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 requires that the MSA-115 be typewritten, handwritten forms will not be accepted. 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 >> Policy, Letters & Forms. The PA request 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 six 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 determination is received.

For complete information on covered services, PA, and documentation requirements, refer to the Therapy Services Chapter of the Michigan Medicaid Provider Manual located at the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual.

Attachments/Additional Documentation

All additional attachments/documentation submitted with the request must contain the beneficiary name and **mihealth** card number, provider name and address, and the provider's National Provider Identifier (NPI) number.

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

Form Completion

The following fields must be completed unless stated otherwise:

Box Number(s)	Instructions
Box 1	MDHHS use only.
Box 2 - 3	The Medicaid enrolled provider's name and 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 Community Health Automated Medicaid Processing System (CHAMPS) (Eligibility Inquiry and/or 270/271 transaction).
Box 11	The date the beneficiary was most recently admitted to the hospital or facility.
Box 12	Enter the beneficiary's 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 the treatment plan.
Box 18	The date MDHHS approved the last approved prior authorization request for the given diagnosis.
Box 19	The requested date range for which treatment is to be rendered, in a eight-digit format (e.g mm/dd/yyyy to mm/dd/yyyy).

Box Number(s)	Instructions
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 the 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 period 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 for additional documentation requirements.
Box 24	Indicate if the beneficiary is receiving therapy services through school-based services program.
Box 25	Indicate the treatment plan frequency (e.g., 1x/week, 3x/week, 1x/month, etc.) and duration per visit in 15-minute increments, i.e., units (e.g. 2 units/visit, 4 units/visit, etc.).
Box 26	Complete a separate line for each unique HCPCS code/modifiers combination.
Box 27	The Therapies Database on the MDHHS website lists the HCPCS codes that describe covered services. The database is located at the MDHHS website www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
Box 28	The Billing & Reimbursement Chapter in the Medicaid Provider Manual list the required modifiers used to describe covered services for therapy providers. The Medicaid Provider Manual is located at the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters, & Forms >> Medicaid Provider Manual.
Box 29	The total number of units the service is to be provided during the requested treatment period.
Box 30	The authorized prescribing practitioner must indicate if this is an initial certification or a re-certification and sign and date. Signature is required each time a request is made.
Box 31	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 32-35	MDHHS use only.

Form Submission:
PA request forms for all eligible Medicaid beneficiaries must be submitted electronically*, mailed or faxed to:

MDHHS – Program Review Division
P.O. Box 30170
Lansing, Michigan 48909
Fax Number: **(517) 335-0075**

If submitting electronically, the completed MSA-115 must be uploaded along with the supporting clinical documentation required.

To check the status of a PA request, contact the Program Review Division via telephone at **1-800-622-0276** or electronically via the **CHAMPS Provider Portal** located at https://milogintp.michigan.gov.

Authority: Title XIX of the Social Security Act.	**Completion**: Is voluntary but is required if payment from applicable programs is sought.
The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.	

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

1. PRIOR AUTHORIZATION NUMBER (MDHHS 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 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 / / to / /	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. TREATMENT REQUESTED
FREQUENCY:
DURATION VISIT: (UNITS)

26. LINE NO.	27. PROCEDURE CODE	28. MODIFIER	29. TOTAL UNITS PER PA
01			
02			
03			
04			
05			

30. 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 60 days or more frequently if the patient's condition requires.

PRESCRIBING PRACTITIONER'S NAME (TYPE OR PRINT)

PRESCRIBING PRACTITIONER'S SIGNATURE DATE

MDHHS USE ONLY

32. REVIEW ACTION:
- APPROVED ☐
- RETURNED ☐
- DENIED ☐
- NO ACTION ☐
- APPROVED AS AMENDED ☐

33. AUTHORIZATION PERIOD APPROVED

34. CONSULTANT REMARKS

☐ See CHAMPS

31. 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'S SIGNATURE DATE

35. CONSULTANT SIGNATURE DATE