries, provider's notes, or any other clinical supporting documentation relevant to the request - Hospice referral or care plan
	The consumer has a temporary medical need to schedule their PCA to work additional approved PA hours, including post-acute hospitalization **OR** Skilled Nursing Facility	At least one of the following: - Post-hospitalization and discharge summaries, provider's notes, or any other clinical supporting documentation relevant to the request - Proof of intensive ADL needs associated with a formal diagnosis (electronic medical records, doctors' letters)

Continuity of Care Authorization

Continuity of care (COC) authorization requests are approved for the length of the prior authorization for PCA services, and are approved when at least one of the following conditions is present:

DURATION	ACCEPTABLE REASONS FOR THE REQUEST OF A COC AUTH	TYPE OF DOCUMENTATION REQUIRED
COC lasts the duration of the PA for PCA services	The consumer needs time to hire additional PCAs because the consumer has one or more circumstances that make it difficult to hire additional PCAs	- Proof associated with the specific circumstance(s) that make it difficult for the consumer to hire additional PCAs - Supporting documentation that the consumer is actively recruiting PCAs, such as job postings, responses, etc. - PCA terminations with a specific termination reason
	The consumer receives Hospice Care	At least one of the following: - Post-hospitalization and discharge summaries, provider's notes, or any other clinical supporting documentation relevant to the request - Hospice referral or care plan
	The consumer has a medical need that requires intensive ADL care and needs to schedule the PCA to work additional approved PA hours. This also includes post-acute hospitalization **OR** post-Skilled Nursing Facility	- Proof of intensive ADL needs associated with a formal diagnosis (electronic medical records, doctors' letters)

Requesting an Overtime PA

The PAU reviews and adjudicates requests for overtime, and FFS covers the cost of the premium rate (half time) for all overtime regardless of the payor/plan. All consumers in all payor types are required to get an Overtime PA (includes SCO and OneCare) through the MassHealth PAU. CCM consumers must consult their CCM Case Manager for their Overtime PA submissions.

To make a request for overtime, the PCM Agency must:

a. Submit an "Overtime" PA request in the form and format required by MassHealth.
b. Select the Overtime PA type: 'Temporary Authorization' or 'Continuity of Care Authorization'
c. Select the reason(s) for the Overtime request from the pre-approved list of reasons (i.e. traveling, time to hire, etc.)
d. The PCM must also include:
    - A completed Overtime Request Form
    - Consumer's name, address, FI number, DOB, MID, phone number and surrogate information as applicable.

- The name, address, and PCA unique identifier of the PCA who needs to work overtime
- Documentation describing how this request meets the requirements of 130 CMR 422.418 (A)(3) specific to type of request submitted (temporary overtime authorization vs. continuity of care overtime authorization).
- Consumer and surrogate (if applicable) signature
- PCA provider signature
- PCM signature

Note: If a PCA works for more than one Consumer, the PCM must submit a separate Overtime request for each Consumer if in the aggregate, the PCA works more than 50 hours a week.. Each PA will have individual PA tracking numbers. (

Once submitted, the PAU will review the request and will:

a. Defer the request if any of the above criteria are missing.
b. Deny the request if the documentation submitted does not support the request.
c. Approve the Overtime PA if all information is in order.
d. Add a new external message will be created and sent to the PCM Agency, Consumer and the FI.

If a Temporary Authorization or Continuity of Care is preferred over the other for the same PCA worker, a termination request must be made for one and a new Overtime request for another. Please see the termination process. Dates are as follows:

1. Temporary Overtime Authorization request (130 CMR 422.418(A)(2)(a))
    - Start date is the Sunday immediately before the date of submission (or date of submission if Sunday)
    - End date is the Saturday, up to 12 weeks from the start date

2. Continuity of Care Overtime Authorization request (130 CMR 422.418(A)(2)(b))
    - Start date is the Sunday immediately before the date of submission (or date of submission if it is a Sunday)
    - End date is the Saturday immediately following the end date of the PA requiring a continuity of care overtime request (or the end date of the PA if it is a Saturday)
    - Continuity of Care authorizations should not be extended under any circumstances, including when the authorization for PCA services is extended. If the PCA authorization is extended, the PCM must submit another Overtime Authorization request with the end date of the extension for PCA services.

Once the PAU processes the Overtime PA, one of the following external messages will appear upon adjudication:

a. <u>Overtime Temporary PA Approved</u>
[Date]: MassHealth has approved your temporary authorization non-emergency overtime approval request. [PCA Name/ PCA Unique Identifier]. CID 2015

b. Overtime Temporary PA Modified
[Date]: MassHealth has modified your temporary authorization non-emergency overtime approval request due to PCM submission error. [Dates modified]. [PCA Name/ PCA Unique Identifier]. CID 2015

c. Overtime Continuity of Care PA Approved
[Date]: MassHealth has approved your continuity of care non-emergency overtime approval request. [PCA Name/ PCA Unique Identifier]. CID 2015

d. Overtime Continuity of Care PA Modified
[Date]: MassHealth has modified your continuity of care non-emergency overtime approval request due to PCM submission error. [Dates modified]. [PCA Name/ PCA Unique Identifier]. CID 2015

XII. Expedited PA Requests

As outlined in 130 CMR 450.000 MassHealth or its designee has a standard amount of days from the date of a request to adjudicate a PA. PA submissions may be marked as "Expedited" to request that it be adjudicated faster than the standard timeline. A PCM Agency can request to expedite any PA type, including re-evaluations and adjustment requests for PCA services under the following circumstances:

a. The PA request is for a consumer who is being discharged from an inpatient facility.
b. The consumer is receiving, or about to receive, hospice services.
c. An adjustment deemed as urgent by the PCM Agency (i.e. acute illness, post-op, absence of family member/primary caregiver) and as approved by the PAU's Associate Director or designee.

If any of the above circumstances arise for a Consumer, the PCM Agency must make every effort to expedite their evaluation process to submit a PA request as soon as possible.

To submit an Expedited PA Request, the PCM Agency:

a. Submits a NEW PA request for the type of PA needed (i.e., Initial, Re-eval, etc.) in the form and format required by MassHealth.
b. The PCM must select "Expedited". .
c. Once "Expedited" is selected, the PCM must utilize the Comment Section labeled 'If Expedited, Explain the Medical Necessity' to note the reason why the request is being expedited. Common notes may be "FACILITY DISCHARGE," "HOSPICE" or "URGENT NEED".
d. The PCM Agency must also follow the specific PA process associated with the type of PA request.

Once the Expedited PA request is submitted, the PAU will adjudicate within the allotted timeframe. If a PA request is submitted and does not meet the requirements to be expedited, the PAU may adjust the PA to be a standard PA request subject to standard PA adjudication timelines.

XIII. Denials

When the PAU's Clinical Reviewer determines that a PA request is not supported by medical necessity, the PAU will defer (See *Deferrals*) the PA to allow the PCM the opportunity to submit further information to support medical necessity.

Reasons for medical necessity denials may include:

a. Not meeting at least 2 ADL requirements (1414 - 130 CMR 422.403(C)(3))
b. Not clinically effective (1901 - 130 CMR 450.204(A)(1))
c. Not having a chronic disabling condition (1451 - 130 CMR 422.403 (C)(2))
d. Having sufficient functional ability (1464 -130 CMR 450.204(A)(1) AND 422.410 M)

If the need for medical necessity remains unsupported after a deferral, the PAU will deny the request. Failing to respond to a deferral may also result in denial.

XIV. Deferrals

If a PCM Agency submits a PA request that does not conform with all submission requirements (See above Sections of this document relevant to PA Type, the MassHealth PCA Regulations at 130 CMR 422.422 (C)(3) and (D), and the MassHealth's Standard Documentation to Include with a Prior Authorization Request for PCA Services), the PAU will defer the request back to the PCM Agency in order to provide the PCM Agency the opportunity to submit missing or additional documentation as soon as possible.

1. The PCM Agency can obtain the specifics regarding the missing, incomplete or expired documentation online by reviewing their Deferred List and choosing the relevant PA.

2. The PCM Agency must submit the missing, incomplete or updated non-expired documentation by. uploading the missing, incomplete or expired documentation..

3. If the PCM Agency submits the requested documentation within the required timeframe noted in the deferral (each PA will have a response date timeframe) , the PA will be adjudicated with the original requested PA start date.

4. PCM Agencies are strongly encouraged to submit the missing documentation as soon as possible to ensure no interruption of services.

5. If the PCM Agency does not have additional documentation to submit, the PCM Agency will respond to the deferral stating no further information can be provided.

If there is no response, the PAU will adjudicate the PA based on the original documentation submitted which may include an administrative or medical denial.

XV. Calculating Units

Unit calculation is as follows: Number of hours x 4 units x Number of weeks

- A traditional PA, such as a Re-evaluation or Initial, has 52.14 weeks and leap year has 52.28 weeks. The PA will contain total authorized units for the life of the PA and contain external messaging noting the authorized hours per week.

- All hours are calculated and combined onto one line item, Line Item A. Consumers can bill the authorized hours/units per week when required but the FI will notify them of any overbilling. Consistent overbilling may lead to a CAP being placed on a PA (where a Consumer will not be able to bill over the authorized hours per week).

- Hours are calculated using 15-minute increments and rounded up to the nearest quarter/increment (1-15 min = 0.25, 16-30 min = 0.50, 31-45 min = 0.75, 0.75-0.99 = **(next rounded up whole number)** (e.g. Authorized 250 minutes for PA: 250/60 minutes = 4.14 rounds to 4hrs and 15 minutes (4.25))
- Adjustments, including temporary adjustments, will be calculated based on the weeks being requested/authorized (i.e. start date of adjustment 9/1/2024 and end date 12/1/2024 = 13.14 weeks)
    a. Additional units will be calculated using the adjusted weeks, and adjusted hours. For example, current authorized hours = 20 hrs/week, increase approved = 5 more hrs/ for a total of 25 hrs/week. Calculations would be for the difference of 5hrs/week x 4 units x13.14 weeks = 263 units added to the PA line-item A.

*Please note: Calculation margins of 4 or less units do not need a PA correction.

XVI. PA Corrections

In the event that the PCM believes that there is an error that was made on an adjudicated PA, they should reach out to LTSS support by emailing support@masshealthltss.com .

Message Text Errors

Message texts are short paragraphs that describe the length, units, and hours of a PA.

If an error is made in a Message Text that gives the member the incorrect amount of hours on a PA, the PAU will provide 14 days' notice upon correction.

If there are 14 days between the start date of the PA and the date a correction is made, the correction will note the correctly authorized hours with the following message:

Date: MassHealth has modified your prior authorization for PCA services due to a MassHealth error in the message text. Corrected message is as follows: This Prior Authorization of PCA services is applicable for dates of service beginning XX/XX/XXXX and ending XX/XX/XXXX. You are authorized for XX hours and XX minutes PER WEEK. Note: all members must be in compliance with the MassHealth Overtime Policy. Please contact your PCM agency with any questions. CID XXXX

Calculation or Dates of Service Errors (Overlapped PA)

If the PA itself requires correction (beyond just the message text), the following will be done:

If a date calculation error occurs, the PCM will notify support via email (support@masshealthltss.com) and request for the correction. The assigned reviewer will review and correct as needed, and a new notice will be generated according to the error type as follows:

Date: MassHealth has modified your prior authorization for PCA services due to a (PCM or MassHealth) (error in dates of entering service or calculation error). (Corrected message as follows:). This Prior Authorization of PCA services is applicable for dates of service beginning XX/XX/XXXX and ending XX/XX/XXXX. You are authorized for XX hours and XX minutes PER WEEK. Note: all members must be in compliance with the MassHealth Overtime Policy. Please contact your PCM agency with any questions. CID XXXX

Consumers must have only one active PCA PA for specific dates of service. The PAU will determine the correct start dates of the new re-eval to prevent overlapping of dates. If the FI or PCM Agency determines that a consumer has been issued a PA with overlapping dates of another PCA PA (Initial or Re-eval), the FI or PCM Agency must notify support to request a correction by emailing support@masshealthltss.com

XVII. Terminations and Closures

There are several reasons why a PCA PA must be terminated. When a termination is needed, the PCM Agency must submit a PA Termination request to the PAU or directly to OLTSS. The PCM must also notify the FI of closed cases or terminations (Section 2.3 D(3)(j) and Section 2.2 I(4) of the PCM Agency Contract).

Termination Requests sent directly to the PAU:

Circumstances under which a PCA PA should be terminated through the PAU include the following:

i. Consumer is deceased
ii. Consumer lost MassHealth eligibility
iii. Consumer has enrolled in AFC/GAFC services
iv. Consumer is admitted to a nursing facility and will no longer use PCA services
v. Consumer has permanently moved out of area/out of state,
vi. Consumer is DDS eligible and is moving to a 24/7 staffed group home, or
vii. Consumer voluntarily refuses to utilize the PCA program any longer

A PCM agency should NOT submit a request for termination for an expired PA. The PAU will void these requests and will contact the PCM via email.

Please note that for Consumers who have lost Clinical eligibility for the PCA Program, their PA must be Adjusted rather than Terminated. (See *Adjustments*)

The PCM must notify the FI when a request to terminate PCA services is submitted to MassHealth when they are made aware that a consumer is deceased, or when a consumer is admitted or discharged to/from an inpatient facility for short or long-term stays.

a. If a termination is being requested for reasons noted above in i-vii, the PCM should:
    - Submit a "Termination Request" in the form and format required by MassHealth.
    - Note the reason for the termination of PA in the request (i.e. Moved Out of Area, Voluntary Program Refusal, etc.).
        - If a termination request is submitted due to clinical ineligibility, the PCM must include:

- The completed and signed RN/LPN evaluation reflecting consumer no longer being clinically eligible for program
- PA# of the active PA to be terminated.
- Reason for the termination request including the clinical rationale for termination of PCA services.

- If the termination request is occurring because the consumer no longer intends to use PCA services, the request must contain a written notification from the consumer/surrogate stating their intent to end services. If the PCM cannot obtain written notification from the consumer/surrogate, the PCM must submit documentation of progress notes to support termination in lieu of written request by consumer /surrogate. The progress notes must include:
  - Date of Conversation
  - Who was spoken to (surrogate, consumer)
  - Name of PCM staff member
  - Dates of service reflecting the original start date
  - New expiration date of current PA

b. Once the PCM submits the termination PA request:
   - The PAU VOIDS the new termination PA request submitted by the PCM Agency and enters internal comments. Additional information regarding the void is communicated to the PCM.
   - The PAU will terminate the current PA in MMIS and will add 14 calendar days to the date of adjudication.

Note: If the reason for termination is because consumer is deceased, the PAU will end the PA effective the date the PCM submitted the request. If a PA has already expired prior to the date the PAU received the request, the PAU will keep the same effective end date on the letter and not extend 14 days.

- The PAU terminates the current PA in MMIS by changing the expiration date of the PA. A PA notice is forwarded to Consumer along with appeal rights, and to the PCM Agency and FI via external text message.

The PAU does **not** process PA terminations for the following reasons:

i. Consumer is failing to participate in evaluations/meetings with the PCM, failing to use EVV, or is unable to contact for scheduling of evals, FST, etc.
ii. Consumer is not utilizing the program (non-utilization)
iii. Consumer does not have a surrogate and requires one
iv. Suspected fraud
v. Consumer is at short term rehabilitation facility
vi. Consumer is out of state temporarily

Reasons noted directly above, at i-iv, are processed by OLTSS. Please see “OLTSS TERMINATIONS” section for those scenarios. For scenarios, v. and vi, PCMs do not need to request a termination but should monitor those consumers closely to ensure that they do not fall into another category of termination (i.e. Failing to participate in required activities for the program).

OLTSS Termination Requests

The PAU will receive terminations directed by OLTSS via email for the following reasons and procedures:

a. *Terminating PCA Services due to Failure to Participate/Unable to contact:* The PCM must send a 30-day failure to participate letter to the consumer after failing to comply after three attempts of MassHealth or PCM request for consumer participation in the program, in accordance with 130 CMR 422.420(A). The PCM must notify OLTSS, via email, with a copy of the letter sent to Consumer, progress notes that support the request for termination, and a copy of the termination spreadsheet with the Consumer information.

   If after 30 days, the Consumer does not cooperate with their PCM to participate in the program rules, MassHealth will send a letter notifying the Consumer that their PA will be terminated in 14 days. OLTSS will send the termination request to the PAU after confirmation that all appropriate communications occurred with the Consumer and they have still yet to come into compliance.

b. *Terminating PCA Services for failing to use Electronic Visit Verification (EVV):* The PCM will send a 30-day failure to use EVV letter to the consumer for refusing to use EVV after outreach by the PCM on multiple occasions (Consumer has gone at least 3 pay-periods without EVV compliance i.e. gets '3-strikes'). The PCM must notify OLTSS, via email, with a copy of the letter sent to the Consumer, progress notes that support the request for termination, and a copy of the termination spreadsheet with the Consumer information.

   If after 30 days, the Consumer does not cooperate with their PCM to become compliant with EVV use, MassHealth will send a letter notifying the Consumer that their PA will be terminated in 14 days. OLTSS will send the termination request to the PAU after confirmation that all appropriate communications occurred with the Consumer and EVV is not in use.

c. *Terminating PCA Services due to lack of required Surrogate:* If the PCM, FI, or MassHealth determines that a Consumer needs a surrogate or needs to identify a new surrogate, the PCM will send a letter to the consumer giving them 30-days to identify a new surrogate. The PCM must notify OLTSS, via email, with a copy of the letter sent to Consumer, a copy of the Consumer's last Consumer Assessment, progress notes that support the request for termination, and a copy of the termination spreadsheet with the Consumer information.

   If after 30 days, the Consumer cannot identify a new surrogate, MassHealth will send a letter notifying the Consumer that their PA will be terminated in 14 days. OLTSS will send the termination request to the PAU after confirmation that all appropriate communications occurred with the Consumer and no surrogate has been appointed.

NOTE: If a terminated consumer demonstrates that they would like to return to the program, are still eligible, and are willing and able to comply with the program rules, PCMs should follow the Reinstatement process outlined in *Reinstatements*.

Any time an agency is aware of a change to a Prior Authorization status, it is best practice to alert the Fiscal Intermediary.

Closures

When a Consumer does not utilize the PCA program for 6 or more months, the PCM should determine if an internal 'closure' is necessary.

a. Consumers who are identified on the monthly non-utilization report should be reviewed by the PCM agencies..
b. The PCM must close the Consumer in their internal system and email the FI at inboxbudgetmanagement@tempusunlimited.org

XVIII. Reinstatements

If a Consumer is terminated from the PCA program for failing to comply with the program rules outlined at 130 CMR 422.420(A) (i.e. Unable to Contact, Failure to Participate, Failure to Identify a Surrogate, Failure to Utilize EVV), and later can demonstrate compliance with the rules, the PCM can request a reinstatement to resume Consumer's PCA services. A reinstatement will utilize an administrative PA extension to cover from the date of compliance with the rules, through the original end date (inclusive of extensions) prior to the Consumer's termination. Reinstated PAs can be adjusted, but they cannot be extended.

Since the reinstatement will start on the day of compliance and go through the original end date of the PA, there will be a gap in PA coverage. PCMs should not request to fill a gap on a reinstated PA unless specifically directed by OLTSS. Consumers should not schedule PCAs to work if they have been terminated from the program.

MassHealth will not reinstate a Consumer if:

- The original PA end date has passed (is expired) **OR**
- The original PA end date prior to termination (inclusive of approved extensions) is within 30 calendar days.

Consumers that do not meet the criteria for reinstatement should be prioritized by PCM agencies for a re-evaluation and have a new PA submitted on their behalf.

To request a Reinstatement, the PCM must:

a. **Speak with the Consumer/Surrogate to ensure compliance with the program rules. PCM must ensure that** Functional Skills Training is completed related to the task(s) that the Consumer was originally terminated for.
b. PCMs must determine how long the Consumer has been terminated and reach out to OLTSS.
    i. PCM must email PCATerminations@mass.gov and cc the respective Coordinator with the Consumer name, PA information, and progress notes that support a reinstatement PA request.
    ii. For reinstatements requests made **within 5 calendar days after the termination date**, OLTSS may reinstate without the need for PCMs to complete an online submission leaving no gap in the PA.

iii. OLTSS will send the PCMs an email confirming whether a reinstatement is appropriate. PCMs must save the email communication. If directed by OLTSS to submit a reinstatement PA request.

c. PCMs should complete an Extension request and denote that it is a "Reinstatement per OLTSS".

d. Attach the required documentation with the reinstatement PA request:

i. A copy of email from OLTSS confirming that the Consumer may be reinstated; the email should include:

1. The PA number
2. The dates of approval by OLTSS
3. The approving OLTSS staff member

ii. Contact notes that contain the following information:

1. The reason that the Consumer was originally terminated
2. The action that the Consumer took to come back into compliance
3. The date that the Consumer came back into compliance
4. Please note that contact notes should all contain the date of contact, the phone number contacted, and the reason for the contact attempt.

Once the reinstatement PA request is submitted, the PAU will review the required information. If all information is submitted, the request will be approved. If the submission is missing information, the PA Request will be Voided. The PAU will create an encounter and inform the PCM what is incomplete.

Upon approval of a reinstatement, PCMs must notify the FI via intake@tempusunlimited.org to ensure the consumer is active in their systems and that the PCA will be paid.

XIX. Appeals/Hearings

When a consumer disagrees with a decision on a PA, the consumer has the right to request a fair hearing on the decision in accordance with the Board of Hearings (BOH) regulations at 130 CMR 610.000. As of January 1, 2026, Consumer's may also appeal a modification decision that decreased the approved weekly hours back to the number of hours from the immediately preceding prior authorization that ended within the past year of the present prior authorization approval date. To submit any appeal, the Consumer must submit the Fair Hearing Request Form that is provided with the Consumer's MMIS PA notice to the BOH in the timeframes specified in the BOH regulations. If a Fair Hearing Request Form is received within the specified timeframes, the PAU must implement "aid pending", if the criteria is met, as well as implement the BOH final decision.

When a consumer appeals a decision by MassHealth, and the consumer is authorized to receive PCA services at the time of MassHealth's decision, MassHealth must continue to provide PCA services at the amount authorized prior to the modification/denial if:

- The BOH receives the initial request for a fair hearing before the implementation date of the appealable action; or
- The appealable action was implemented before a timely request for a hearing and the BOH receives the request for a fair hearing within 10 days of the MassHealth/Optum mailing of the notice of appealable action.

Note: Aid pending remains in place until such time as the BOH renders a written decision to MassHealth or the hearing request is withdrawn or dismissed

If a Consumer receives Aid Pending while awaiting an appeal decision, the Consumer may be eligible to keep their benefits between the time the appeal is submitted and the time that the Board of Hearings makes a written decision to approve or deny the appeal. If a consumer decides to keep their benefits while the appeal is pending, and then loses the appeal, they may have to pay back the cost of the benefits received. If the consumer does not get benefits, and then wins the appeal, MassHealth will restore benefits. The consumer will keep their benefits if the hearing form is received either before the benefits stop or within 10 calendar days from the date, they receive the MassHealth notice, whichever is later. Consumers must mark their choice in the 'Other Information' section of the Fair Hearing form.

PCM Agencies should continue their re-evaluation process as usual, regardless of the timing of scheduled hearings or hearing decisions.

XX. Reporting A New Surrogate or Change in Surrogate

Consistent with MassHealth regulations at 130 CMR 422.422 (B)(5) regarding Surrogates, the PCM Agency must provide the MassHealth agency and the FI with the name, address, email address, and phone number of the consumer's surrogate, and report any changes in surrogate information.

If a Surrogate is needed, the PCM Agency must:

1. Conduct a written assessment of the consumer's capacity to manage PCA services independently in accordance with the PCM Contract.
2. A full assessment is not required if the consumer has a legal guardian or is a minor. All consumers who are minors or who have legal guardians must have a surrogate.
3. The PCM Agency must complete all appropriate surrogate information on the MassHealth Evaluation for PCA Services form and the MassHealth PCA Re-evaluation form when submitting a PA request.
4. The PCM Agency must maintain the surrogate's name, address, email, telephone number and relationship to the consumer in the consumer's record and forward a copy of the information to the FI and forward any updates to the FI should a consumer's surrogate information change.
5. The PCM Agency must notify the FI of any surrogate changes listed below that occur during a PA year by e-mailing the FI (Intake@tempusunlimited.org) (enter SURROGATE CHANGE in the subject line). The e-mail must include:
    - Consumer Name
    - Consumer Number
    - New Surrogate Name
    - Pg.8 of the Service Agreement
    - Surrogate/AP cover page
6. The FI will document Surrogate Change and update surrogate related information in their system.

XXI. Circumstances Under Which PAU Conducts Home Visits

As part of the PAU scope of work, and under direction of OLTSS, PAU Clinical Reviewers may conduct home visits independently or with PCM Agencies. The PAU may initiate the request to attend a Home Visit, or the PCM may ask the PAU to attend.

PAU Initiates Home Visit:

The PAU Clinical Reviewer may initiate a home visit as a means of gathering additional information to make determination on medically necessary PCA services or to observe the PCM Agency evaluation process.

Situations where a home visit to gather additional information that will benefit the PAU's medical necessity review include:

a. Consumer has a high volume of appeals on PCA services
b. Consumer has significant residential supports from other agencies
c. PCM Agency has requested a significant increase in hours without a documented change in the consumers' medical condition or living situation.
d. Calls/complaints from the consumer or external parties (political, legal, other state agencies) regarding the level of services being authorized or utilized.

Situations that may require observation of the PCM Agency evaluation process:

a. PAU Clinical Reviewer new hire/training orientation
b. PAU Clinical Reviewer annual training curriculum.
c. Trends/patterns in prior authorization requests for a specific PCM Agency.

The PAU will collaborate with MassHealth and the PCM Agency to coordinate home visits so that all parties are aware of the intent of the home visit. Under no circumstances will there be an interruption of services for the consumer.

PCM Agency Initiated Requests for PAU to Conduct Home Visits

The PCM Agency may initiate a request for the PAU to complete a home visit as a means to better understand the PAU rationale for decisions. Situations where this may be appropriate include:

a. Cases with repeated modifications year after year (repeated prior authorization requests that are continually modified).
b. Complex cases in which the determination of medical necessity has been difficult.
c. Calls/complaints from the consumer or external parties (political, legal, state agency) regarding level of services being authorized or utilized.
d. Situations where there are questions related to the appropriateness of PCA services versus skilled nursing service.

The PAU will collaborate with MassHealth and the PCM Agency to coordinate home visits so that all parties are aware of the intent of the home visit. Under no circumstances will there be an interruption of services for the consumer.

XXII. Transitional Living Program

Transitional Living Program (TLP) services are Prior Authorized in accordance with the regulation 130 CMR 422.431. Any entity requesting a PA for TLP consumer must be registered with MassHealth as a TLP Provider.

PA requests for TLP are not submitted online. TLP PA Requests must be emailed to PCA.Coordinators@mass.gov. The request must include:

1.) The dates for which the PA is being requested
2.) The Name and MassHealth ID of the Consumer
3.) Attach the “Request for Prior Authorization” Form
4.) Attach the “Evaluation” Form

Note: TLP is not a wrap service. If a Consumer is enrolled in an ICO or SCO plan, the TLP must seek payment from the consumer’s plan.

XXIII. Helpful Resources and References

Medical Necessity	The MassHealth agency does not pay a provider for services that are not medically necessary and may impose sanctions on a provider for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary. Please see the regulation at 130 CMR 450.204 for specific information on Medical Necessity. The documentation for ADL service on the PA requests must include documentation to support the medical necessity of the request in accordance with 130 CMR 422.416 and the *List of Standard Documentation to Include with a Prior Authorization for PCA Services.* If more PCA hours are requested the following year for a PCA re-evaluation, documentation must be provided to support the need for the additional time requested.
Appeals and Aid Pending	"Aid Pending" is the terminology used to reference the "Continuation of Benefits Pending Appeal" noted at 130 CMR 610.036. This regulation states that when an appealable action involves the reduction, suspension, termination, or restriction of assistance, such assistance will be continued until the Board of Hearings decides the appeal or, where applicable, the rehearing decision is rendered if the Board of Hearings receives the initial request for the fair hearing before the implementation date of the appealable action. See 130 CMR 610.00: MassHealth: fair hearing rules | Mass.gov Eligibility Operations Memo 23-05: Clarification of MassHealth Fair Hearing Rules Related to Aid Pending
Skilled service vs. Unskilled service	PCA services may be requested for unskilled care. Skilled clinicians, parents, legal guardians or designee(s) are responsible for providing skilled care services that may be considered high **risk and affect the safety of the consumer, both pediatric and adult. These services require individuals with training in specialized skills and clinical assessment**. Examples include Intravenous (IV) admin or care, Total Parenteral Nutrition (TPN) administration, complex wound care, complex vent care, and deep tracheostomy suctioning.

	Passive Range of Motion (PROM) is sometimes conducted by skilled Physical Therapists (PT)/Occupational Therapists (OT)/nurses. If PROM is conducted by skilled OT/PT (specific days per week) in conjunction with a therapeutic treatment program for a specific condition (like spasticity), then frequency of the task should be documented and adjusted in the request. PROM is not considered a skilled activity within the context of the MassHealth PCA Program. Consumers (or surrogates) may direct PCAs to perform PROM, when it is considered an unskilled ADL activity. Tasks authorized under a Complex Care Prior Authorization will be considered Unskilled Services.
Passive Range of Motion	Passive Range of Motion (PROM) is movement applied to a joint or extremity by another person solely for the purpose of maintaining or improving the distance and direction through which a joint can move. It is not a strengthening exercise. MassHealth does not approve PCA services for exercise or active ROM. In the PCA program, PROM is considered an activity of daily living (ADL). PROM, as an unskilled ADL activity, may be performed by PCAs. PCAs should be trained by the consumer or surrogate to perform PROM. A consumer can do his/her own range of motion (ROM) if and when he/she or the surrogate has the knowledge and understanding of their range of motion in appropriate joints/extremity. When a consumer has the strength and endurance to do their PROM unassisted, then there is no medical necessity for a PCA to perform PROM. PROM may be requested for the joints/extremities that the consumer has limited or no ability to perform his/her own ROM on. The OT's functional status assessment, completed as part of the initial PCA evaluation, should document the current range of motion restrictions. PROM should be documented on initial evaluation by the nurse (need/medical necessity, time and frequency); as part of this initial evaluation, the nurse should consider the OT's functional status assessment. On re-evaluations, the nurse or OT must document any ongoing PROM (need/medical necessity, time and frequency).
Instrumental Activities of Daily Living (IADL)	When requesting time for IADLs, the PCM agency should review 130 CMR 422.410 for qualifying IADLs, and must assume the following: (1) When a member is living with family members, the family members will provide assistance with most IADLs. For example, routine laundry, housekeeping, shopping, and meal preparation and clean-up should include those needs of the member.

	(2) When a member is living with one or more other members who are authorized for MassHealth PCA services, PCA time for homemaking tasks (such as shopping, housekeeping, laundry, and meal preparation and clean-up) must be calculated on a shared basis. (3) The MassHealth agency will consider individual circumstances when determining the number of hours of physical assistance that a member requires for IADLs
Family member	Family Member is defined in the PCA Program as: the spouse of the consumer, the parent of a minor consumer, including an adoptive parent, or any legally responsible relative.
Administrative Proxy	Administrative Proxy (AP) is defined in the PCA Program as: The member's legal guardian, a family member, or any other person as identified in the service agreement who is responsible for performing certain administrative functions related to PCA management that the member is unable or unwilling to perform. Please note that the AP role is not the same as the Surrogate role.
Surrogate	Surrogate is defined in the PCA Program as: the member's legal guardian, family member, or other person older than 18 years of age as identified in the service agreement, who is responsible for performing certain PCA management tasks that the member is unable or unwilling to perform
Schematics Pediatric Tool	The Schematics of Age Ranges at which Non-Disabled Children Master Functional Items tool using the 50% percentile for clinical assessment will continue to be used. Please see the tool above in *Schematics of Age Ranges at which Non-Disabled Children Master Functional Items*
Parental Responsibility and non-covered services	Consistent with the Operating Standards last revised in 2015, the Personal Care Program Regulations at 130 CMR 422.410 (D), 422.412(J), and 422.422(C) and 422.422(D) specifically address parental responsibility and family member obligations related to the time requested and approved for the PCA tasks. PCMs should review these regulations prior to PA submission for minors. The PAU will utilize these regulations in their review for medically necessary services. Parents/legal caregivers are responsible for providing assistance and care for a minor, including for ADLs and IADLs, that is typical for a child of the same age and developmental stage. PCA services are not intended to supplant or replace those ordinary parental ADL/IADL responsibilities. For example, consistent with developmental milestones, parents are expected to support bathing, feeding, dressing, toileting, laundry, housekeeping and shopping. PCA services for minors will not be authorized for tasks that the Clinical

	Evaluator determines would typically be provided by a parent due to the child's functional ability and age range for the mastery of those functional skills; (i.e. PCA services will not be authorized for toileting a 1-year-old child who cannot toilet themselves). PCA services shall not be utilized for babysitting, cueing, supervision, or coaching.
Definition of Disability in Children (the Office of Social Security Website)	The law defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. Under title XVI, a child under age 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months. A medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only be the individual's statement of symptoms. *https://www.ssa.gov/disability/professionals/childhoodssi-pub048.htm*
Service Animals	The time specified will be utilized when adjudicating Personal Care Attendant (PCA) requests containing time to care for a Service Animal (either a dog or miniature horse). The allowable time is based upon the consumer's overall level of assistance. The time allowed can be used as needed to care for their service animal, including care, feeding, vet appointments, etc. The below time is the maximum time allowed for Service Animal care. 1. Consumer with Overall Minimum Assistance: 1 Hour per week maximum 2. Consumer with Overall Moderate Assistance: 1.5 Hours per week maximum 3. Consumer with Overall Maximum Assistance: 2 Hours per week maximum 4. Consumer with Overall Total Dependent Assistance: 2.5 Hours per week. Requests for Service Animal care time should be documented in the IADLs section of the Time-to-Task Tool. Allowable Time

	1. If the requested time for the Service Animal is below the allowable maximum time, the service will be approved for the amount of time requested. If the requested time for the Service Animal exceeds the allowable time, the request will be modified based upon the consumer's overall level of assistance.
LINKS:	PCM Agency Resources Page: Personal Care Management Agency | MassHealth LTSS Provider Portal PCA Regs- 130 CMR 422.000: Personal Care Attendant Services | Mass.gov Bulletins- MassHealth provider bulletins by provider type O - P | Mass.gov Transmittal Letters- MassHealth Personal Care Attendant Transmittal Letters | Mass.gov
Documentation Best Practices	Documents submitted for a PA should contain 2 identifiers so the PAU may confirm the identity of the member. Documentation submitted for each PA should be unique and specifically tied to the member who the PCM is requesting a PA for. Instances of copying/pasting information can increase the likelihood of HIPPA violations (submitting the incorrect member's information on a PA) and may lead to deferrals, denials, or voids.
Documents/Forms in PA Submission:	As noted at *Identifying Duplication of Services*,, when submitting or authorizing PCA prior authorization requests, the PCM Agency and PAU must make every effort to ensure PCA services are medically necessary and are not requested or authorized for times that the member is participating in other MassHealth programs as described in 130 CMR 422.412 (E) (F), or that the PCA services being requested are not otherwise provided through another service provider or payer. Because of this, the PAU may request additional information from the PCM. Please see the *Standard Documentation to Include with a PA Request for PCA Services* (Standard Doc Form) for details related to those documents and when they may be required for submission. **Consumer/Surrogate/Legal Guardian Signature Requirements:** PCM agencies are required to obtain signatures from Consumers, Surrogates, or Legal Guardians on all required forms and documentation, including (but not limited to) Initial Clinical Evaluations, Clinical Re-evaluations, Consumer Assessments,

	Service Agreements, and Overtime Prior Authorization Requests, according to the PCA program regulations at 130 CMR 422.000. Consumer Assessment forms must be completed on an annual basis. **Consumer Assessment Form:** The "Consumer Assessment to Manage PCA Services," or the "Consumer Assessment." MassHealth requires Personal Care Management (PCM) agencies to complete a Consumer Assessment for every Consumer who applies for, or is approved for, Personal Care Attendant (PCA) services. **PCP Summary Form:** the *PCP Summary Form for PCA Services* must be fully completed and signed by the member's primary care provider in order to be evaluated for PCA Services. If the Consumer requires Complex Care, the correct criteria for Complex Care must be outlined on this form (*See Bulletin 17*). **The Request for Prior Authorizations for PCA Services (Portal PCA – 1):** PCMs may find references to "the PCA-1" – This was previously a paper form but has been built into an online system as part of the PA Submission. The paper form is still available on the PCM Agency Resources page at masshealthltss.com. **Adult Evaluation for PCA Services (Portal PCA- 2):** PCMs may find references to "the PCA-2" – This was previously a paper version of the Adult Time-To-Task but has been built into an online system as part of the PA Submission. The paper form is still available on the PCM Agency Resources page at masshealthltss.com. **Pediatric Evaluation for PCA Services (Portal PCA-2):** PCMs may find references to "the PCA-2" – This was previously a paper version of the Adult Time-To-Task but has been built into an online system as part of the PA Submission. The paper form is still available on the PCM Agency Resources page at masshealthltss.com.