MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services

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Request and Justification for Home Health Therapy Services

Complete and attach this form when submitting a prior-authorization (PA) request for physical, occupational, or speech/language therapy on paper or using MassHealth's Provider Online Service Center (POSC). If submitting a PA request through the POSC, providers can download the form from the POSC or complete the form online and submit it electronically as part of the request. **ALL** sections must be completed for consideration and to avoid a delay in decision by MassHealth. Enter "N/A" if a section is not applicable.

I. Provider information

Provider name _____ Group provider ID/SL _____

Provider address _____

Provider telephone no. _____ Individual provider ID/SL _____

II. Member information

Last name _____ First name _____ MI _____

Member date of birth (mm/dd/yyyy) _____ MassHealth member ID no. _____

III. Other insurance information

MassHealth is the payer of last resort. The provider must make a diligent effort to verify whether other insurance exists and to obtain payment first from the other insurance.

Other insurance carrier _____ Policyholder's name _____

Policy no. _____

Has the insurance carrier changed since the last PA request? ☐ yes ☐ no

Why is the requested service not covered by this insurance? _____

IV. Prescribing Provider referral

Prescribing Provider name _____ Address _____

Primary medical diagnosis name and ICD-CM diagnosis code _____

Secondary medical diagnosis name and ICD-CM diagnosis code _____

Date of onset _____ Date of referral _____

Reason for referral for therapy services _____

V. Health-related services currently provided to the member

Check the box for each service below that member is currently receiving. Enter "NA" if the member is not receiving the service. **Note: It is the responsibility of the provider to request this information from the member or parent/guardian, to ensure requested services are not duplicative.**

Service	Frequency and payer
☐ Adult day health	
☐ Chapter 766/School-based Medicaid	
☐ Day habilitation	
☐ Early intervention services	
☐ Home health aide	
☐ Hospice	
☐ Nursing services	
☐ Occupational therapy	
☐ Personal care attendant	
☐ Physical therapy	
☐ Speech/language therapy	
☐ Other (specify) _____	

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VI. Requested Therapy and, if applicable, Home Health Aide Services

ALL Sections must be completed to avoid a delay in processing of the PA.

Location of service delivery ☐ home ☐ or other (explain) _____

Date of initial evaluation _____ Date of reevaluation (if applicable) _____

Has (or will) the member used all of the visits allowed without PA as part of the current treatment plan? ☐ yes ☐ no

If yes, estimate the number of additional visits that will be needed to achieve treatment goals. _____

How do your goals differ from the other therapy services currently being provided? _____

_____

What other therapy services has the member received in the past 12 months? _____

_____

In what specific ways do your goals differ from other services currently being provided to the member in other settings (e.g., school, early intervention, home health, etc.)? _____

_____

Who will be responsible for the carryover of the home exercise program, if applicable? _____

If other than the member, is this person able to attend therapy sessions on a regular basis to obtain training? ☐ yes ☐ no

If yes, has the member been compliant with the home exercise program to date? ☐ yes ☐ no

Please indicate the type, frequency, duration, and length of visit per day that you are requesting.

Type	Frequency per week (i.e., number of visits)	Estimated duration (i.e., weeks, months)	Length of visit per day
Physical therapy	_____	_____	_____
Occupational therapy	_____	_____	_____
Speech/language therapy	_____	_____	_____
Home Health Aide	_____	_____	_____

VII. Medical necessity

MassHealth does not pay for therapy services unless they are medically necessary as specified in 130 CMR 450.204, and meet the applicable MassHealth Guidelines for Medical Necessity.* Providers should address how the services

- provide specific, effective, and reasonable treatment of the member's diagnosis and physical condition;
- are directly and specifically related to an active treatment regimen;
- are of a level of complexity and sophistication that the judgment, knowledge, and skills of a licensed therapist are required;
- can achieve a specific diagnosis-related goal; and
- are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity.

Provide a brief summary below of the medical necessity for the treatment you are proposing, including individual therapies and therapeutic activities. **If requesting home health aide services, please include a description of how these services will be utilized in your treatment plan. This field must be completed and legible. See attached is not acceptable.**

_____

_____

What are the objective measures you have used to chart progress toward the stated goals? **This field must be completed.**

_____

_____

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VIII. Home Health Aide Services

If requesting home health aide services in addition to skilled therapy services, indicate member's functional level for all items below.

You must complete this section only when requesting home health aide services.

Cognitive

- ☐ Alert/Oriented
- ☐ Able to Direct Care
- ☐ Impaired/Developmental Delay
- ☐ Disoriented

Bathing

- ☐ Independent
- ☐ Requires Set-Up/Minimal Assistance
- ☐ Requires Moderate Hands-on Assistance
- ☐ Requires Total Assistance, Unable to Participate

Dressing

- ☐ Independent
  - ☐ Lower Body ☐ Upper Body
- ☐ Requires Set-Up/Minimal Assistance
  - ☐ Lower Body ☐ Upper Body
- ☐ Requires Moderate Hands-On Assistance
  - ☐ Lower Body ☐ Upper Body
- ☐ Requires Total Assistance, Unable to Participate

Toileting

- ☐ Independent
- ☐ Requires Set-Up/Minimal Assistance
- ☐ Requires Moderate Hands-On Assistance
- ☐ Requires Total Assistance, Unable to Participate

Ambulation

- ☐ Independent
- ☐ Requires Set-Up/Minimal Assistance
- ☐ Requires Moderate Hands-On Assistance
- ☐ Requires Total Assistance, Unable to Participate

Grooming

- ☐ Independent
- ☐ Requires Set-Up/Minimal Assistance
- ☐ Requires Moderate Hands-On Assistance
- ☐ Requires Total Assistance, Unable to Participate

Eating

- ☐ Independent
- ☐ Requires Set-Up/Minimal Assistance
- ☐ Requires Moderate Hands-On Assistance
- ☐ Requires Total Assistance, Unable to Participate

Range of Motion Exercises

- ☐ Independent
- ☐ Upper Extremities
- ☐ Lower Extremities

Other:

_____

_____

_____

_____

Comments:

_____

_____

_____

_____

Important: You must attach a copy of the current prescription for therapy services and signed 485, if applicable, for all requests in addition to completing this section. If requesting home health aide, please include the home health aide plan of care. For first and subsequent requests, you must also attach a copy of your initial comprehensive evaluation, or most recent reevaluation, and at least the four most recent treatment notes or progress reports.

* Please refer to the MassHealth *Guidelines for Medical Necessity Determination for Physical Therapy*; the MassHealth *Guidelines for Medical Necessity Determination for Occupational Therapy*; or the MassHealth *Guidelines for Medical Necessity Determination for Speech and Language Therapy*, as applicable, for additional information. These MassHealth guidelines are located on the MassHealth website at www.mass.gov/masshealth/guidelines.

Signature

Therapist's name and title _____

Therapist's signature _____ Date _____

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