STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

June 1, 2009

Dear Therapy Providers:

This letter is to inform you that effective July 1, 2009, the MSA-115 (Occupational Therapy-Physical Therapy-Speech Therapy Prior Approval Request/Authorization) form is being revised.

The wording in Box 12 of the form, and its instructions, are being revised to require both the ICD-9-CM diagnosis(es) code(s) and description(s) that will be evaluated and/or treated. The current version of the form requires only the description(s) of the diagnosis(es).

A copy of the form is attached for your information. The revised form is available from the Michigan Department of Community Health website at www.michigan.gov/medicaidproviders >>Policy and Forms >>Forms.

If you have any questions regarding this form, please contact the Dental/Special Services hotline at 1-800-622-0276.

Sincerely,

Stephen Fitton, Acting Director
Medical Services Administration

attachment

Michigan Department of Community Health

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. MDCH 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 Community Heath (MDCH) website 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
Box 1	MDCH use only.
Box 2 - 3	The Medicaid enrolled provider's name and National Provider Identifier (NPI).
Box 4 - 6	The provider's telephone number (including area code), address and fax number (including area code).
Box 7- 10	The beneficiary's name (last, first, and middle initial), sex, **mihealth** card number, and birth date (in the eight-digit format: MM/DD/YYYY). The information should be taken directly from the **mihealth** card and should be verified through the Michigan Eligibility Verification System.
Box 11	The date the beneficiary was most recently admitted to the hospital or facility.
Box 12	Enter the beneficiary's ICD-9-CM diagnosis(es) code(s) and description(s) that relate to the service being requested.
Box 13	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.
Box 14 -16	The therapist's name, office telephone number (including area code), and applicable license/certification number.
Box 17	**Initial:** The treatment authorization request is the initial prior authorization request for the beneficiary under this treatment plan. **Continuing:** 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.

Box Number(s)	Instructions
Box 18	The date MDCH signed the last approved prior authorization request for the given diagnosis.
Box 19	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).
Box 20	The date treatment was started for the given diagnosis (if treatment was initiated previously).
Box 21	The total number of sessions rendered since the development of this treatment plan.
Box 22	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.
Box 23	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.
Box 24	Indicate if the beneficiary is receiving therapy services through a school-based services program.
Box 25	Complete a separate line for each unique HCPCS code/modifier combination.
Box 26	The Outpatient Therapy and Home Health Databases on the MDCH website list the HCPCS Codes that describe covered services. The database is located at the MDCH website www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
Box 27	The Outpatient Therapy Database on the MDCH website lists the required modifiers used to describe covered services for outpatient hospital and nursing care facility providers. The database is located at the MDCH website www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
Box 28	The total number of units the service is to be provided during the requested treatment period.
Box 29	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.
Box 30	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.
Box 31-34	MDCH use only.

Form Submission

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

MDCH - 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 MDCH - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276.**

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

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

1. PRIOR AUTHORIZATION NUMBER (MDCH USE ONLY)

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 ☐ M ☐ F	9. MIHEALTH CARD NUMBER	10. BIRTH DATE	11. ADM. DATE
12. ICD-9-CM DIAGNOSIS(ES) CODE(S) AND DESCRIPTION(S) TO BE TREATED/EVALUATED				13. ONSET DATE

14. THERAPIST NAME (LAST, FIRST, MIDDLE INITIAL)	15. OFFICE PHONE NUMBER	16. LICENSE/CERTIFICATION NUMBER

17. TREATMENT AUTHORIZATION REQUEST ☐ INITIAL ☐ 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 ☐ YES ☐ NO

25. LINE NO.	26. PROCEDURE CODE	27. MODIFIER	28. TOTAL UNITS PER PA
01			
02			
03			
04			
05			

29. PHYSICIAN CERTIFICATION

I certify ☐ re-certify ☐ 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.

PHYSICIAN NAME (TYPE OR PRINT)

PHYSICIAN SIGNATURE DATE

MDCH USE ONLY

31. REVIEW ACTION:

- APPROVED ☐
- INSUFFICIENT DATA ☐
- DENIED ☐
- NO ACTION ☐
- APPROVED AS AMENDED ☐

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