

**Michigan Department of Health and Human Services**  
**Completion Instructions for MSA-115**  
**Occupational Therapy - Physical Therapy -**  
**Speech Therapy**  
**Prior Approval Request/Authorization**

**General Instructions**

The MSA-115 must be used by Medicaid enrolled outpatient hospitals, outpatient therapy providers, nursing facilities and home health agencies to request Prior Authorization (PA) for therapy services. MDHHS requests that the MSA-115 be typewritten to facilitate processing. Fill-in enabled copies of this form can be downloaded from the Michigan Department of Health and Human Services (MDHHS) website [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders) >> Policy and Forms >> Forms. The request for PA must be complete and of adequate clarity to permit a determination of the appropriateness of the service without examination of the beneficiary.

PA may be authorized for a period not to exceed three months for outpatient therapy providers and outpatient hospitals, or two months for home health agencies and nursing facilities. If continued treatment is necessary, a subsequent request for PA must be submitted. The provider should retain a copy of the PA form until the approval or denial is returned.

For complete information on covered services and PA requirements, refer to the Hospital, Outpatient Therapies, Nursing Facility or Home Health Chapters of the Michigan Medicaid Provider Manual.

**Attachments/Additional Documentation**

Any additional documentation submitted with the request must contain the beneficiary name and **mihealth** card number, provider name and address, and the provider's NPI number.

When requesting the initial PA, the provider must attach a copy of the initial evaluation and written treatment plan to the PA request.

**Form Completion**

The following fields must be completed unless stated otherwise:

Box Number(s)	Instructions
<b>Box 1</b>	MDHHS use only.
<b>Box 2 - 3</b>	The Medicaid enrolled provider's name and National Provider Identifier (NPI).
<b>Box 4 - 6</b>	The provider's telephone number (including area code), address and fax number (including area code).
<b>Box 7- 10</b>	The beneficiary's name (last, first, and middle initial), sex, <b>mihealth</b> card number, and birth date (in the eight-digit format: MM/DD/YYYY). The information should be taken directly from the <b>mihealth</b> card and should be verified through the Community Health Automated Medicaid Processing System (CHAMPS) (Eligibility Inquiry and/or 270/271 transaction).
<b>Box 11</b>	The date the beneficiary was most recently admitted to the hospital or facility.
<b>Box 12</b>	Enter the beneficiary's diagnosis(es) code(s) and description(s) that relate to the service being requested.
<b>Box 13</b>	The date of onset must be entered. The approximate date of exacerbation must be cited if the beneficiary has a chronic disease (e.g., arthritis) and recently suffered such exacerbation.
<b>Box 14 -16</b>	The therapist's name, office telephone number (including area code), and applicable license/certification number.
<b>Box 17</b>	<b>Initial:</b> The treatment authorization request is the initial prior authorization request for the beneficiary under this treatment plan. <b>Continuing:</b> The treatment authorization request is to continue treatment for additional calendar month(s) of service under this treatment plan.

AUTHORITY: Title XIX of the Social Security Act.  
 COMPLETION: Is Voluntary, but is required if payment from applicable programs is sought.

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Box Number(s)	Instructions
<b>Box 18</b>	The date MDHHS signed the last approved prior authorization request for the given diagnosis.
<b>Box 19</b>	The calendar months in which treatment is to be rendered, in a two-digit format (e.g., April should be shown as 04, April - May should be shown as 04, 05).
<b>Box 20</b>	The date treatment was started for the given diagnosis (if treatment was initiated previously).
<b>Box 21</b>	The total number of sessions rendered since the development of this treatment plan.
<b>Box 22</b>	Goals must be measurable. In functional terms, the provider's expectation for the beneficiary's ultimate achievement and the length of time it will take (e.g., ambulation unassisted for 20 feet; able to dress self within 15 minutes; oral expression using 4-5 word phrases to express daily needs). See Medicaid Provider manual for additional documentation requirements.
<b>Box 23</b>	Documentation of the beneficiary's progress from the prior month to the current time in reference to the measurable and functional goals stated in the treatment plan. Documentation of the beneficiary's nursing and family education may be included. The final month of anticipated treatment should include the discharge plan for the carry-over of achieved goals to supportive personnel. See Medicaid Provider manual.
<b>Box 24</b>	Indicate if the beneficiary is receiving therapy services through a school-based services program.
<b>Box 25</b>	Complete a separate line for each unique HCPCS code/modifier combination.
<b>Box 26</b>	The Outpatient Therapy and Home Health Databases on the MDHHS website list the HCPCS Codes that describe covered services. The database is located at the MDHHS website <a href="http://www.michigan.gov/medicaidproviders">www.michigan.gov/medicaidproviders</a> >> Billing and Reimbursement >> Provider Specific Information.
<b>Box 27</b>	The Outpatient Therapy Database on the MDHHS website lists the required modifiers used to describe covered services for outpatient hospital and nursing care facility providers. The database is located at the MDHHS website <a href="http://www.michigan.gov/medicaidproviders">www.michigan.gov/medicaidproviders</a> >> Billing and Reimbursement >> Provider Specific Information.
<b>Box 28</b>	The total number of units the service is to be provided during the requested treatment period.
<b>Box 29</b>	The attending physician must indicate if this is an initial certification or a re-certification and sign and date. The attending physician's signature is required each time a request is made.
<b>Box 30</b>	The therapist certification is the signature of an authorized representative. The business office of a hospital may designate the director of the department providing the service as its representative. All unsigned requests will be returned for signature.
<b>Box 31-34</b>	MDHHS use only.

### **Form Submission**

PA request forms for all eligible Medicaid beneficiaries must be mailed or faxed to:

MDHHS - Medical Services Administration  
Program Review Division  
P.O. Box 30170  
Lansing, Michigan 48909

Fax Number: **(517) 335-0075**

To check the status of a PA request, contact the MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276**.

**OCCUPATIONAL THERAPY - PHYSICAL THERAPY –  
SPEECH THERAPY  
PRIOR APPROVAL REQUEST/AUTHORIZATION**

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)
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**The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.  
All fields must be completed and typewritten.**

2. TREATMENT SITE (Medicaid enrolled provider's name)		3. PROVIDER NPI NUMBER		4. PHONE NUMBER	
5. ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				6. FAX NUMBER	
7. BENEFICIARY NAME (LAST, FIRST, MIDDLE INITIAL)		8. SEX <input type="checkbox"/> M <input type="checkbox"/> F	9. MIHEALTH CARD NUMBER		10. BIRTH DATE
		11. ADM. DATE			13. ONSET DATE
12. ICD DIAGNOSIS(ES) CODE(S) AND DESCRIPTION(S) TO BE TREATED/EVALUATED					
14. THERAPIST NAME (LAST, FIRST, MIDDLE INITIAL)		15. OFFICE PHONE NUMBER		16. LICENSE/CERTIFICATION NUMBER	
17. TREATMENT AUTHORIZATION REQUEST <input type="checkbox"/> INITIAL <input type="checkbox"/> CONTINUING		18. LAST AUTHORIZATION	19. TREATMENT MONTHS		20. DATE STARTED
					21. # PREV. SESSIONS
22. GOALS (NOTE: SEE MEDICAID PROVIDER MANUAL FOR ADDITIONAL DOCUMENTATION REQUIREMENTS.)					
SHORT TERM GOALS			LONG TERM GOALS		
23. PROGRESS SUMMARY (NOTE: SEE MEDICAID PROVIDER MANUAL)					
24. SCHOOL THERAPY PROGRAMS <input type="checkbox"/> YES <input type="checkbox"/> NO				29. PHYSICIAN CERTIFICATION	
25. LINE NO.				I certify <input type="checkbox"/> re-certify <input type="checkbox"/> that I have examined the patient named above and have determined that skilled therapy is necessary; that services will be furnished on an in-patient and/or out-patient basis while the patient is under my care; that I approve the above treatment goals and will review every 30 days or more frequently if the patient's condition requires.	
26. PROCEDURE CODE					
27. MODIFIER					
28. TOTAL UNITS PER PA					
01					
02					
03					
04					
05					
				PHYSICIAN NAME (TYPE OR PRINT)	
				PHYSICIAN SIGNATURE	
				DATE	
<b>MDHHS USE ONLY</b>					
31. REVIEW ACTION: APPROVED <input type="checkbox"/> INSUFFICIENT DATA <input type="checkbox"/> DENIED <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED <input type="checkbox"/>		32. TREATMENT MONTHS APPROVED			
33. CONSULTANT REMARKS					
30. THERAPIST CERTIFICATION					
The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.					
THERAPIST SIGNATURE					
DATE					
34. CONSULTANT SIGNATURE				DATE	