**Michigan Department of Health and Human Services**
**Completion Instructions for MSA-181**
**Home Health Aide Prior Approval Request/Authorization**

## General Instructions

The MSA-181 must be used by Medicaid enrolled and home health agencies to request Prior Authorization (PA) for home health aide services. MDHHS requires that the MSA-181 be typewritten; handwritten forms will not be accepted. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Forms.

This form must be used to request Prior Authorization (PA) for home health aide services for beneficiaries with Medicaid. A request to begin services may be submitted by a person other than the home health agency such as the hospital Discharge Planner or physician. When this is the case, the person submitting the request must do so in consultation with the beneficiary (parent or guardian if applicable), and home health agency who will be assuming responsibility for the care of the beneficiary.

PA may be authorized for a period not to exceed ninety days. If need for home health aide services are medically 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.

Refer to the Medicaid Provider Manual, Home Health Chapter, Prior Authorization Subsection, for the listing of required documentation to accompany each request.

Completion of this form is as follows:

| Item# | Instructions |
|---|---|
| **1** | Prior Authorization Number. MDHHS use only. |
| **2** | The Home Health Agency Provider Name. |
| **3** | The Medicaid enrolled provider's name and National Provider Identifier (NPI). |
| **4-9** | The Home Health Agency provider's telephone number (including area code), address and fax number (including area code). |
| **10** | **Initial:** The authorization request is the initial prior authorization request for the beneficiary under this treatment plan.<br>**Continuing:** The treatment authorization request is to continue treatment for additional calendar month(s) of service under this treatment plan. |
| **11-19** | Beneficiary information. Provide complete name, sex, mi health card number, date of birth, complete address (including city, state, and zip code), and phone number. |
| **20-21** | Enter the beneficiary's diagnosis(es) code(s) and and onset date that relate to the service being requested. |
| **22** | The beneficiary's most recent hospital discharge date for the requesting prior authorization period. |
| **23-25** | Hospital information including complete address and phone number, anticipated discharge date, and name and contact information of Discharge Planner, if beneficiary is currently hospitalized. |
| **26** | The start date of the last approved authorization period. |
| **27** | The previous total number of home health aide visits rendered (since services were first started). |
| **28** | The date home health services were first started. |
| **29** | For this current request being submitted, indicate requested start and end dates, total quantity of procedure code G0156 (i.e. visits) requested, and the planned visit frequency during the requested authorization period. |
| **30** | Indicate if the current authorization request is an increase or decrease from previous authorization, or if a change is being requested for the currently approved authorization period. |
| **31** | List the beneficiary's current medications relevant to the medical diagnosis. |
| **32** | Documentation of the beneficiary's cognitive status. |
| **33** | Identify the beneficiary's ability to complete range of motion for upper and lower extremities. |

| | |
|---|---|
| **34** | Evaluation includes OASIS coding of the beneficiary.<br><br>**OASIS Coding**<br>06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper.<br>05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.<br>04 **Supervision or touching assistance** – Helper providers VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.<br>03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.<br>02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.<br>01 **Dependent** – Helper does ALL the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.<br>**If activity was not attempted, code reason:**<br>07 **Patient refused**<br>09 **Not applicable**<br>88 Not attempted due to **medical condition or safety concerns** |
| **35** | Indicate the service and frequency of the service for this authorization request. |
| **36** | Identify the medical need for additional services. Service request must be specific, include supportive documentation of the beneficiary's current level of function and the medical necessity of requested service(s). |
| **37** | List all other services in the home. Must include the frequency of the service(s) and payer(s). Failure to disclose all services in the home may result in recoupment of Medicaid dollars for home health aide reimbursement. |
| **38** | Signature certifies that Parent/Guardian of beneficiary attests that information provided on this form is accurate and complete to the best of their ability. All unsigned requests will be returned for signature. |
| **39** | The physician, nurse practitioner, clinical nurse specialist, or physician assistant's signature certifies that (1) the Home Health agency requesting the services understands the medical necessity for obtaining prior authorization for Home Health services and; (2) the information provided on this form is accurate and complete. All unsigned requests will be returned for signature. |
| **40** | The licensed supervising professional's signature certifies that (1) the licensed, registered nurse, physical therapist, occupational therapist, or speech/language therapist provides supervision of the home health aide; (2) the services are medically necessary for obtaining prior authorization for Home Health aide services and; (3) the information provided on this form is accurate and complete. All unsigned requests will be returned for signature. |
| **41-42** | MDHHS use only |

**RETURN COMPLETED FORM AND REQUIRED DOCUMENTATION TO:**

MDHHS
Program Review Division
PO Box 30170
Lansing, MI 48909

OR

Fax to: 517-335-0075

Questions should be directed to MDHHS – Health Services, Program Review Division via telephone at **1-800-622-0276.**

| | |
|---|---|
| **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 (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy. | |

# HOME HEALTH AIDE
# PRIOR APPROVAL REQUEST/AUTHORIZATION

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

The provider is responsible for eligibility verification.
Approval does not guarantee beneficiary eligibility or payment.

| 1. Prior Authorization Number (MDHHS USE ONLY) |
|---|
| |

**MDHHS requires this form to be typewritten; handwritten forms will not be accepted.**

| 2. Home Health Agency Provider Name | 3. Provider NPI Number | 4. Provider Phone Number | 5. Provider Fax Number |
|---|---|---|---|
| | | | |

| 6. Home Health Agency Provider Address (Number, Street, Building, Suite Number, etc.) | 7. City | 8. State | 9. Zip Code |
|---|---|---|---|
| | | | |

10. Home Health Aide Authorization Request ☐ Initial ☐ Continuing

| 11. Beneficiary Name (Last, First, Middle Initial) | 12. Beneficiary Date of Birth | 13. Sex | 14. mihealth ID Number | 15. Beneficiary Telephone Number |
|---|---|---|---|---|
| | | ☐ M ☐ F | | - - |

| 16. Beneficiary Address (Number, Street, Apt/Lot, etc.) | 17. City | 18. State | 19. ZIP Code |
|---|---|---|---|
| | | | |

| 20. Medical ICD Diagnosis(es) Code(s) Requiring Home Health Services | 21. Onset Date | 22. Most Recent Hospital Discharge Date |
|---|---|---|
| | | |

| 23. Primary Caregiver(s) | 24. Relationship(s) to Beneficiary | 25. Primary Caregiver(s) Phone Number(s) |
|---|---|---|
| | | - - |
| | | - - |

| 26. Date of Last Authorization | 27. Number of Previous Visits | 28. Date Home Health Aide Service(s) Started | 29. Current Request | 30. Number of Visits Requested compared to Last Authorization |
|---|---|---|---|---|
| | | | Requested Start Date:<br>Requested End Date:<br>Requested Qty Code G0156:<br>Visit Frequency: | ☐ Increase<br>☐ Decrease<br>☐ Change to current authorization |

**Beneficiary's Current Functional Level and Services**

31. List Current Medications:

32. Cognitive: ☐ Alert/oriented ☐ Able to Direct Care ☐ Impaired/Developmental Delay ☐ Disoriented ☐ Unresponsive

33. Range of Motion Exercises: Upper Extremity: ☐ Independent ☐ Requires Assistance / Dependent

Lower Extremity: ☐ Independent ☐ Requires Assistance / Dependent

| 34. SCORE: (see instructions) | 06 | 05 | 04 | 03 | 02 | 01 | 07 | 09 | 88 | 35. Services & frequency to be performed by aide |
|---|---|---|---|---|---|---|---|---|---|---|
| Bathing/Skin Care | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Toileting | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Grooming | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Oral Hygiene | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dressing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eating | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Transfers | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Positioning | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ambulation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Medication Management, if applicable | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Laundry | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Shopping | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vital Signs | | | | | | | | | | ☐ |

36. Other Services (Must specify service(s) include documentation of current level of function and medical necessity for each)

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

Beneficiary Name: _____ mihealth ID Number: _____

| 37. Other Services Currently Received By Beneficiary (Check All) | | | | Frequency | Payer |
|---|---|---|---|---|---|
| Skilled Nursing Visits | ☐ No | ☐ Yes | | | |
| Private Duty Nursing | ☐ No | ☐ Yes | | | |
| Physical Therapy | ☐ No<br>☐ Home | ☐ Yes<br>☐ School | ☐ Outpatient | | |
| Occupational Therapy | ☐ No<br>☐ Home | ☐ Yes<br>☐ School | ☐ Outpatient | | |
| Speech Therapy | ☐ No<br>☐ Home | ☐ Yes<br>☐ School | ☐ Outpatient | | |
| Home Help | ☐ No | ☐ Yes | | | |
| Community Living Services (CLS) | ☐ No | ☐ Yes | | | |
| Other Behavioral Health Services | ☐ No | ☐ Yes | Specify: | | |
| Waiver Services | ☐ No | ☐ Yes | Specify: | | |
| Hospice | ☐ No | ☐ Yes | | | |
| Other Services | ☐ No | ☐ Yes | Specify: | | |

☐ Home Health Agency Plan of Care Attached (Most Recent Plan Of Care Must Accompany Request)

☐ Copy of Oasis Must Be Attached With Initial Request And Annually Thereafter

**38. PATIENT (PARENT / GUARDIAN IF APPLICABLE) CERTIFICATION**

I, the patient (parent/guardian) named above, understand the necessity to request prior authorization for the medically necessary services indicated. I understand that services requested herein require prior authorization and, if approved and submitted by the agency on the appropriate invoice, payment of authorized services will be from general and/or state funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.

PATIENT NAME (PARENT / GUARDIAN)

PRINTED

SIGNATURE DATE

**39. PRACTITIONER CERTIFICATION**

I certify that I have examined the patient named above and have determined that home health aide services are medically necessary, as supervised by a licensed, registered nurse or other authorized licensed professional. I understand that home health aide services require prior authorization to validate that such services are deemed medically necessary in accordance with Michigan Medicaid Provider Manual policy. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.

PRACTITIONER NAME

PRINTED

SIGNATURE DATE

**40. LICENSED SUPERVISING PROFESSIONAL CERTIFICATION**

I hereby attest as a licensed professional (registered nurse, physical therapist, occupational therapist, or speech/language pathologist) that supervision of the home health aide is under my authority and deemed medically necessary. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment of approved services will be from federal and/or state funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.

SUPERVISING PROFESSIONAL NAME

PRINTED

SIGNATURE DATE

## MDHHS USE ONLY

41. REVIEW ACTION:

☐ APPROVED ☐ DENIED
☐ RETURN ☐ NO ACTION
☐ APPROVED AS AMENDED

42. CONSULTANT REMARKS AND AUTHORIZATION PERIOD IF APPROVED:

☐ See CHAMPS ☐ KEEP IN FILE

☐ KEEP IN FILE

☐ KEEP IN FILE

CONSULTANT SIGNATURE / DATE