MSA MEDICAL SERVICES ADMINISTRATION

# Bulletin

**Michigan Department of Community Health**

**Bulletin Number:** MSA 06-18

**Distribution:** Outpatient Hospitals
Rehab Facilities
Nursing Facilities
Home Health Agencies
Medical Suppliers

**Issued:** April 1, 2006

**Subject:** MSA-115 Prior Authorization Form Changes;
Speech Generating Device (SGD) Prior Authorization Criteria Changes

**Effective:** May 1, 2006

**Programs Affected:** Medicaid, Children's Special Health Care Services (CSHCS)

The purpose of this bulletin is to transmit changes to the Michigan Department of Community Health (MDCH) requirements for prior authorization (PA) requests submitted for occupational therapy, physical therapy and speech therapy services and for speech generating devices (SGD).

**MSA-115 Occupational Therapy - Physical Therapy - Speech Therapy Prior Approval Request/Authorization Form**

The MSA-115 is required for all therapy PA requests. The form has been modified to better reflect the current needs of both MDCH and providers. Effective May 1, 2006, only versions of the MSA-115 dated 03/06 will be accepted. All previous editions will be considered obsolete.

A copy of the updated MSA-115 and the associated completion instructions accompany this bulletin as an attachment.

An electronic copy of the MSA-115 can be found on the MDCH website at www.michigan.gov/mdch >>Providers>>Information for Medicaid Providers>>Medicaid Provider Forms and Other Resources. The Word version of the form is fill-in enabled. Box 22 "Goals" and Box 23 "Progress Summary" will expand to accommodate the necessary text entered into these fields. The PDF version of the form allows for viewing and printing only.

**SGD Prior Authorization Requests**

PA is required for all SGDs. Currently, PA requests are submitted to MDCH on the MSA-1653-C. Effective May 1, 2006, MDCH will no longer accept the MSA-1653-C. Instead, MDCH will require that certain documentation be submitted for all original and replacement/upgrade SGD prior authorization requests submitted using the MSA-115. The documentation requirements are as follows:

| | Original Device | Replacements and Upgrades |
|---|---|---|
| **Demographic Information** | | |
| Beneficiary Name | X | X |
| Beneficiary Medicaid Identification Number | X | X |
| Referring Physician | X | X |
| Referring Physician Specialty | X | X |
| Medical Diagnosis | X | X |
| Medical Diagnosis Onset Date | X | X |
| **SLP Evaluation** | | |
| SLP Name and Credentials | X | X |
| Current Level of Therapy or Support Services (Include Frequency and Duration) | X | |
| Cognitive Level (Include Assessments and Testing Used, Results, Evaluator, Date) | X | X |
| Communication (Include Assessment Tools and Testing, Evaluator, Date) | X | X |
| • Both Expressive and Receptive Testing Results | X | X |
| • Developmental Age in Years | X | X |
| • Prognosis for Functional Oral Speech | X | X |
| Current Communication Skills (With and Without SGD) | X | |
| Oral Examination (Include Test Results, Evaluator, Date) | X | |
| Status of the Patient | X | |
| • Current Hearing Status | X | |
| • Current Vision Status | X | |
| • Current Educational Status | X | |
| • Current Employment Status | X | |
| List of Interactive Settings in Which SGD Will Be Used | X | |
| Daily Functional Communication Needs | X | |
| • To enable the meeting of physical needs | X | |

| | Original Device | Replacements and Upgrades |
|---|---|---|
| • To carry out family and community interactions | X | |
| • To obtain necessary medical care and participate in medical decision making | X | |
| Treatment Plan, which includes: | X | |
| • Follow-Up Training in Use of the Device | X | |
| • Communication Goals | X | |
| • Timeline | X | |
| • Acknowledgement of Caregiver Participation and Support | X | |
| Reassessment Report | | X |
| Assessment and Effectiveness of Currently Used Device | | X |
| Purchaser of Currently Used Device | | X |
| **OT/PT Evaluation/Report** | | |
| OT/PT Name and Credentials | X | X |
| Functional Ambulation/Mobility | X | |
| SGD Positioning Requirements | X | |
| Description of Physical Change Since Last Device Recommendation | | X |
| Patient Ability to Directly Access Currently Used SGD | | X |
| **Experience with Communication Technology** | | |
| Chronological listing by Date, Device and Experience | X | X |
| **Device Trials and Outcomes** | | |
| Evaluator Name(s) and Credentials | X | X |
| Evaluation of Experience by Device (Include With and Without Modifications and Accommodations) | X | X |
| **Device Recommendation and Reasoning** | | |
| Make and Model of Recommended Device | X | X |
| Reasoning for Recommendation Based on Evaluations, Trials and Outcomes | X | X |
| Functional Benefit of Upgrade | | X |

**Manual Maintenance**

The provider should retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

**Questions**

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

**Approved**

Paul Reinhart, Director
Medical Services Administration

**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 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 MDCH website www.michigan.gov/mdch >> Providers >> Information for Medicaid Providers >> Medicaid Provider Forms and Other Resources. 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 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 Therapy, 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 Medicaid ID number, provider name and address, and the provider's Medicaid ID 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 on the MSA-115 unless stated otherwise:

| Box Number(s) | Instructions |
|---|---|
| **Box 1** | The prior authorization number issued by MDCH if the service is authorized. The provider must enter this number on the claim when billing. If the service is denied, no number will be assigned to the request. |
| **Box 2 - 4** | The Medicaid enrolled provider's name, provider type code, and seven-digit identification number are used to identify the provider. The information should be taken directly from the Medical Assistance Enrollment Turn-Around Form, page 2. |
| **Box 5 - 6** | The provider's telephone number (including area code) and mailing address (must correspond with the treatment site). |
| **Box 7- 10** | The beneficiary's name (last, first, and middle initial), sex (M or F), Medicaid ID number, and birth date (in the six-digit format: month, day, year) identifies the beneficiary. 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** | The diagnosis for which the beneficiary requires therapy. |
| **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. |

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 17** | **Initial:** The treatment authorization request is the initial prior authorization request for this 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. |
| **Box 18** | 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 19** | The date treatment was started for the given diagnosis (if treatment was initiated previously). |
| **Box 20** | The date MDCH signed the last approved prior authorization request for the given diagnosis. |
| **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). |
| **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. |
| **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 or Home Health Databases on the MDCH website list the HCPCS Codes that describe covered services. (Refer to the Michigan Medicaid Provider Manual, Directory Appendix for website information.) |
| **Box 27** | The Outpatient Therapy or Home Health Databases on the MDCH website list the required modifiers used to describe covered services. (Refer to the Michigan Medicaid Provider Manual, Directory Appendix for website information.) |
| **Box 28** | The 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 the MSA-115. The attending physician's signature is required each time a request is made unless a signed treatment plan is included with the request. |
| **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** | For the MDCH consultant's use only upon review of the request. The service will be approved by MDCH as presented, approved as amended, or denied. If all or part of the plan is approved, a Prior Authorization Number will be assigned in Box 1. |

**Form Submission**

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

MDCH Prior Authorization Division
P.O. Box 30170
Lansing, Michigan 48909

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

To check the status of a PA request, contact the MDCH Prior Authorization 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)

(All fields must be typewritten.)

| 2. TREATMENT SITE | 3. TYPE | 4. PROVIDER I.D. NUMBER | 5. PHONE NUMBER |
|---|---|---|---|
| | | | |

6. ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)

| 7. BENEFICIARY NAME (LAST, FIRST, MIDDLE INITIAL) | 8. SEX | 9. MEDICAID I.D. NUMBER | 10. BIRTH DATE | 11. ADM. DATE |
|---|---|---|---|---|
| | | | | |

| 12. DIAGNOSIS 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. TREATMENT MONTHS | 19. DATE STARTED | 20. LAST AUTH. | 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. 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

| 32. APPROVED AS: | | 33. TREATMENT MONTHS APPROVED | 34. CONSULTANT SIGNATURE DATE |
|---|---|---|---|
| PRESENTED ☐ | DENIED ☐ | | |
| AMENDED ☐ | NO ACTION ☐ | | |
| | INSUFFICIENT DATA ☐ | | |

**Approval refers to services and does not guarantee beneficiary eligibility.**